Medical Management Policy

**Service:** Back and Nerve Pain Procedures - Radiofrequency Ablation, Facet and Other Injections

*PUM 250-0035-1706*

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<thead>
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<th>Medical Policy Committee Approval</th>
<th>05/31/19</th>
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<td>Effective Date</td>
<td>10/01/19</td>
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<tr>
<td>Prior Authorization Needed</td>
<td>Yes</td>
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**Disclaimer:** This policy is for informational purposes only and does not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may or may not provide coverage for all services listed in this policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact customer services as listed on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG to assist in administering health benefits. This medical policy and MCG guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG, email [medical.policies@wpsic.com](mailto:medical.policies@wpsic.com).

**Related Medical Policies:**

- Back Pain Procedures-Epidural Injections
- Back Pain Procedures-Sacroiliac Joint and Coccydynia Treatments
- Non-covered Services and Procedures

Pain injection services are **subject to medical necessity review.** If a limit is not specified in the member’s health plan, the maximum follows the medical necessity guidelines in this policy. If a year is not described in the member health plan (e.g. per calendar year), a year is defined as the 12-month period starting from the date of service of the first approved injection.

**Description:** A **facet joint injection** is the injection of a local anesthetic with or without steroid into one or more of the facet joints of the spine. A **medial branch nerve block** is an injection of a local anesthetic near the medial branch nerves that innervate the facet joint. Both the diagnostic facet joint injection and the diagnostic medial branch nerve block are performed to determine whether the facet joint is the source of the pain symptoms, in order to guide future treatment such as neuroablation.

This policy addresses diagnosis of facet joint pain using **diagnostic** facet and medial branch block injections **in preparation for treatment of non-radicular* spine pain using neuroablation.** **Therapeutic** facet and medial branch injections are considered experimental, investigational, and unproven to affect health outcomes.

Non-pulsed Continuous Radiofrequency Ablation / Neuroablation (CRFA or RFA) is also known as thermal radiofrequency (RF) ablation, percutaneous radiofrequency facet denervation (RF denervation), RF coagulation, RF lesioning, RF neurolysis, RF facet joint rhizotomy, or facet...
neurotomy. The procedure is used to interrupt pain impulses. It involves placement of a needle or electrode that destroys the nerves around the facet joint.

*For purposes of this policy, **non-radicular (axial) pain** is pain that does **not** follow the pattern of radiation from the spine into the extremity along the course of the spinal nerve root. **Radicular pain** is pain that radiates from the spine into the extremity along the course of the spinal nerve root, following the pattern of the sensory dermatome associated with the irritated nerve root(s) identified. Radicular pain may also be described as a burning or tingling sensation.

**Indications of Coverage:**

A. **Initial diagnostic** facet joint injection / medial branch block (MBB) injection of the cervico-lumbar spine region is considered medically necessary when **ALL** the following criteria (1 through 6 below) are met:

1. Documentation states that the injection(s) is / are for diagnostic purpose in preparation for neuroablation.

2. Documentation of chronic axial low back or neck pain symptoms for at least three (3) months **without** radicular pain symptoms (unless the provider documents the coexistence of both radicular and axial symptoms).

3. Within the last six months, the individual has completed a 6-week trial of medications such as anti-inflammatories, muscle relaxants, analgesics, opioids, gabapentin, and pregabalin.

4. Within the last six months, the individual has completed a 6-week trial of physical therapy (PT) or chiropractic manipulations (performed after the current episode of symptoms started and directed toward the area of symptoms/dysfunction).

   **Note:** Documentation of therapy administered by a Certified Athletic Trainer or regular participation in a program such as the Arthritis Foundation Exercise Program may also meet medical criteria for therapy.

   **Note:** If the symptoms are severe (requiring urgent medical care), the trial of conservative treatments (number 3 and / or 4 above) may not be required.

5. Symptoms are not caused by another identified source (such as disc herniation, radiculitis, spinal stenosis, tumor, infection, or fracture)

6. Documentation of average pain levels of 6 or greater on a scale of 0 to 10, or intermittent or continuous pain causing functional disability.

