National Imaging Associates, Inc.*

# 2024 NIA Clinical Guidelines For Medical Necessity Review

## INTERVENTIONAL PAIN MANGEMENT GUIDELINES

Effective July 1, 2024 – July 1, 2025

*National Imaging Associates, Inc. (NIA) is a subsidiary of Evolent Health, LLC.

# Guidelines for Clinical Review Determination

**Preamble**

NIA is committed to the philosophy of supporting safe and effective treatment for patients. The medical necessity criteria that follow are guidelines for the provision of diagnostic imaging. These criteria are designed to guide both providers and reviewers to the most appropriate diagnostic tests based on a patient's unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice will be used when applying the guidelines. Determinations are made based on both the guideline and clinical information provided at the time of the request. It is expected that medical necessity decisions may change as new evidence-based information is provided or based on unique aspects of the patient's condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient.

**Guideline Development Process**

These medical necessity criteria were developed by National Imaging Associates, Inc. (NIA) for the purpose of making clinical review determinations for requests for therapies and diagnostic procedures. The developers of the criteria sets included representatives from the disciplines of radiology, internal medicine, nursing, cardiology, and other specialty groups. NIA's guidelines are reviewed yearly and modified when necessary following a literature search of pertinent and established clinical guidelines and accepted diagnostic imaging practices.

All inquiries should be directed to:
Evolent Specialty Services, Inc.
c/o Privacy
1812 N. Moore St, Suite 1705
Arlington, VA 22209
Fax: 800-830-1762/Privacy@Evolent.com

## TABLE OF CONTENTS

| | |
|---|---|
| ***National Imaging Associates, Inc.** | |
| **Clinical guidelines:**<br><br>**EPIDURAL SPINE INJECTIONS** | **Original Date: October 2012** |
| **CPT Codes:**<br><br>**Cervical Thoracic Region:**<br>**62320, 62321, 64479 (+64480)**<br><br>**Lumbar Sacral Region:**<br>**62322, 62323, 64483 (+64484)** | **Last Revised Date: January 2024** |
| **Guideline Number: NIA_CG_300** | **Implementation Date: July 2024** |

# TABLE OF CONTENTS

## GENERAL INFORMATION

*It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*

## STATEMENT

Therapeutic Spinal Epidural Injections or Select Nerve Root Blocks (Transforaminal) are types of interventional pain management procedures. The therapeutic use of epidural injections is for short-term pain relief associated with acute back pain or exacerbation of chronic back pain. With therapeutic injections, a corticosteroid is injected close to the target area with the goal of pain reduction. Epidural injections should be used in combination with other active conservative treatment* modalities and not as stand-alone treatment for long-term back pain relief. The rationale for the use of spinal epidural injections is that the sources of spinal pain, e.g., discs and joints, are accessible and amendable to neural blockade.

## SPECIAL NOTE

**NEW EPISODES OF CARE**

Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **initial** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

**See LEGISLATIVE REQUIREMENTS for specific mandates in the State of Washington**

**PURPOSE**

This guideline describes indications, contraindications, and exclusions for the performance of epidural spine injections, based on The American Society of Interventional Pain Physicians (ASIPP) recommended algorithmic approach. [4]

**SCOPE**

This guideline applies to all licensed participating network practitioners who provide this service.

# INDICATIONS FOR EPIDURAL SPINE INJECTIONS/NERVE BLOCKS

**GENERAL TO ALL CAUDAL, INTERLAMINAR, AND TRANSFORAMINAL INJECTIONS**

- Fluoroscopic guidance should be used for caudal and interlaminar injections and is necessary for transforaminal injections.
- For all injections, patients must exhibit pain causing functional disability or average pain level of ≥6 on a scale of 0 to 10 [5, 6, 7] related to the requested spinal region.

**TREATMENT PURPOSES**

- **Acute pain or exacerbation of chronic radicular pain** [4] **(all of the following must be met):**
  - Neck or back pain with acute radicular symptoms
  - Duration of pain < 3 months
  - Failure to respond to non-operative conservative treatment targeting the requested spinal region for a minimum of 2 weeks unless the medical reason this treatment cannot be done is clearly documented (active therapy components not required) [6]
- **Spinal stenosis causing axial or radicular pain** [4] **(all of the following must be met):**
  - Failure to respond to non-operative conservative treatment* targeting the requested spinal region for a minimum of six (6) weeks in the last six (6) months unless the medical reason this treatment cannot be done is clearly documented;
    - **OR** details of engagement in ongoing non-operative conservative treatment if the individual has had prior spinal injections in the same region [5] [8]
- **Failed back surgery syndrome or epidural fibrosis causing axial or radicular pain (all of the following must be met):** [4, 9]
  - Documentation of a medical reason that clearly indicates why an injection is needed (not typically done immediately post-surgery) [5]
  - Failure to respond to non-operative conservative treatment* targeting the requested spinal region for a minimum of six (6) weeks in the last six (6) months unless the medical reason this treatment cannot be done is clearly documented;
    - **OR** details of engagement in ongoing non-operative conservative treatment if the individual has had prior spinal injections in the same region [6]

**NOTE:** Failure of conservative treatment is defined as one of the following:

- Lack of meaningful improvement after a full course of treatment; **OR**
- Progression or worsening of symptoms during treatment; **OR**
- Documentation of a medical reason the member is unable to participate in treatment (*Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute "inability to complete" treatment)*

**DIAGNOSTIC PURPOSES**

- Transforaminal injection to identify the pain generator for surgical planning (all of the following must be met):
    - Documentation of a pre-operative evaluation and plan for surgery

**NOTE:** No more than 2 levels of transforaminal blocks should be done in one day.

**REPEAT INJECTIONS**

Epidural injections may be repeated only as medically necessary. Each epidural injection requires an authorization, and the following criteria must be met for repeat injections:

- Up to 3 epidural injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 30% pain relief or significant documented functional improvement is obtained [7]
    - If an injection during the initial treatment phase is unsuccessful, another injection may be performed at a different level in the **same spinal region** or with a change in technique given there is a question about the pain generator or evidence of multi-level pathology
- Epidural injections may only be repeated after the initial treatment phase if the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** after each therapeutic injection [5]
- The patient:
    - continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 [5, 7] related to the requested spinal region.
    - is engaged in ongoing active conservative treatment, unless the medical reason this treatment cannot be done is clearly documented [10]
- In the first year of treatment, a total of 6 epidural injections may be performed **per spinal region**
    - (this includes up to 3 injections in the initial treatment phase and 3 additional therapeutic injections). [5]
- After the first year of treatment, a maximum of 4 epidural injections may be performed in a 12-month period **per spinal region**. [5, 7]
    - If special circumstances are documented (e.g., elderly individual with severe spinal stenosis and not an operative candidate), then repeat injections are limited to a maximum of 6 epidural injections in a 12-month period per spinal region. [7]
- If different spinal regions are being treated, injections should be administered at intervals of at least 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see **NOTE**). [5]

## EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Intrathecal injections for pain or spasticity prior to permanent pump insertion
- Implantation of intrathecal catheters or ports for chemotherapy
- Post-operative pain control
- Caudal or spinal anesthesia for surgery

## CONTRAINDICATIONS FOR EPIDURAL SPINAL INJECTIONS

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Severe spinal stenosis resulting in intraspinal obstruction

---

## LEGISLATIVE LANGUAGE

### Washington

- **Washington State Health Care Authority Technology Assessment**
  20160318B – Spinal Injections [1, 2]
  Limitations of Coverage[‡]:
    - Therapeutic epidural injections in the lumbar or cervical-thoracic spine for chronic pain are a covered benefit when all of the following conditions are met:
        - For treatment of radicular pain
        - With fluoroscopic guidance or CT guidance
        - After failure of conservative therapy
        - No more than two without clinically meaningful improvement in pain and function; and
        - Maximum of three in six months.
    - Washington State Health Care Authority oversees the Apple Health (Medicaid) program and the Public Employees Benefits Board (PEBB) Program [3]

[‡] This coverage policy does not apply to those with a known systemic inflammatory disease such as: ankylosing spondylitis, psoriatic arthritis or enteropathic arthritis

---

## BACKGROUND

### MEDICAL NECESSITY

Medical necessity management for epidural injections includes an initial evaluation including history and physical examination as well as a psychosocial and functional assessment. The following must be determined:

- Nature of the suspected organic problem
- Non-responsiveness to active conservative treatment
- Level of pain and functional disability
- Conditions which may be contraindications to epidural injections
- Responsiveness to prior interventions

NOTE: It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI performed during the same session for a synovial cyst confirmed on imaging.

