Interventional Pain Management

Origination: 5/21/08	**Revised:** 10/02/17	**Annual Review:** 11/02/17

Purpose:

To provide interventional pain management clinical coordination criteria for the Medical Department staff 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 medication s(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. Intradiscal Electrothermal Therapy (IDET) and Percutaneous intradiscal radiofrequncy thermocoagulation (PIRFT), also known as percutaneous radiofrequency thermomodulation, Coblation percutaneous disc decompression or Nucleoplasty (CPT codes 22526, 22527).
2. Radiofrequency lesioning of dorsal root ganglia.
3. Radiofrequency lesioning of therminal (peripheral) nerve endings.
4. Epiduroscopy, also known as epidural spinal endoscopyp, spinal endoscopy, myeloscopy, and epidural myeloscopy (CPT codes 62263, 62264, 0027T).
5. Epidural injections of lyytic agents (e.g., hypertonic saline, hyaluronidase) or mechanical lysis.
6. Yeung Endoscopic Spinal Surgery System (Y.E.S.S.) also known as Arthroscopic Microdiskectomy or Percutaneous Endoscopic Diskectomy with or without laser, or SMART Endoscopic Spine System.
7. Microsurgical anterior foraminotomy for cervical spondylotic myelopathy or other indications.
8. Sacroiliac fusion for the treatment of low back pain due to sacroiliac joint syndrome.
9. Sacroplasty for osteoporotic sacral insufficiency fractures and other indications.
10. Racz procedure epidural adhesiolysis with the Racz catheter.

11. Microendoscopic discectomy (MED) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications.
12. Dynamic stabilization (e.g., Dynesys Dynamic Neutralization System).
13. Endoscopic laser formaminoplasty.
14. Piriformis muscle resection.

Procedure:

1.0 This procedure provided interventional pain management clinical coordination criteria for the Medical Department staff to reference when making benefit determinations and defines AvMed's coverage position. The list of procedures is not considered to be all inclusive.

References:

1. Wagner AL. Paraspinal injections: Facet joint and nerve root blocks. eMedicine Radiology Topic 884. Omaha, NE: eMedicine.com; updated June 17, 2003.
2. van Tulder M, Koes B. Low back pain and sciatica (chronic). In: BMJ Clinical Evidence. London, UK: BMJ Publishing Group; April 2006.
3. Sanders SH, Rucker KS, Anderson KO, et al. Clinical practice guidelines for chronic non-malignant pain syndrome patients. J Back Musculoskeletal Rehab. 1995;5:115-120.
4. American medical Association (AMA). Assessing & treating persistent nonmalignant pain: An overview. Pain Management: Online Series. Continuing Medical Education Library. Chicago, IL: AMA; December 2003.
5. Bigos S, Bowyer O, Braen G, et al. Acute low back problems in adults, Clinical Practice Guidelines No 14. AHCPR Publication No. 95-0642. Rockville, MD: Agency for Health Care Policy and Research (AHCPR); December 1994.
6. American Society of Anesthesiologists. Practice guidelines for chronic pain management. A Report by the American Society of Anesthesiologists Task Force on Pain Management, Chronic Pain Section. Anesthesiology. 1997; 86:995-1004.
7. National Institute for Clinical excellence (NICE). Endoscopic epidural procedures. Interventional Procedure Consultation Document. London, UK: NICE: February 2004.
8. Mississippi Workers Compensation Commission (MWCC). Pain Management Guidelines. Mississippi W/C Medical Fee Schedule. Jackson, MS: MWCC; June 2003.
9. U.S. Food and Drug Administration (FDA), Center for Devices and Radiological Health (CDRH). Complications related to the use of bone cement and bone void fillers in treating compression fractures of the spine. FDA Public Health Web Notification. Rockville, MD: FDA; updated May 7, 2004.
10. U.S. Food and Drug Administration (FDA), Center for Devices and Radiological Health (CHRH). Orthopaedic and Rehabilitation Devices Panel Meeting Brief Summary for August 31, 2004. Rockville, MD: FDA; updated September 3, 2004.

11. North American Spine Society (NASS). Diagnosis and treatment of degenerative lumbar spinal stenosis. Burr Ridge, IL: North American Spine Society (NASS); 2007.
12. Boswell, M, et al. Interventional Techniques: Evidence based Practice guidelines in the management of chronic Spinal Pain. Pain Physician 2007; 10:7-111.

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.