B. **A confirmatory** (second) facet joint injection / medial branch block (MBB) injection of the cervico-lumbar spine region is considered medically necessary when **ALL** the following criteria (1 through 5 below) are met:

1. All criteria listed in Indications of Coverage, letter A, 1 through 6 above, are met.
2. The initial / first diagnostic facet joint injection/medial branch block must have provided significant (at least 50%) relief from baseline pain scores following the procedure. (If the initial / first diagnostic injection / block does not provide at least 50% relief, a confirmatory / second diagnostic injection or block is considered not medically necessary).

3. Documentation of the individual’s ability to perform previously painful maneuvers following the initial / first facet joint injection / medial branch block.

4. The confirmatory (second) diagnostic injection procedure must be performed at the same side and same level as the initial injection using an anesthetic with a different duration of action.

5. The confirmatory (second) diagnostic injection procedure must be performed at least one week after the initial injection procedure.

   **Note:** Prior authorization is required for each diagnostic facet injection/medial branch block.

   **Note:** A maximum limit of two (2) diagnostic facet or medial branch block sessions in the cervical spine region and a maximum limit of two (2) diagnostic facet or medial branch block sessions in the lumbar spine region may be allowed per year*. If the left and right injections are performed on two separate dates of service, this will count as two (2) sessions, unless otherwise approved by the Health Plan’s Medical Director. *If a year is not described in the member health plan (e.g. per calendar year), a year is defined as the 12-month period starting from the date of service of the first approved injection.

C. **Neuroablation** of the cervical or lumbar spine region is considered medically necessary when **ALL** of the following (1 through 5 below) are met:

1. All criteria listed in Indications of Coverage, letter A above are met.

2. All criteria listed in Indications of Coverage, letter B above are met.

3. Documentation of appropriately performed positive diagnostic and confirmatory cervical or lumbar facet or medial branch anesthetic blocks. (Due to the high rate of placebo effect and confounding variables such as addition of steroid to the injection, a confirmatory injection, using an anesthetic with a different duration of action than the initial diagnostic block is required).

4. Each level and side to be ablated must have documentation of a positive (provided at least 50% relief of symptoms) diagnostic and confirmatory facet joint injection / medial branch block.

5. If chemical agents (for example phenol or alcohol) are planned for the neuroablation procedure, there must be documentation of the contraindication to thermal neuroablation (for example, spinal instrumentation, pacemaker, implantable cardiac defibrillator).
**Note:** If the criteria for neuroablation are met, a maximum of one (1) neuroablation date of service per side (left or right), per spinal region (cervical or lumbar) in a 6 month period is considered medically necessary.

**Note:** Fluoroscopic or CT (computed tomography) guidance is required during medial branch neuroablation, facet injections, and medial branch blocks.

**D. Repeat Neuroablation** of the cervical or lumbar spine region is considered medically necessary when **ALL** of the following (1 through 6 below) are met:

1. The criteria listed in Indications of Coverage, letter C, were met for the initial / prior neuroablation.

2. The repeat neuroablation is at the same location (level and side) as the initial / prior neuroablation.

3. There is documentation of at least a 50% pain reduction that lasted over at least six (6) months following the initial/prior neuroablation.

4. Cervical or lumbar spine region symptoms recur after six (6) months **and** the symptomatology is similar to the previous.

5. The initial / prior neuroablation was performed within eighteen (18) months of the planned repeat neuroablation.

6. If chemical agents (for example phenol or alcohol) are planned for the ablation procedure, there must be documentation of the contraindication to thermal neuroablation (for example, spinal instrumentation, pacemaker, implantable cardiac defibrillator).

**Note:** Repeat diagnostic facet injection / medial branch block in preparation for repeat neuroablation are considered not medically necessary, unless the prior neuroablation was greater than 18 months ago.

**Note:** The requirement for physical therapy / chiropractic manipulation may be waived before repeat neuroablation if the member has had successful neuroablation within the past eighteen (18) months at the same level and side, for the same condition, with relief of at least six (6) months.

**E. Trigger Point Injections:** Trigger point injections do not require prior authorization. An initial trigger point injection session for the treatment of myofascial pain syndrome using local anesthetic, with or without steroid is considered medically necessary when all of the following are met:

1. There is (are) palpable trigger point(s)

2. Within the last six months, the individual has completed a 6-week trial of conservative therapy including medications such as anti-inflammatories, muscle
relaxants, or analgesics (unless contraindicated), physical therapy or activity modification.