***CONSERVATIVE TREATMENT**

Non-operative conservative treatment should include a multimodality approach consisting of at least one (1) active and one (1) inactive component targeting the affected spinal region.

- Active components
  - Physical therapy
  - Physician-supervised home exercise program (HEP)**
  - Chiropractic care [10, 11]
- Inactive components
  - Medications (e.g., NSAIDs, steroids, analgesics)
  - Injections (e.g., epidural steroid injection, selective nerve root block)
  - Medical devices (e.g., TENS unit, bracing)

****HOME EXERCISE PROGRAM (HEP)**

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor [10]

  **AND**

- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (i.e., increased pain or inability to physically perform exercises)

**POLICY HISTORY**

| Date | Summary |
|---|---|
| January 2024 | • Added conservative tx language<br>• Added legislative language for WA state |
| May 2023 | • Added in references<br>• Removed Additional Resources<br>• Added Legislative language for Washington State |
| May 2022 | • Added note to clarify when **INITIAL** injection requirements must be met for approval<br>• Reorganized indications for clarity and uniformity<br>• Added region-specific wording to conservative treatment requirement (e.g., conservative therapy targeting the requested spinal region)<br>• Clarified acute pain as duration less than 3 months<br>• Updated Frequency of Repeat Injections section and Removed 'Therapeutic' from Section Title (since up to 3 diagnostic injections are allowed by GL)<br>• Exclusions section:<br>  ○ Added caudal or spinal anesthesia for surgery<br>  ○ Updated intrathecal injections for pain or spasticity prior to permanent pump insertion<br>• Updated and simplified contraindications list for epidural injections |
| January 2022 | • Off-cycle change: Changed pain relief period after initial injection: At least 50% or more pain relief obtained for a minimum of 6 weeks  2 months after initial injections (Manchikanti, 2013) |

## REFERENCES


[1] Authority WSHC, "Health Technology Assesment - Spinal Injections," [Online]. Available: https://www.hca.wa.gov/assets/program/spinal_injections-rr_final_findings_decision_060216.pdf. [Accessed 2023].

[2] Authority WSHC, "Health Technology Reviews - Spinal Injections," [Online]. Available: https://www.hca.wa.gov/about-hca/programs-and-initiatives/health-technology-assessment/spinal-injections. [Accessed 2023].

[3] Authority WSHC, "About the Health Care Authority (HCA)," 2023. [Online]. Available: https://www.hca.wa.gov/about-hca.

[4] L. Manchikanti, N. Knezevic, A. Navani, P. J. Christo, G. Limerick and A. K. Calodney, "Epidural Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines," *Pain Physician,* vol. 24, pp. S27-208, 2021.

[5] L. Manchikanti, S. Abdi, S. Atluri, R. Benyamin, M. V. Boswell and R. M. Buenaventura, "An Update of Comprehensive Evidence-Based Guidelines for Interventional Techniques in Chronic Spinal Pain. Part II: Guidance and Recommendations," *Pain Physician,* vol. 16, pp. S49-283, 2013.

[6] North American Spine Society, "Clinical Guidelines for Diagnosis and Treatment of Lumbar Disc Herniation with Radiculopathy," 2012. [Online]. [Accessed 2023].

[7] North American Spine Society, "Lumbar Transforaminal Epidural Steroid Injections: Review and Recommendation Statement," 2013. [Online]. [Accessed 2013].

[8] D. Sayed, J. Grider, N. Strand, J. M. Hagedorn, S. Falowski, C. M. Lam, V. T. Francio and D. P. Beall, "The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain," *Journal of Pain Research,* vol. 15, 2022.

[9] V. J. Orhurhu, R. Chu and J. Gill, "Failed Back Surgery Syndrome," in *StatPearls [Internet]*, Treasure Island, FL: StatPearls Publishing, 2023.

[10] Annals of Internal Medicine, "Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians," 2017. [Online].

[11] The American College of Radiology, *ACR Appropriateness Criteria Low Back Pain: 2021 Update,* 2021.

**Reviewed / Approved by NIA Clinical Guideline Committee**

**Disclaimer:** *National Imaging Associates, Inc. (NIA) authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Evolent Health LLC subsidiaries including, but not limited to, National Imaging Associates ("NIA"). The policies constitute only the reimbursement and coverage guidelines of NIA. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. NIA reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.*

| *National Imaging Associates, Inc. | |
|---|---|
| **Clinical guidelines:**<br>**EPIDURAL SPINE INJECTIONS AND SINGLE INJECTION TRIALS FOR INTRATHECAL PUMPS** | **Original Date: May 2022** |
| **CPT Codes:**<br>**Cervical Thoracic Region:**<br>**62320, 62321, 64479 (+64480)**<br>**Lumbar Sacral Region:**<br>**62322, 62323, 64483 (+64484)** | **Last Revised Date: January 2024** |
| **Guideline Number: NIA_CG_408** | **Implementation Date: July 2024** |

# TABLE OF CONTENTS

## GENERAL INFORMATION

*It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*

## STATEMENT

Therapeutic Spinal Epidural Injections or Select Nerve Root Blocks (Transforaminal) are types of interventional pain management procedures. The therapeutic use of epidural injections is for short-term pain relief associated with acute back pain or exacerbation of chronic back pain. With therapeutic injections, a corticosteroid is injected close to the target area with the goal of pain reduction. Epidural injections should be used in combination with other active conservative treatment* modalities and not as stand-alone treatment for long-term back pain relief. The rationale for the use of spinal epidural injections is that the sources of spinal pain, e.g., discs and joints, are accessible and amendable to neural blockade.

An implantable infusion pump (IIP), also referred to as an implantable drug delivery system (IDDS), is a device for the delivery of medication to manage severe, chronic, intractable pain and/or chronic intractable spasm. An intrathecal/intraspinal drug trial utilizes a temporary implant to demonstrate efficacy and appropriateness of an IIP.

### PURPOSE

This guideline describes indications, contraindications, and exclusions for the performance of epidural spine injections, based on The American Society of Interventional Pain Physicians (ASIPP) recommended algorithmic approach [1], and indications, contraindications and exclusions for single injection intraspinal drug trials for intrathecal pumps.

## SPECIAL NOTE

### NEW EPISODE OF CARE

Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **initial** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

### INTRATHECAL PUMP INDICATIONS

There are no medical indications for intrathecal treatments except chronic pain and intractable spasticity.

**See LEGISLATIVE REQUIREMENTS for specific mandates in the State of Washington**

# INDICATIONS FOR INITIAL EPIDURAL SPINAL INJECTIONS/NERVE BLOCKS

**General to all caudal, interlaminar and transforaminal injections**

- Fluoroscopic guidance should be used for caudal and interlaminar injections and is necessary for transforaminal injections.
- For all injections, patients must exhibit pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 [2, 3, 4] related to the requested spinal region.

**TREATMENT PURPOSE:**

- **Acute pain or exacerbation of chronic radicular pain** [1] **(all of the following must be met):**
  - Neck or back pain with acute radicular symptoms
  - Duration of pain < 3 months
  - Failure to respond to non-operative conservative treatment* targeting the requested spinal region for a minimum of 2 weeks unless the medical reason this treatment cannot be done is clearly documented (active therapy components not required) [3]
- **Spinal stenosis causing axial or radicular pain** [1] **(all of the following must be met):**
  - Failure to respond to non-operative conservative treatment* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; **OR**
    - Details of engagement in ongoing non-operative conservative treatment if the individual has had prior spinal injections in the same region [2] [5]
- **Failed back surgery syndrome or epidural fibrosis causing axial or radicular pain (all of the following must be met):** [1, 6]
  - Documentation of a medical reason that clearly indicates why an injection is needed (not typically done immediately post-surgery) [2]
  - Failure to respond to non-operative conservative treatment* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; **OR**
    - Details of engagement in ongoing non-operative conservative treatment if the individual has had prior spinal injections in the same region [3]

**NOTE:** Failure of conservative treatment is defined as one of the following:

- Lack of meaningful improvement after a full course of treatment; **OR**
- Progression or worsening of symptoms during treatment; **OR**
- Documentation of a medical reason the member is unable to participate in treatment *(Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute "inability to complete" treatment)*

