Interventional Pain Management

Origination: 5/21/08	**Revised:** 8/11/20	**Annual Review:** 12/19/23
Line of Business: Commercial Only ☐ QHP/Exchange Only ☐ Medicare Only ☐ Commercial & QHP/Exchange ☐ Commercial, QHP/Exchange, & Medicare ☒		

Purpose:

To provide interventional pain management clinical coordination criteria for Population Health and Provider Alliances associates to reference when making benefit determinations.

Coverage Guidelines

The following procedures are considered medically necessary after the following criteria are met:

A. Facet joint injections: considered appropriate in the management of chronic back or neck pain (pain lasting more than two [2] months despite appropriate conservative treatment) when used either as a diagnostic trial to determine the origin of the Member's pain; to establish the effectiveness of the facet injections in relieving the Member's pain; or to achieve a therapeutic effect.

Frequency: A set of facet joint injections, under direct guidance (Fluoro, CT, or U/S), is appropriate for up to three (3) levels per sitting and can be repeated up to three (3) times every 6 (six) months with intervals of 2-3 weeks or longer between injections, provided that >50% relief is obtained.

Facet joint injections are not covered for any other indications.

B. Trigger point injections: Considered appropriate for treating chronic neck or back pain or myofascial pain syndrome, when *all* of the following section criteria are met:
   - Trigger points have been identified by palpation, *and*
   - Symptoms have persisted for more than three (3) months, *and*
   - Conservative therapies such as bed rest, exercises, heating or cooling modalities, massage, and medications such as non-steroidal anti-inflammatory medications, muscle relaxants, non-narcotic analgesics should have been tried and failed.

Frequency: up to four (4) sets of injections are considered medically necessary to diagnose the origin of a Member's pain and achieve a therapeutic effect but should not be performed more frequently than once every two (2) months up to a maximum of six (6) times per year, provided that >50% relief is obtained for six (6) weeks.

Trigger point injections are not covered for any other indications.

C. Sacroiliac joint injections: Considered appropriate to relieve lumbosacral pain present for more than three (3) months.

Frequency: It is rarely medically necessary to repeat sacroiliac injections more than frequently than once every two (2) months. If approved, can authorize up to two (2) sacroiliac injections as considered medically necessary to diagnose the Member's pain and achieve a therapeutic effect but should not be performed more frequently than once every two (2) months for a maximum of six (6) times over a one (1) year period provided that >50% relief is obtained for six (6) weeks.

Sacroiliac joint injections are not covered for any other indications.

D. Epidural injections: Considered appropriate in the outpatient setting for management of back or neck pain when *all* of the following are met:
- Intraspinal tumor or other space-occupying lesion, or non-spinal origin for pain has been ruled out as the cause of pain; *and*
- Member has failed to improve after six (6) or more weeks of conservative measures (e.g., rest, systemic analgesics, and/or physical therapy); *and*

Frequency: Up to three (3) epidural injections, with at least 14 days between injections, are considered medically necessary to diagnose and achieve a therapeutic effect. It is rarely medically necessary to repeat a series of three (3) epidural injections more frequently than once every three (3) months and limited up to six (6) injections over a 12 (twelve) month period provided that >50% relief is obtained.

Epidural injections are not covered for any other indications.

E. Chemonucleolysis: Considered appropriate for the treatment of sciatica due to a herniated disc when *all* of the following are met:
- Leg pain worse than low back pain; *and*
- Radicular symptoms reproduced by sciatic stretch tests; *and*
- Only a single level herniated disc with nerve root impingement at clinically suspected level demonstrated by MRI, CT, or myelography; *and*
- Objective neurologic deficit; *and*
- Pain not relieved by at least six (6) weeks of conservative therapy.

Frequency: If approved, can authorize one (1) treatment procedure per level per side as considered medically necessary in a six (6) month period.

Chemonucleolysis is not covered for any other indications.

F. Radiofrequency facet denervation (i.e., neurotomy, rhizotomy, rhizolysis): Considered appropriate for treatment of intractable cervical or back pain with or without sciatica in the outpatient setting when *all* of the following are met:
- Severe pain limiting activities of daily living for at least six (6) months; *and*

- No prior spinal fusion surgery; *and*
- Neuroradiologic studies are negative or fail to confirm disc herniation; *and*
- No significant narrowing of the vertebral canal or spinal instability requiring surgery; *and*
- Failure of conservative treatment such as bed rest, physiotherapy, back bracing, as well as medications (e.g., anti-inflammatory agents, analgesics and muscle relaxants); *and*
- Trial of facet joint injections has been successful in relieving at least 50% of the pain.

Frequency: One (1) treatment procedure per level per side is considered medically necessary in a six (6) month period provided that >50% relief is obtained for 10-12 weeks.

Radiofrequency facet denervation is not covered for any other indications.