F. **Repeat Trigger Point Injections**: May be performed (up to the maximum listed below) when all of the following are met:

1. The individual is experiencing a return of pain or decrease in function since the initial or previous trigger point injection(s).

2. The individual experienced at least a 50% reduction in pain and/or symptoms following the previous injection(s).

3. At least 2 months have passed since the performance of previous trigger point injection(s).

**Note**: If the criteria for trigger point injections are met, a maximum limit of 6 trigger point injection sessions (regardless of location) per year* may be considered medically necessary. This includes all initial and repeat trigger point injection sessions. *If a year is not described in the member health plan (e.g. per calendar year), a year is defined as the 12-month period starting from the date of service of the first approved injection.

**Limitations of Coverage:**

A. Review health plan and endorsements for exclusions and prior authorization or benefit requirements.

B. If used for a condition or diagnosis other than is listed in the Indications of Coverage, it will be denied as experimental, investigational, and unproven to affect health outcomes.

C. If used for a condition/diagnosis that is listed in the Indications of Coverage, but the criteria are not met, it will be denied as not medically necessary.

D. Therapeutic injections including: facet joint, medial branch block injections (MBB), zygapophysial joint injection, paravertebral facet joint injection, dorsal ramus injection, posterior ramus injection, and pars interarticularis injections will all be denied as experimental, investigational, and unproven to affect health outcomes.

E. Destruction of the medial branch nerve by any method other than thermal neuroablation (for example, cryoablation or phenol), without documentation of the contraindication to thermal ablation, will be denied as experimental, investigational, and unproven to affect health outcomes.

F. Neuroablation is considered investigative/unproven (and will be denied) in ANY of the following situations as there is insufficient peer-reviewed scientific literature supporting neuroablation in these situations:
1. When fluoroscopic or computed tomography (CT) guidance is not used during the procedure.

2. For any nerve other than the medial branch nerve (including but not limited to occipital, genicular, sphenopalatine, supraorbital, and supratrochlear nerves). See also: Non-Covered Services and Procedures medical policy.

3. When there is no diagnostic block to identify the appropriate level and side to be treated.

4. When pulsed radiofrequency, also known as: cold radiofrequency, cold ablation, pulsed radiofrequency (PRF), or pulsed radiofrequency ablation (PRFA), is used.

G. Injection or neuroablation of lumbar or sacral facets or medial / lateral nerve branches or dorsal rami for treating sacroiliac joint pain will be denied as experimental, investigational, and unproven to affect health outcomes. See medical policy, Back Pain: Sacroiliac and Coccydynia Treatments.

H. The following treatments for management of back/ buttocks pain or sacroiliac (SI) joint dysfunction will be denied as experimental, investigational, and unproven to affect health outcomes: Sacroiliac joint ablation, sacroiliac neuroablation, sacroiliac fusion, diagnostic lateral (sacral) branch nerve blocks and diagnostic sacroiliac joint injections in preparation for an ablation or fusion. See medical policy, Back Pain: Sacroiliac and Coccydynia Treatments.

I. Neuroablation will be denied as not medically necessary when it is performed less than six (6) months after a previous neuroablation procedure in the same spinal region.

J. Neuroablation (facet neurotomy) and facet injection / medial branch block (MBB) of the thoracic or sacral spine (except L5-S1 medial branch block) will be denied as experimental, investigational, and unproven to affect health outcomes in both diagnostic and therapeutic settings.

K. Neuroablation (facet neurotomy) for treatment of cervicogenic headache will be denied as experimental, investigational, and unproven to affect health outcomes.

L. Laser facet denervation will be denied as experimental, investigational, and unproven to affect health outcomes.

M. Injection of a caustic agent such as phenol, alcohol, or sodium morrhuate into a facet joint will be denied as experimental, investigational, and unproven to affect health outcomes.

N. If the use of fluoroscopic or computed tomography (CT) guidance is not documented, the facet joint injection or medial branch nerve block will be denied as experimental, investigational, and unproven to affect health outcomes.

O. A facet joint injection and / or medial branch nerve block performed for primary radicular symptoms or other unexplained neurologic symptoms will be denied as not medically necessary.
P. A facet joint arthrogram in conjunction with a facet joint injection is included in the fluoroscopic guidance for the injection, is considered an integral component of the procedure, and is not reimbursed separately.