**DIAGNOSTIC PURPOSES**

- **Transforaminal injection to identify the pain generator for surgical planning (all of the following must be met):**
    - Documentation of a pre-operative evaluation and plan for surgery

**NOTE:** No more than 2 levels of transforaminal blocks should be done in one day

**REPEAT EPIDURAL SPINAL INJECTIONS**

Epidural injections may be repeated only as medically necessary. Each epidural injection requires an authorization, and the following criteria must be met for repeat injections:

- Up to 3 epidural injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 30% pain relief or significant documented functional improvement is obtained [4]
    - If an injection during the initial treatment phase is unsuccessful, another injection may be performed at a different level in the **same spinal region** or with a change in technique given there is a question about the pain generator or evidence of multi-level pathology
- Epidural injections may only be repeated after the initial treatment phase if the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** after each therapeutic injection [2]
- The patient;
    - Continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 [2, 4] related to the requested spinal region.
    - Engaged in ongoing active conservative treatment, unless the medical reason this treatment cannot be done is clearly documented [7]
- In the first year of treatment, a total of 6 epidural injections may be performed **per spinal region**
    - This includes up to 3 injections in the initial treatment phase and 3 additional therapeutic injections [2]
- After the first year of treatment, a maximum of 4 epidural injections may be performed in a 12-month period **per spinal region** [2, 4]
    - If special circumstances are documented (e.g., elderly individual with severe spinal stenosis and not an operative candidate), then repeat injections are limited to a maximum of 6 epidural injections in a 12-month period per spinal region [4]
- If different spinal regions are being treated, injections should be administered at intervals of at least 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see **NOTE**). [2]

## CONTRAINDICATIONS FOR EPIDURAL SPINAL INJECTIONS

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Severe spinal stenosis resulting in intraspinal obstruction

## INDICATIONS FOR INTRASPINAL DRUG TRIAL

**For the treatment of chronic intractable pain in non-terminal individuals**
(**ALL** the following criteria must be met):

- Pain causing functional disability that significantly interferes with activities of daily living including ability to work and overall quality of life; **OR** persistent pain level of ≥ 6 on a scale of 0 to 10 despite treatment
- Failure to respond to non-operative conservative therapy* targeting the requested spinal region for a minimum of 12 weeks unless the medical reason this treatment cannot be done is clearly documented

**For the treatment of spasticity in non-terminal individuals**
(**ALL** the following must be met):

- Intractable spasticity that results in the individual's inability to maintain an upright posture, severely impairs balance in ambulation, or significantly interferes with activities of daily living related to **one** of the following conditions [8]:
    - Spinal cord injury
    - Multiple sclerosis
    - Stiff person syndrome
    - Other medical conditions causing intractable spasms
- Failure to respond to a minimum of 12 weeks of standard therapies (e.g., oral medications, physical therapy, etc.)

**Additional Trials**
A second intraspinal drug trial is indicated when documentation of the first trial of intraspinal (intrathecal or epidural) medication administered as a bolus or by continuous infusion resulted in one of the following:

    - Less than 50% pain relief
    - Intolerable side effects
- Limit of two intraspinal drug trials for preliminary consideration of chronic intractable pain or spasticity management with permanent implantable device in non-terminal individuals.

**NOTE:** Intrathecal trials are not indicated in opiate-naïve individuals.

## CONTRAINDICATIONS FOR INTRASPINAL DRUG TRIAL

- Active systemic or spinal infection
- Body habitus that is insufficient to support the weight and bulk of the device

## EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Implantation of intrathecal catheters or ports for chemotherapy
- Post-operative pain control
- Caudal or spinal anesthesia for surgery

---

## LEGISLATIVE LANGUAGE

### Washington

- **Washington State Health Care Authority Technology Assessment**
  20160318B – Spinal Injections [9, 10]
  Limitations of Coverage[ǂ]:
    - Therapeutic epidural injections in the lumbar or cervical-thoracic spine for chronic pain are a covered benefit when all of the following conditions are met:
    - For treatment of radicular pain
        - With fluoroscopic guidance or CT guidance
        - After failure of conservative therapy
        - No more than two without clinically meaningful improvement in pain and function; and
        - Maximum of three in six months.
    - Washington State Health Care Authority oversees the Apple Health (Medicaid) program and the Public Employees Benefits Board (PEBB) Program [11]

[ǂ] This coverage policy does not apply to those with a known systemic inflammatory disease such as: ankylosing spondylitis, psoriatic arthritis or enteropathic arthritis

---

## BACKGROUND

### MEDICAL NECESSITY

Medical necessity management for epidural injections includes an initial evaluation including history and physical examination as well as a psychosocial and functional assessment. The following must be determined:

- Nature of the suspected organic problem
- Non-responsiveness to active conservative treatment

- Level of pain and functional disability
- Conditions which may be contraindications to epidural injections
- Responsiveness to prior interventions

**NOTE:** It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI performed during the same session for a synovial cyst confirmed on imaging.

***CONSERVATIVE TREATMENT**

Non-operative conservative treatment should include a multimodality approach consisting of at least one active and one inactive component targeting the affected spinal region.

- Active components
  - Physical therapy
  - Physician-supervised home exercise program (HEP)**
  - Chiropractic care [7, 12]
- Inactive components
  - Medications (e.g., NSAIDs, steroids, analgesics)
  - Injections (e.g., epidural steroid injection, selective nerve root block)
  - Medical devices (e.g., TENS unit, bracing)

****HOME EXERCISE PROGRAM (HEP)**

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor [7]

  **AND**

- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (i.e., increased pain or inability to physically perform exercises).

**POLICY HISTORY**

| Date | Summary |
|---|---|
| January 2024 | • Added conservative tx language<br>• Added legislative language for WA state<br>• Added criteria for additional intrathecal trials |
| May 2023 | • Added references<br>• Removed Additional Resources<br>• Added Legislative Language for Washington State |
| May 2022 | New policy |

**REFERENCES**


[1] L. Manchikanti, N. Knezevic, A. Navani, P. J. Christo, G. Limerick and A. K. Calodney, "Epidural Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines," *Pain Physician,* vol. 24, pp. S27-208, 2021.

[2] L. Manchikanti, S. Abdi, S. Atluri, R. Benyamin, M. V. Boswell and R. M. Buenaventura, "An Update of Comprehensive Evidence-Based Guidelines for Interventional Techniques in Chronic Spinal Pain. Part II: Guidance and Recommendations," *Pain Physician,* vol. 16, pp. S49-283, 2013.

[3] North American Spine Society, "Clinical Guidelines for Diagnosis and Treatment of Lumbar Disc Herniation with Radiculopathy," 2012. [Online]. [Accessed 2023].

[4] North American Spine Society, "Lumbar Transforaminal Epidural Steroid Injections: Review and Recommendation Statement," 2013. [Online]. [Accessed 2013].

[5] D. Sayed, J. Grider, N. Strand, J. M. Hagedorn, S. Falowski, C. M. Lam, V. T. Francio and D. P. Beall, "The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain," *Journal of Pain Research,* vol. 15, 2022.

[6] V. J. Orhurhu, R. Chu and J. Gill, "Failed Back Surgery Syndrome," in *StatPearls [Internet]*, Treasure Island, FL: StatPearls Publishing, 2023.

[7] Annals of Internal Medicine, "Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians," 2017. [Online].

[8] A. McIntyre, R. Mays, S. Mehta, S. Janzen, A. Townson, J. Hsieh, D. Wolfe and R. Teasell, "Examining the effectiveness of intrathecal baclofen on spasticity in individuals with chronic spinal cord injury: A systematic review," *The Journal of Spinal Cord Medicine,* vol. 37, no. 1, 2014.

[9] Authority WSHC, "Health Technology Assesment - Spinal Injections," [Online]. Available: https://www.hca.wa.gov/assets/program/spinal_injections-rr_final_findings_decision_060216.pdf. [Accessed 2023].

[10] Authority WSHC, "Health Technology Reviews - Spinal Injections," [Online]. Available: https://www.hca.wa.gov/about-hca/programs-and-initiatives/health-technology-assessment/spinal-injections. [Accessed 2023].

[11] Authority WSHC, "About the Health Care Authority (HCA)," 2023. [Online]. Available: https://www.hca.wa.gov/about-hca.

[12] The American College of Radiology, *ACR Appropriateness Criteria Low Back Pain: 2021 Update,* 2021.