Exclusion Criteria

Experimental and Investigational Procedures:

The following injections or procedures are considered experimental and investigational and are not a covered benefit. This includes, but is not limited to:

1. AccuraScope procedure
2. Annulus repair devices (Xclose Tissue Repair System, Barricaid, Disc Annular Repair Technology (DART) System)
3. BacFast HD for isolated facet fusion
4. Biomet Aspen fusion system (an interlaminar fixation device)
5. Chemical ablation (including but not limited to alcohol, phenol, or sodium morrhuate) of facet joints
6. Coccygeal ganglion (ganglion impar) block for coccydynia, pelvic pain, and all other indications
7. Cooled radiofrequency ablation for facet denervation
8. Cryoablation (cryoanesthesia, cryodenervation, cryoneurolysis, or cryosurgery) for the treatment of lumbar facet joint pain
9. Deuk Laser Disc Repair
10. Devices for annular repair (e.g., Inclose Surgical Mesh System)
11. Direct visual rhizotomy (extradural transection or avulsion of other spinal nerve) for the treatment of chronic low back pain
12. Dynamic (intervertebral) stabilization (e.g., BioFlex, CD Horizon Agile Dynamic Stabilization Device, DSS Dynamic Soft Stabilization System, Dynabolt Dynamic Stabilization System, Dynesys Spinal System, Graf ligamentoplasty/Graf artificial ligament, Isobar Spinal System, NFix, Satellite Spinal System, Stabilimax NZ Dynamic Spine Stabilization System, and the Zodiak DynaMo System)
13. Facet chemodenervation/chemical facet neurolysis
14. Facet joint allograft implants (NuFix facet fusion, TruFuse facet fusion)

15. Facet joint implantation (Total Posterior-element System (TOPS) (Premia Spine), Total Facet Arthroplasty System (TFAS) (Archus Orthopedics), ACADIA Facet Replacement System (Facet Solutions/Globus Medical)
16. Far lateral microendoscopic diskectomy (FLMED) for extra-foraminal lumbar disc herniations or other indications
17. Hardware injections/blocks
18. Interlaminar lumbar instrumented fusion (ILIF)
19. Interspinous fixation devices (Benefix Interspinous Fixation System, CD HORIZON SPIRE Plate, PrimaLOK SP, SP-Fix Spinous Process Fixation Plate, and Stabilink interspinous fixation device) for spinal stenosis or other indications
20. Intradiscal Electrothermal Therapy (IDET) and Percutaneous intradiscal radiofrequncy thermocoagulation (PIRFT), also known as percutaneous radiofrequency thermomodulation
21. Coblation percutaneous disc decompression or Nucleoplasty (CPT codes 22526, 22527)
22. Intracept System (intra-osseous basivertebral nerve ablation) for the treatment of low back pain
23. Intradiscal injections of notochordal cell-derived matrix for the treatment of intervertebral disc disease
24. Intradiscal injection of platelet-rich plasma
25. Intradiscal, paravertebral, or epidural oxygen or ozone injections
26. Intradiscal steroid injections
27. Intravenous administration of corticosteroids, lidocaine, magnesium, Toradol or vitamin B12 (cyanocobalamin) as a treatment for back pain and neck pain
28. Khan kinetic treatment (KKT)
29. Laser facet denervation
30. Least invasive lumbar decompression interbody fusion (LINDIF)
31. Microendoscopic discectomy (MED; same as lumbar endoscopic discectomy utilizing microscope) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications
32. Microsurgical anterior foraminotomy for cervical spondylotic myelopathy or other indications
33. Microsurgical lumbar sequestrectomy for the treatment of lumbar disc herniation
34. Radiofrequency lesioning of dorsal root ganglia
35. Radiofrequency lesioning of terminal (peripheral) nerve endings
36. Radiofrequency denervation for sacroiliac joint pain
37. Radiofrequency/pulsed radiofrequency ablation of trigger point pain
38. Epiduroscopy, also known as epidural spinal endoscopy, spinal endoscopy, myeloscopy, and epidural myeloscopy (CPT codes 62263, 62264, 0027T)
39. Epidural injections of lyytic agents (e.g., hypertonic saline, hyaluronidase) or mechanical lysis
40. Endoscopic disc decompression, ablation, or annular modulation using the DiscFX System
41. Endoscopic transforaminal discectomy
42. Epidural fat grafting during lumbar decompression laminectomy/discectomy
43. Yeung Endoscopic Spinal Surgery System (Y.E.S.S.) also known as Arthroscopic Microdiskectomy or Percutaneous Endoscopic Diskectomy (PELD) with or without laser, or SMART Endoscopic Spine System

44. Microsurgical anterior foraminotomy for cervical spondylotic myelopathy or other indications
45. Minimally invasive/endoscopic cervical laminoforaminotomy for cervical radiculopathy/lateral and foraminal cervical disc herniations or other indications
46. Minimally invasive thoracic discectomy for the treatment of back pain
47. Minimally invasive endoscopic transforaminal lumbar interbody fusion (endoscopic MITLIF; same as endoscopic MAST fusion) for lumbar disc degeneration and instability or other indications
48. OptiMesh grafting system
49. Percutaneous cervical discectomy
50. Sacroiliac fusion for the treatment of low back pain due to sacroiliac joint syndrome, (e.g., by means of the iFuse System and the Simmetry Sacroiliac Joint Fusion System) or pinning for LBP due to sacroiliac joint syndrome
51. Sacroplasty for osteoporotic sacral insufficiency fractures and other indications
52. Racz procedure, epidural adhesiolysis with the Racz catheter, for the treatment of members with adhesive arachnoiditis, epidural adhesions, failed back syndrome from multiple previous surgeries for herniated lumbar disk, or other indications
53. Microendoscopic discectomy (MED) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications
54. Dynamic stabilization (e.g., Dynesys Dynamic Neutralization System)
55. Endoscopic laser formaminoplasty
56. Piriformis muscle resection
57. Posterior intrafacet implants (e.g., DTRAX Cervical Cage) for posterior cervical fusion
58. Psoas compartment block for lumbar radiculopathy or myositis ossification
59. Total Facet Arthroplasty System (TFAS) for the treatment of spinal stenosis
60. Vesselplasty (e.g., Vessel-X)

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Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed's benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.