Q. More than two (2) diagnostic facet or medial branch block sessions per covered spinal region (cervical or lumbar) in a year are considered not medically necessary. **If the left and right injections are performed on two separate dates of service, this will count as two (2) sessions.**

R. If more than one type of pain treatment is requested / performed on the same day, only **one** type will be considered medically necessary at the discretion of the health plan. The other will be denied as not medically necessary.

S. Cryoablation for the treatment of lumbar facet joint pain will be denied as experimental, investigational, and unproven to affect health outcomes.

T. Ultrasound guidance for facet injection, medial branch block, or trigger point injection will be denied as experimental, investigational, and unproven to affect health outcomes.

U. Performing a session involving both the lumbar and cervical regions on the same date of service is considered not medically necessary.

V. Destruction or neurolysis of the medial branch nerve, or any other nerve, by any method other than thermal neuroablation (e.g., chemical, cryotherapy, or electrical) is typically considered experimental, investigational and unproven to affect health outcomes and requires review by the Health Plan’s Medical Director for rare instances of medical necessity.

W. Ablation, cryotherapy, or treatment intended to cause nerve dysfunction (e.g. iovera, Coolief) will be denied as experimental, investigational, and unproven to affect health outcomes.

X. The following nerve blocks or neurablations including, but not limited to, sphenopalantine ganglion, occipital, dorsal root ganglion, genicular, peripheral nerve for knee pain, and cluneal will be denied as experimental, investigational, and unproven to affect health outcomes.

Y. Ganglion impar block or radiofrequency thermocoagulation for the treatment of chronic coccydynia will be denied as experimental, investigational, and unproven to affect health outcomes.

Z. Intraosseous radiofrequency ablation of the basivertebral nerve (e.g., The Intracpect Procedure / Intracpect Intracoeceous Nerve Ablation System®) will be denied as as experimental, investigational, and unproven to affect health outcomes.

AA. Occipital Neurectomy/Nerve Decompression (supra orbital, supratrochlear, zygomaticotemporal or greater occipital nerve) for treatment of headache or occipital
neuralgia will be denied as experimental, investigational, and unproven to affect health outcomes.

BB. Dry needling of trigger points will be denied as experimental, investigational, and unproven to affect health outcomes.

CC. Monitored anesthesia care (MAC) for adults for trigger point injections, medial branch blocks, or facet joint injections will be denied as not medically necessary.

**Documentation Required:**

- Office notes including documentation of the symptoms that suggest the presence of facet joint pathology and exclude any correctable spinal pathology condition (for example, spinal cord tumor, severe spinal stenosis, infection, or intervertebral disc disease requiring surgical treatment, such as a large disc herniation)

- Documentation of the failure of conservative therapies (Physical therapy notes, chiropractic treatment notes, medication trials)

- For the second (confirmatory) injection / block: Office notes documenting the results of the first injection / block. Documentation of the effect of the initial / first injection may include a patient diary or office telephone records.

**WPS/Arise Review History:**

**Back Pain Procedures - Radiofrequency Ablation, Facet Joint Injection, and others**

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<td>06/03/16, 06/16/17, 06/15/18, 05/31/19</td>
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<tr>
<td>Revised</td>
<td>Errata correction 10/25/16. 06/16/17 (includes title change), 06/15/18, 05/31/19</td>
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<td>Developed</td>
<td>06/03/016 - New consolidated policy developed</td>
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10/25/17 Errata: Under indications: **Neuroablation of the cervical… corrected to Neuroablation/facet injection of the cervical…**

**Facet Joint Injection and Medial Branch Block:** *Retired to Back Pain Procedures - Radiofrequency Ablation, Facet Joint Injection, and others*

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Medial Branch Neuroablation. *Retired to Back Pain Procedures - Radiofrequency Ablation, Facet Joint Injection, and others

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Sacroiliac Joint Treatments and Coccydynia Injections* Retired to Back Pain Procedures - Radiofrequency Ablation, Facet Joint Injection, and others. Coccydynia Injections also retired to Back Pain Procedures – Epidural Injections

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<td>09/12/14, 09/11/15, Retired 06/03/16 effective 09/30/16, Reinstated 06/16/17 as Back Pain: Sacroiliac and Coccydynia Treatments. Further review history dates are documented on the reinstated medical policy.</td>
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- Note: For review/revision history prior to 2014 see previous Medical Policy or Coverage Policy Bulletin

Approved by the Medical Director