**Reviewed / Approved by NIA Clinical Guideline Committee**

**Disclaimer:** *National Imaging Associates, Inc. (NIA) authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Evolent Health LLC subsidiaries including, but not limited to, National Imaging Associates ("NIA"). The policies constitute only the reimbursement and coverage guidelines of NIA. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. NIA reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.*

| *National Imaging Associates, Inc. | |
|---|---|
| **Clinical guidelines:**<br>**PARAVERTEBRAL FACET JOINT INJECTIONS OR BLOCKS** | **Original Date: October 2012** |
| **CPT Codes:**<br>**Cervical Thoracic Region: 64490 (+ 64491, +64492) 0213T, +0214T, +0215T**<br>**Lumbar Region: 64493 (+64494, +64495) 0216T, +0217T, +0218T** | **Last Revised Date: January 2023** |
| **Guideline Number: NIA_CG_301** | **Implementation Date: July 2024** |

# TABLE OF CONTENTS

## GENERAL INFORMATION

*It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted*

## SPECIAL NOTE

Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **INITIAL** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

***See Legislative Requirements for specific mandates in the State of Washington***

## INDICATIONS

### FACET JOINT INJECTIONS OR MEDIAL BRANCH NERVE BLOCKS [1, 2]

To confirm non-radicular pain suggestive of facet joint or pars interarticularis origin, **ALL** the following must be met:

- History of mainly axial or non-radicular pain unless stenosis is caused by synovial cyst [3]
- Lack of evidence that the primary source of pain being treated is from sacroiliac joint pain, discogenic pain, disc herniation, or radiculitis
- Chronic lumbar spondylolysis
    - Imaging studies confirming the presence of a pars interarticularis fracture/defect are required
- Pain causing functional disability or average pain level of ≥ 6 (scale of 0 to 10) related to the requested spinal region.
- Duration of pain for at least **3 months**
- Failure of conservative treatment* for a minimum of six (6) weeks within the last six (6) months

  **NOTE**: Failure of conservative treatment is defined as one of the following:

    - Lack of meaningful improvement after a full course of treatment; **OR**
    - Progression or worsening of symptoms during treatment; **OR**
    - Documentation of a medical reason the member is unable to participate in the treatment (*Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute 'inability to complete' treatment*)

**IMAGING GUIDANCE [4, 5, 6, 7]**

The facet joint is commonly identified under image guidance by Computed tomography (CT) or Fluoroscopy. Medial Branch Blocks are commonly identified by Fluoroscopy. With proper use by skilled interventional pain physicians with ultrasound experience, the use of ultrasound guidance is similar to CT or Fluoroscopy but can have a lower accuracy of needle placement.

Ultrasound guidance can be an effective alternative if CT or fluoroscopy guided techniques are contraindicated; however, individual patient factors such as poor visualization due to deeper tissue layers (e.g., increased Body Mass Index (BMI) may contribute to substandard image resolution.

**NOTE: ALL** procedures must be performed under imaging guidance

**REPEAT INJECTIONS [1, 7]**

Facet joint injections and medial branch nerve blocks may be repeated only as medically necessary. **Each** injection requires an authorization, and the following criteria must be met for repeat injections:

- Up to 2 injections may be performed in the initial diagnostic phase, no sooner than 2 weeks apart, provided at least 50% pain relief or significant documented functional improvement is obtained
    - If the most recent injection was a diagnostic block with local anesthetic only, there must be at least 7 days between injections
- If the first injection is unsuccessful, a second injection may be performed at a different spinal level or with a change in technique (e.g., from an intra-articular facet injection to a medial branch nerve block) given there is a question about the pain generator or evidence of multi-level pathology
- Facet joint injections may only be repeated after the initial diagnostic phase if the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** after each therapeutic injection
- The individual continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 related to the requested spinal region.
- The individual is engaged in ongoing active conservative therapy*, unless the medical reason this treatment cannot be done is clearly documented [8]
    - Diagnostic injections within 1 month of the previous injection do not require documentation of ongoing active conservative therapy
- In the diagnostic phase, a maximum of 2 procedures may be performed. Repeat diagnostic injections after prior radiofrequency neurolysis are allowable if there is a question about the pain generator, different levels are to be targeted, or if there is surgery in the same spinal region.

- A maximum of 4 facet injections may be performed in a 12-month period **per spinal region** (except under unusual circumstances, such as a recurrent injury)
    - Unilateral injections performed at the same level on the right vs. left within 1 month of each other would be considered as one procedure toward the total number of facet procedures allowed per 12 months
- If different spinal regions are being treated, injections should be administered at intervals of no sooner than 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see **NOTE**)

**NOTE:** Radiofrequency neurolysis procedures should be considered in individuals with a successful medial branch nerve block (at least 70% pain relief or improved ability to function), but with insufficient sustained relief (less than 2-3 months improvement).

## EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Sacral lateral branch blocks (S1, S2, S3)
- Atlantoaxial joint injections (C1-2)
- Occipital nerve blocks
- Hardware injection or block for diagnosis or treatment of post-surgical or other spine pain

## CONTRAINDICATIONS

Although there are no absolute contraindications there are relative contraindications that include;

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Inability to obtain percutaneous access to the target facet joint

---

## LEGISLATIVE REQUIREMENTS

### State of Washington

- Washington State Health Care Authority Health Technology Assessment 20160318B – Spinal Injections [9, 10]
    - Therapeutic medial branch nerve block injections, intradiscal injections and facet injections are not a covered benefit

---

## BACKGROUND [2]

Facet joints may refer pain to adjacent structures, making the underlying diagnosis difficult as referred pain may assume a pseudoradicular pattern. Lumbar facet joints may refer pain to the back, buttocks, and lower extremities while cervical facet joints may refer pain to the head, neck, and shoulders.

Imaging studies may detect changes in facet joint architecture, but correlation between radiologic findings and symptoms is unreliable. Although clinical signs are also unsuitable for diagnosing facet joint-mediated pain, they may be of value in selecting individuals for controlled local anesthetic blocks of either the medial branches or the facet joint itself.

Facet joint interventions include intraarticular injections and medial branch nerve blocks in the lumbar, cervical, and thoracic spine. Prior to performing this procedure, shared decision-making between patient and physician must occur, and the patient must understand the procedure and its potential risks and results. Facet joint injections or medial branch nerve blocks require guidance imaging.

### MEDICAL NECESSITY

Medical necessity management for paravertebral facet injections includes an initial evaluation including history and physical examination and a psychosocial and functional assessment. The following must be determined: nature of the suspected organic problem; non-responsiveness to conservative treatment*; level of pain and functional disability; conditions which may be contraindications to paravertebral facet injections; and responsiveness to prior interventions.

It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI performed during the same session for a synovial cyst confirmed on imaging.

### *CONSERVATIVE TREATMENT [11, 7]

Non-operative treatment should include a multimodality approach consisting of at least one (1) active and one (1) inactive component targeting the affected spinal region.

- Active components
    - Physical Therapy
    - Physician-supervised home exercise program**
    - Chiropractic Care
- Inactive Modalities
    - Medications (e.g., NSAIDs, steroids, analgesics)

- Injections (e.g., epidural steroid injection, selective nerve root block)
- Medical Devices (e.g., TENS unit, bracing)

****HOME EXERCISE PROGRAM (HEP) [12, 7]**

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor

  **AND**

- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (e.g., increased pain or inability to physically perform exercises).

## POLICY HISTORY

| Date | Summary |
|---|---|
| January 2023 | • Added Legislative Language for the State of Washington<br>• Added section on Image guidance<br>• Adjusted conservative treatment language in body and background sections<br>• Prolotherapy removed from the Exclusion section<br>• Reduced Background section<br>• Added table of contents<br>• Updated references |
| May 2023 | • Expanded indication for pars interarticularis<br>• Added to exclusions<br>  ○ Sacral lateral branch block (S1, S2, S3)<br>  ○ Atlantoaxial joint injections (C1-2)<br>  ○ Hardware injection or block for dx or treatment of post-surgical or other spine pain<br>• Added references |
| May 2022 | • Added note to clarify when INITIAL injection requirements must be met for approval<br>• Reorganized indications for clarity and uniformity<br>• Added region-specific wording to conservative treatment requirement (e.g., conservative therapy targeting the requested spinal region)<br>• Simplified indications by combining two "lack of evidence" indications<br>• Clarified "average" pain levels<br>• Add US guidance for procedure as option (in addition to fluoroscopic or CT guidance)<br>• Extended the interval from 2 weeks to 1 month<br>• Clarified that repeat diagnostic injections are allowable after an unsuccessful rf denervation under certain conditions<br>• Updated Contraindications section<br>• Added an Exclusions section, including lateral branch blocks and occipital nerve blocks<br>• Updated Frequency of Repeat Injections section<br>• Clarified lack of medical necessity of performing multiple pain procedures on same DOS |

## REFERENCES


[1] L. Manchikanti, A. D. Kaye, A. Soin, S. L. Albers, D. Beall, R. Latchaw, M. R. Sanapati, S. S. Sairam Atluri, A. . Abd-Elsayed, S. Abdi, S. Aydin, S. Bakshi, M. V. Boswell, R. . Buenaventura, J. Cabaret, A. K. Calodney, K. D. CAndido, P. J. Christo, L. Cintron, S. Diwan, C. Gharibo, J. Grider, M. Gupta, B. Haney, M. E. Harned, S. Helm li, J. Jameson, S. Jha, A. M. Kaye, N. N. Knezevic, R. Kosanovic, M. V. Manchikanti, A. Navani, G. R. Vidyasagar Pampati, R. Pasupuleti, C. Philip, K. Rajput, N. S. Gururau Sudarshan, R. VAnaparthy, B. W. Wargo and J. A. Hirsch, "Comprehensive Evidence-Based Guidelines for Facet Joint Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines Facet Joint Interventions 2020 Guidelines," *Pain Physician,* vol. 23, no. 3S, pp. S1-S127, 2020.

[2] D. T. Le and N. Alem, "Facet Joint Injection," StatsPearls, 20 June 2023. [Online]. Available: https://www.ncbi.nlm.nih.gov/books/NBK572125/. [Accessed 21 September 2023].

[3] S. Rana, A. Pradhan, J. Casaos, K. Mozaffari, F. Ghodrati, B. Sugimoto , I. Yang and D. T. Nagasawa, "Lumbar spinal ganglion cyst: A systematic review with case illustration," *Journal of the Neurological Sciences,* vol. 445, p. 120539, 2023.

[4] M.-L. . Nisolle, D. Ghoundiwal, E. Engelman, W. E. Founas, J. Gouwy, E. Guntz, P. Kapessidou and T. Tuna, "Comparison of the effectiveness of ultrasound-guided versus fluoroscopy-guided medial lumbar bundle branch block on pain related to lumbar facet joints: a multicenter randomized controlled non-inferiority study [published correction appears in BMC Anesthe," *BMC Anesthesiol,* vol. 23, no. 1, p. 76, 11 March 2023.

[5] Z. M. Ashmore, M. M. Bies, J. B. Meiling, R. N. Moman, L. C. Hassett, C. L. Hunt, S. P. Cohen and W. M. Hooten, "Ultrasound-guided lumbar medial branch blocks and intra-articular facet joint injections: a systematic review and meta-analysis," *Pain Rep,* vol. 7, no. 3, p. e1008, 16 May 2022.

[6] D. Sayed, J. Grinder, N. Strand, J. Hagedorn, S. Falowski, C. M. Lam, V. T. Francio, D. P. Beall, N. D. Tomycz, J. R. Davanzo, R. Aiyer, D. W. Lee, H. Kalia, S. Sheen, M. N. Malinowski, M. Verdolin, S. Vodapally, A. Carayannopoulos, S. . Jain, N. Azeem, R. Tolba, G. C. Chang Chien, P. Ghosh, A. J. Mazzola, K. Amirdelfan, K. Chakravarthy, E. Petersen, M. E. Schatman and T. Deer, "The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain [published correction appears in J Pain Res," *J Pain Res,* vol. 15, pp. 3729-3832, 6 December 2022.

[7] S. P. Cohen, A. Bhaskar, A. Bhatia, A. Buvanendran, T. Deer, S. Garg, W. M. Hooten, R. W. Hurley, D. J. Kennedy, B. C. McLean, J. Y. Moon, S. Narouze, S. Pangarkar, D. A. Provenzano, R. . Rauck, B. T. Sitzman, M. Smuch, J. van Zundert, K. Vorenkamp, M. S. Wallace and Z. Zhao, "Consensus practice guidelines on interventions for lumbar facet joint pain from a multispecialty, international working group," *Reg Anesth Pain Med,* vol. 56, no. 6, pp. 424-467, 2020.

[8] R. H. Hurley, M. C. Adams, M. Barad, A. Bhaskar , A. Bhatia, A. Chadwick, T. R. Deer, J. Hah, W. M. Hooten, N. R. Kissoon, D. W. Lee, Z. Mccormick, J. Y. Moon, S. Narouze, D. A. Provenzano, B. J. Schneider, M. van Eerd, J. Van Zundert, M. S. Wallace, S. M. Wilson, Z. Zhao and S. P. Cohen, "Consensus practice guidelines on interventions for cervical spine (facet) joint pain from a multispecialty international working group," *Reg Anesth Pain Med,* vol. 47, no. 1, pp. 3-59, 2022.

[9] Washington State Health Care Authority, "Spinal Injections," 20 May 2016. [Online]. Available: http://hca.wa.gov/assets/program/spinal_injections-rr_final_findings_decision_060216.pdf. [Accessed 21 September 2023].

[10] Washington State Health Care Authority, "Health technology reviews: spinal injections," 2023. [Online]. Available: http://hca.wa.gov/about-hca/programs-and-initiatives/health-technology-assessment/spinal-injections. [Accessed 21 September 2023].

[11] S. P. Cohen, S. Hayek, Y. Semenov, P. F. Pasquina, R. L. Whtie, E. Veizi, J. H. Huang, C. Kurihara, Z. Zhao, K. B. Guthmiller, S. R. Griffith, A. V. Verdun, D. M. Giampetro and Y. Vorobeychik, "Epidural steroid injections, conservative treatment, or combination treatment for cervical radicular pain: a multicenter, randomized, comparative-effectiveness study," *Anesthesiology,* vol. 121, no. 5, pp. 1045-1055, 2014.

[12] A. Qaseem, T. J. Wilt, R. M. McLean, M. A. Forciea, T. D. Denberg, M. J. Barry, C. Boyd, R. D. Chow, N. . Fitterman, R. P. Harris, L. L. Humphrey and S. Nijan, "Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians," *Ann Intern Med,* vol. 166, no. 7, pp. 514-530, 2017.

[13] Washington State Health Care Authority, "About the Health Care Authority (HCA)," 2023. [Online]. Available: http://hca.wa.gov/about-hca. [Accessed 21 September 2023].

**Reviewed / Approved by NIA Clinical Guideline Committee**

**Disclaimer:** *National Imaging Associates, Inc. (NIA) authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Evolent Health LLC subsidiaries including, but not limited to, National Imaging Associates ("NIA"). The policies constitute only the reimbursement and coverage guidelines of NIA. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. NIA reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.*

| *National Imaging Associates, Inc. | |
|---|---|
| **Clinical guidelines:**<br>**PARAVERTEBRAL FACET JOINT DENERVATION (RADIOFREQUENCY NEUROLYSIS)** | **Original Date: October 2012** |
| **CPT Codes:**<br>**Cervical Thoracic Region: 64633, +64634**<br>**Lumbar Region: 64635, +64636** | **Last Revised Date: January 2023** |
| **Guideline Number: NIA_CG_302** | **Implementation Date: July 2024** |

# Table of Contents

## GENERAL INFORMATION

*It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*

## SPECIAL NOTE

- Unilateral procedures performed at the same level(s) on the right vs left;
  - If performed within 1 month of each other are counted as one procedure
  - A minimum timeframe is not required between denervation procedures
  - Opposite side denervation procedures performed within 1 month of the first side do not require follow-up information to be submitted

***See Legislative Requirements for specific mandates in the State of Washington***

## INDICATIONS

**PARAVERTEBRAL FACET JOINT DENERVATION/RADIOFREQUENCY NEUROLYSIS [1, 2, 3, 4]**

For the treatment of facet-mediated pain **ALL** of the following must be met:

- Lack of evidence that the primary source of pain being treated is from sacroiliac joint pain, discogenic pain, disc herniation or radiculitis
- Pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 [1-3]
- Duration of pain of at least **3 months**
  - For radiofrequency ablation following diagnostic medial branch blocks, a positive response to at least one local anesthetic block of the facet joint nerves (medial branch blocks), with at least 70% pain relief or improved ability to function for a minimal duration at least equal to that of the local anesthetic, but with insufficient sustained relief (less than 3 months duration) [5] documented as:
  - Continued pain, after the diagnostic relief period, causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 related to the requested spinal region. [5]
- Failure of conservative treatment* for a minimum of six (6) weeks in the last six (6) months a

  **NOTE**: Failure of conservative treatment is defined as one of the following:

  - Lack of meaningful improvement after a full course of treatment; **OR**
  - Progression or worsening of symptoms during treatment; **OR**
  - Documentation of a medical reason the member is unable to participate in the treatment (*Closure of medical or therapy offices, patient inconvenience, or*

*noncompliance without explanation does not constitute 'inability to complete' treatment*)

**IMAGING GUIDANCE [5, 6, 4]**
The facet joint is commonly identified under image guidance by Computed tomography (CT) or Fluoroscopy. Medial Branch Blocks are commonly identified by Fluoroscopy.

**NOTE: All** procedures must be performed using fluoroscopic or CT guidance

**REPEAT PROCEDURES [5, 6, 4]**

Facet joint denervation procedures may be repeated only as medically necessary. **Each** denervation procedure requires an authorization, and the following criteria must be met for repeat procedures:

- Positive response to prior radiofrequency denervation procedures with at least 50% pain relief or improved ability to function for at least 4 months
- The individual continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0-10 related to the requested spinal region.
- The individual is engaged in ongoing non-operative conservative therapy* unless the medical reason this treatment cannot be done is clearly documented.
- A maximum of 2 facet denervation procedures may be performed in a 12-month period **per spinal region**

**NOTE**: It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient).

## EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Radiofrequency denervation of the sacroiliac joint and/or sacral lateral branches (S1, S2, S3)

## CONTRAINDICATIONS

**FACET JOINT DENERVATION [1, 3]**

- Active systemic or spinal infection

- Skin infection at the site of needle puncture

## LEGISLATIVE REQUIREMENTS

**State of Washington**

- Washington State Health Care Authority Health Technology Assessment – 20140321B – Facet Neurotomy [7]
    - Facet Neurotomy is a **covered benefit with conditions** consistent with the criteria identified in the reimbursement determination
    - Lumbar Facet Neurotomy is a **covered benefit with the following conditions**;
        - Patient(s) must be over 17 years of age, and:
        - Has at least six months of continuous low back pain referable to the facet joint
        - The pain is non-radicular pain
        - Condition is unresponsive to other therapies including conservative care
        - There are no other clear structural cause of back pain
        - There is no other pain syndrome affecting the spine
        - For identification, diagnosis, and treatment:
            - Patient must be selected by at least 80% improvement in pain after each of two differential medial branch blocks, one short-acting; one long-acting
            - One or two joints per each intervention, with documented, clinically significant improvement in pain and/or function for six months before further neurotomy at any level
    - Cervical Facet Neurotomy for cervical pain is a **covered benefit with the following conditions**:
        - Limited to C3 - 4, through C6 -7
        - Patient(s) over 17 years of age, and:
        - Has at least six months of continuous neck pain referable to the facet joint
        - The pain is non-radicular
        - Condition is unresponsive to other therapies including conservative care
        - There are no other clear structural cause of neck pain
        - No other pain syndrome affecting the spine
        - For identification, diagnosis, and treatment:
            - Patient must be selected by 100% improvement in pain after each of two differential medial branch blocks, one short-acting; one long-acting

- One joint per each intervention, with documented, clinically significant improvement in pain and/or function for six months before further neurotomy at any level.

- Non-Covered Indicators
  - Facet Neurotomy for the thoracic spine **is not covered**.
  - Facet Neurotomy for headache **is not covered**.

---

## BACKGROUND

Facet joints may refer pain to adjacent structures, making the underlying diagnosis difficult as referred pain may assume a pseudoradicular pattern. Lumbar facet joints may refer pain to the back, buttocks, and lower extremities while cervical facet joints may refer pain to the head, neck, and shoulders.

Imaging studies may detect changes in facet joint architecture, but correlation between radiologic findings and symptoms is unreliable. Although clinical signs are also unsuitable for diagnosing facet joint-mediated pain, they may be of value in selecting individuals for controlled local anesthetic blocks of either the medial branches or the facet joint itself.

Interventions used in the treatment of individuals with a confirmed diagnosis of facet joint pain include medial branch nerve blocks in the lumbar, cervical, and thoracic spine; and radiofrequency neurolysis. The medial branch of the primary dorsal rami of the spinal nerves has been shown to be the primary innervations of facet joints.

**THERAPEUTIC PARAVERTEBRAL FACET JOINT DENERVATION (RADIOFREQUENCY NEUROLYSIS):**

Local anesthetic block is followed by the passage of radiofrequency current to generate heat and coagulate the target medial branch nerve. Traditional radiofrequency and cooled radiofrequency are included by this definition. Pulsed radiofrequency, cryo-ablation, or laser ablation are not included in this definition.

Radiofrequency neurolysis is a minimally invasive treatment for cervical, thoracic, and lumbar facet joint pain. It involves using energy in the radiofrequency range to cause necrosis of specific nerves (medial branches of the dorsal rami), preventing the neural transmission of pain. The objective of radiofrequency neurolysis is to both provide relief of pain and reduce the likelihood of recurrence.

Members of the American Society of Anesthesiologists (ASA) and the American Society of Regional Anesthesia and Pain Medicine (ASRA) have agreed that conventional or thermal radiofrequency ablation of the medial branch nerves to the facet joint should be performed for neck or low back pain. Radiofrequency neurolysis has been employed for over 30 years to treat facet joint pain. Prior to performing this procedure, shared decision-making between patient

and physician must occur, and the patient must understand the procedure and its potential risks and results.

# OVERVIEW

*****Conservative Treatment **[4, 8]**

Non-operative treatment should include a multimodality approach consisting of at least one (1) active and one (1) inactive components targeting the affected spinal region.

- Active components
  - Physical therapy
  - Physician-supervised home exercise program**
  - Chiropractic care
- Inactive Modalities
  - Medications (e.g., NSAIDs, steroids, analgesics)
  - Injections (e.g., epidural steroid injection, selective nerve root block)
  - Medical Devices (e.g., TENS unit, bracing)

****Home Exercise Program (HEP) [4, 9]**

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor

  **AND**

- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (e.g., increased pain or inability to physically perform exercises).

## POLICY HISTORY

| Date | Summary |
|---|---|
| January 2023 | • Added Legislative Language for the State of Washington<br>• Added section on image guidance<br>• Adjusted conservative treatment language in body and background sections<br>• Reduced background<br>• Added table of contents<br>• Updated references |
| May 2023 | • Moved RFA to RFA requirements to "Repeat Procedure" section |
| May 2022 | • Added note to clarify when INITIAL injection requirements must be met for approval<br>• Added region-specific wording to conservative treatment requirement (e.g., conservative therapy targeting the requested spinal region)<br>• Clarified average pain levels<br>• Added Exclusions section, including Denervation of any nerves other than medial branch nerves (i.e., sacroiliac joint denervation, sacral lateral branch denervation, etc.)<br>• Increased interval time frame from 2 weeks to 1 month for unilateral rf denervation's performed at same level<br>• Increased interval time from 2 weeks to 1 month for 2nd side denervation procedures<br>• Updated Contraindication Section<br>• Clarified lack of medical necessity of performing multiple pain procedures on same DOS |

## References


[1] J. K. Wray, B. Dixon and R. Przkora, "Radiofrequency Ablation," 12 June 2023. [Online]. Available: https://www.ncbi.nlm.nih.gov/books/NBK482387/. [Accessed 22 September 2023].

[2] Y. S. Chen, B. Liu, F. Gu and L. Sima, "Radiofrequency Denervation on Lumbar Facet Joint Pain in the Elderly: A Randomized Controlled Prospective Trial," *Pain Physician,* vol. 25, no. 8, pp. 569-576, 2022.

[3] D. Sayed, J. Grinder, N. Strand, J. Hagedorn, S. Falowski, C. M. Lam, V. T. Francio, D. P. Beall, N. D. Tomycz, J. R. Davanzo, R. Aiyer, D. W. Lee, H. Kalia, S. Sheen, M. N. Malinowski, M. Verdolin, S. Vodapally, A. Carayannopoulos, S. Jain, N. Azeem, R. Tolba, G. C. Chang Chien, P. Ghosh, A. J. Mazzola, K. Amirdelfan, K. Chakravarthy, E. Petersen, M. E. Schatman and T. Deer, "The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain [published correction appears in J Pain Res," *J Pain Res,* vol. 15, pp. 3729-3832, 6 December 2022.

[4] S. P. Cohen, A. Bhaskar, A. Bhatia, A. Buvanendran, T. Deer, S. Garg, W. M. Hooten, R. W. Hurley, D. J. Kennedy, B. C. McLean, J. Y. Moon, S. Narouze, S. Pangarkar, D. A. Provenzano, R. . Rauck, B. T. Sitzman, M. Smuch, J. van Zundert, K. Vorenkamp, M. S. Wallace and Z. Zhao, "Consensus practice guidelines on interventions for lumbar facet joint pain from a multispecialty, international working group," *Reg Anesth Pain Med,* vol. 56, no. 6, pp. 424-467, 2020.

[5] R. Perolat, A. Kastler, B. Nicot, J.-M. Pellat, F. Tahon, A. Attye, O. Heck, K. Boubagra, S. Grand and A. Krainik, "Facet joint syndrome: from diagnosis to interventional management," *Insights Imaging,* vol. 9, no. 5, pp. 773-789, 2018.

[6] C. E. Alexander, M. A. Cascio and M. Varacallo, "Lumbosacral Facet Syndrome," 4 August 2023. [Online]. Available: https://www.ncbi.nlm.nih.gov/books/NBK441906/. [Accessed 22 September 2023].

[7] Washington State Health Care Authority, "20140321B Facet Neurotomy," 16 May 2014. [Online]. Available: https://www.hca.wa.gov/about-hca/programs-and-initiatives/health-technology-assessment/facet-neurotomy; https://www.hca.wa.gov/assets/program/052714_facet_final_findings_decision%5B1%5D.pdf. [Accessed 25 September 2023].

[8] S. P. Cohen, S. Hayek, Y. Semenov, P. F. Pasquina, R. L. Whtie, E. Veizi, J. H. Huang, C. Kurihara, Z. Zhao, K. B. Guthmiller, S. R. Griffith, A. V. Verdun, D. M. Giampetro and Y. Vorobeychik, "Epidural steroid injections, conservative treatment, or combination treatment for cervical radicular pain: a multicenter, randomized, comparative-effectiveness study," *Anesthesiology,* vol. 121, no. 5, pp. 1045-1055, 2014.

[9] A. Qaseem, T. J. Wilt, R. M. McLean, M. A. Forciea, T. D. Denberg, M. J. Barry, C. Boyd, R. D. Chow, N. Fitterman, R. P. Harris, L. L. Humphrey and S. Nijan, "Noninvasive Treatments for

Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians," *Ann Intern Med,* vol. 166, no. 7, pp. 514-530, 2017.

**Reviewed / Approved by NIA Clinical Guideline Committee**

**Disclaimer:** *National Imaging Associates, Inc. (NIA) authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Evolent Health LLC subsidiaries including, but not limited to, National Imaging Associates ("NIA"). The policies constitute only the reimbursement and coverage guidelines of NIA. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. NIA reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.*

| *National Imaging Associates, Inc. | |
|---|---|
| **Clinical guidelines:**<br>**SACROILIAC JOINT INJECTIONS** | **Original Date: January 2014** |
| **CPT Codes: 27096, G0260** | **Last Revised Date: January 2023** |
| **Guideline Number: NIA_CG_305** | **Implementation Date: July 2024** |

# Table of Contents

## GENERAL INFORMATION

*It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*

## SPECIAL NOTE

Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **INITIAL** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

***See Legislative Requirements for specific mandates in the State of Washington***

## INDICATIONS [1, 2, 3]

**SACROILIAC JOINT (SIJ) INJECTIONS (Intraarticular or ligamentous injections only)**

For the treatment of Sacroiliac Joint (SIJ) pain **ALL** of the following must be met:

- Primarily axial low back pain (below level of L5) which may radiate to the groin or lower extremity
- Pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 related to the requested spinal region.
- A cluster of any three (3) of the following positive provocation exam [2, 4, 5] findings to suggest the diagnosis:
    - Pelvic (SI) distraction test
    - Pelvic (SI) compression test
    - Sacral Thrust test
    - FABER (Patrick's test)
    - Posterior shear test
    - Yeoman's test
    - Gaenslen's test
    - Thigh Thrust test
- Duration of pain of at least **3 months**
- Failure to respond to non-operative conservative therapy* targeting the requested spinal region for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented; **OR** details of active engagement in ongoing non-operative conservative non-operative therapy* if the individual has had prior spinal injections in the same region

**SPONDYLOARTHROPATHY TREATMENT [4, 6, 7]**

**ALL** of the following must be met:

- The individual has experienced ≥ 3 months of low back pain
- Age of onset < 45 years
- Comprehensive pain management program is in place including physical therapy, home exercise, patient education, psychosocial support, and/or oral medication
- Prior history of evidence of sacroiliitis on imaging (i.e., active inflammation on magnetic resonance imaging [MRI] or definite radiographic sacroiliitis grade > 2 bilaterally *or* grade 3-4 unilaterally)
- ***1 or more*** spondyloarthropathy features:
    - Inflammatory back pain with **at least 4** of the following criteria present:
        - Age at onset < 45 years
        - Insidious onset
        - Improvement with exercise
        - No improvement with rest
        - Pain at night (with improvement upon getting up)
    - Arthritis
    - Enthesitis of the heel (irritability of muscles, tendons, or ligaments where they enter the bone)
    - Uveitis (inflammation of the uvea, the middle layer of the eye)
    - Dactylitis (inflammation of a finger or toe)
    - Psoriasis
    - Crohn's/colitis
    - Good response to NSAIDs
    - Family history of spondyloarthropathy
    - Positive testing for HLA-B27
    - Elevated C-reactive protein (CRP)

**IMAGING GUIDANCE [1, 2, 3, 8]**

The sacroiliac joint is commonly identified under image guidance by Fluoroscopy or Computed tomography (CT). CT is less effective than Fluoroscopy regarding observing of the escape of the injectate to the adjacent structures and cannot rule out concurrent intravascular flow. With proper use by skilled interventional pain physicians with ultrasound experience, the use of ultrasound guidance is similar to CT or Fluoroscopy but can have a lower accuracy of needle placement.

Ultrasound guidance can be an effective alternative if fluoroscopy or CT guided techniques are contraindicated; however, individual patient factors such as poor visualization due to deeper tissue layers (e.g., increased Body Mass Index (BMI) may contributes to substandard image resolution).

**NOTE: ALL** procedures must be performed under imaging guidance

**DIAGNOSTIC PURPOSES FOR SURGICAL PLANNING [4, 9]**

- For diagnostic purposes all of the following must be met:
  - The sacroiliac joint injection is an image-guided, contrast-enhanced intra-articular injection
  - At least 75% pain relief for the expected duration of the anesthetic after each diagnostic injection
  - After the diagnostic relief period, the individual continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 related to the requested spinal region.
  - No more than two diagnostic injections per diagnostic phase
  - Documentation of a pre-operative evaluation and plan for SIJ surgery

**REPEAT INJECTIONS [2, 4]**

Sacroiliac joint injections may be repeated only as medically necessary. **Each** sacroiliac joint injection requires an authorization, and the following criteria must be met for repeat injections:

- Up to 2 sacroiliac joint injections may be performed in the initial treatment phase, no sooner than 2 weeks apart, provided that at least 50% pain relief or significant documented functional improvement is obtained
- Sacroiliac joint injections may only be repeated after the initial treatment phase if the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** after each therapeutic injection
- The individual continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 related to the requested spinal region.
- The individual is engaged in ongoing active conservative therapy*, unless the medical reason this treatment cannot be done is clearly documented
- For individuals that have received other interventional pain injections in the lumbar/sacral region (e.g., epidural steroid injection or facet joint injection) since the last SIJ injection, at least one repeat positive provocative exam finding is required (pelvic (SI) distraction test, pelvic (SI) compression test, sacral thrust test, FABER (Patrick's test), posterior shear test, Yeoman's test, Gaenslen's test, or thigh thrust).
- A maximum of 4 sacroiliac joint injections may be performed in a 12-month period

## EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Sacral lateral branch blocks (S1, S2, S3)

- Radiofrequency denervation of the sacroiliac joint

## CONTRAINDICATIONS [1, 3]

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Local malignancy

---

## LEGISLATIVE REQUIREMENTS

### State of Washington

- **Washington State Health Care Authority Technology Assessment** - 20160318B – Spinal Injections [10]
  Limitations of Coverage*:
  - Therapeutic sacroiliac joint injections for chronic pain is a covered benefit when all of the following conditions are met: ƒ
    - With fluoroscopic guidance or CT guidance ƒ
    - After failure of conservative therapy; and ƒ
    - No more than one without clinically meaningful improvement in pain and function, subject to agency review ƒ

* This coverage policy does not apply to those with a known systemic inflammatory disease such as: ankylosing spondylitis, psoriatic arthritis or enteropathic arthritis.

---

## BACKGROUND

Low back pain originating from the SIJ can result from inflammatory conditions such as sacroiliitis, spondyloarthropathy (e.g., ankylosing spondylitis, rheumatoid spondylitis), or from postsurgical or traumatic injury, degeneration (wear and tear), or pregnancy. SIJ pain most often occurs in the buttocks and lower back and may radiate down through the buttocks and the leg. Physical examination and radiographic techniques may confirm a diagnosis related to spondyloarthropathy. Physical examination, including provocative maneuvers to elicit pain response, and controlled SIJ injections can help diagnose noninflammatory pain arising from the SIJ.

Spinal injections for the treatment of SIJ pain syndrome are typically performed as one part of a comprehensive treatment program, but initial treatment usually includes over-the-counter analgesics, home exercise program to improve or maintain spinal mobility, and therapy sessions with a physical therapist involving range-of-motion, stretching, and strengthening exercises.

**Sacroiliac joint injections are typically used for the following conditions:**

- **Sacroiliac joint (SIJ) syndrome** may be caused by various events, including pain secondary to postsurgical or traumatic injury, degeneration (wear and tear), or pregnancy.
- **Diagnostic SIJ injections** are used to determine if the SIJ pain originates with the SIJ. Diagnostic blocks can reveal (or fail to reveal) that the source of pain is originating from the SIJ; appropriate treatment plan can be developed.
- **Therapeutic SIJ injections** used to treat SIJ pain once it has been determined that the SIJ is the origin of the pain. A therapeutic injection typically includes a corticosteroid and a local anesthetic that can be injected directly into the joint (intra-articular) or into the tissues surrounding the joint (periarticular).
- **Spondyloarthropathy** (also known as spondyloarthritis) is the name for a family of rheumatic diseases that cause arthritis. Sacroiliitis is a key indicator of spondyloarthritis and is diagnosed with imaging. Individuals with spondyloarthropathy are generally managed by rheumatologists.

The indications for coverage for the treatment of spondyloarthropathy have been established through criteria developed by the Assessment of SpondyloArthritis International Society (ASAS) for the classification of axial spondyloarthritis. [7] They are in keeping with the benefit guidelines developed by the Centers for Medicare & Medicaid Services (CMS). [11]

Telehealth visits have become routine in modern medical practice. However, sacroiliac joint injections cannot be performed via telehealth encounters. Individuals who can schedule an in-person encounter for injection are expected to also schedule an in-person encounter for provocative physical examination, prior to injection, in order to document the medical necessity of the joint injection.

**MEDICAL NECESSITY**

It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient).

*C**ONSERVATIVE TREATMENT [12, 13]**

Non-operative treatment should include a multimodality approach consisting of at least one (1) active and one (1) inactive component targeting the affected spinal region.

- Active components
  - Physical Therapy
  - Physician-supervised home exercise program**
  - Chiropractic Care
- Inactive Modalities
  - Medications (e.g., NSAIDs, steroids, analgesics)

- Injections (e.g., epidural steroid injection, selective nerve root block)
- Medical Devices (e.g., TENS unit, bracing)

****HOME EXERCISE PROGRAM (HEP) [14, 12]**

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor

  **AND**

- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (e.g., increased pain or inability to physically perform exercises).

## POLICY HISTORY

| Date | Summary |
|---|---|
| January 2023 | • Added Legislative Language for the State of Washington<br>• Updated provocation test to 3 to reflect EBM<br>• Removed Anterior Impingement Test and Log roll as provocation tests<br>• Added section on imaging guidance<br>• Added diagnostic section to repeat injections<br>• Added clarification to VAS section to include 'related to the requested spinal region'<br>• Added Local Malignancy and removed Prolotherapy from contraindications section<br>• Adjusted conservative treatment language in the body and background sections<br>• Updated CPT Codes per the Matrix<br>• Reduced background section<br>• Added table of contents<br>• Updated references |
| May 2023 | • Adjusted time interval for repeat injections from minimum of 6 weeks to 2 months after each injection<br>• Added Washington State Legislative Language |
| May 2022 | • Added note to clarify when **INITIAL** injection requirements must be met for approval<br>• Reorganized indications for clarity and uniformity<br>• Added region-specific wording to conservative treatment requirement (e.g., conservative therapy targeting the requested spinal region)<br>• For consistency among guidelines, changed wording and order of contraindications to injections<br>• Add US guidance for injections as option (in addition to fluoroscopic or CT guidance)<br>• Under treatment of spondyloarthropathy, replaced 'or' with 'and' in list of required components of a comprehensive pain management program<br>• Updated Frequency of Repeat Injections section<br>• Clarified lack of medical necessity of performing multiple pain procedures on same DOS<br>• Updated Contraindications |

## References


[1] L. Wu, D. Tafti and M. Varacallo, "Sacroiliac Joint Injection," StatPearls, 4 August 2023. [Online]. Available: https://www.ncbi.nlm.nih.gov/books/NBK513245/. [Accessed 25 September 2023].

[2] L. Manchikanti, A. D. Kaye, A. Soin, S. L. Albers, D. Beall, R. Latchaw, M. R. Sanapati, S. S. Sairam Atluri, A. Abd-Elsayed, S. Abdi, S. Aydin, S. Bakshi, M. V. Boswell, R. Buenaventura, J. Cabaret, A. K. Calodney, K. D. CAndido, P. J. Christo, L. Cintron, S. Diwan, C. Gharibo, J. Grider, M. Gupta, B. Haney, M. E. Harned, S. Helm li, J. Jameson, S. Jha, A. M. Kaye, N. N. Knezevic, R. Kosanovic, M. V. Manchikanti, A. Navani, G. R. Vidyasagar Pampati, R. Pasupuleti, C. Philip, K. Rajput, N. S. Gururau Sudarshan, R. VAnaparthy, B. W. Wargo and J. A. Hirsch, "Comprehensive Evidence-Based Guidelines for Facet Joint Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Guidelines Facet Joint Interventions 2020 Guidelines," *Pain Physician,* vol. 23, no. 3S, pp. S1-S127, 2020.

[3] D. Sayed, J. Grinder, N. Strand, J. Hagedorn, S. Falowski, C. M. Lam, V. T. Francio, D. P. Beall, N. D. Tomycz, J. R. Davanzo, R. Aiyer, D. W. Lee, H. Kalia, S. Sheen, M. N. Malinowski, M. Verdolin, S. Vodapally, A. Carayannopoulos, S. Jain, N. Azeem, R. Tolba, G. C. Chang Chien, P. Ghosh, A. J. Mazzola, K. Amirdelfan, K. Chakravarthy, E. Petersen, M. E. Schatman and T. Deer, "The American Society of Pain and Neuroscience (ASPN) Evidence-Based Clinical Guideline of Interventional Treatments for Low Back Pain [published correction appears in J Pain Res," *J Pain Res,* vol. 15, pp. 3729-3832, 6 December 2022.

[4] J. MacVicar, D. S. Kreiner, B. Duszynski and D. J. Kennedy, "Appropriate Use Criteria for Fluoroscopically Guided Diagnostic and Therapeutic Sacroiliac Interventions: Results from the Spine Intervention Society Convened Multispecialty Collaborative," *Pain Med,* vol. 18, no. 11, pp. 2081-2095, 2017.

[5] H. Telli, S. Telli and M. Topal, "The Validity and Reliability of Provocation Tests in the Diagnosis of Sacroiliac Joint Dysfunction," *Pain Physician,* vol. 21, no. 4, pp. E367-E376, 2018.

[6] E. Tomero, J. Mulero, E. de Miguel, C. Fernandez-Espartero, M. Gobbo, M. A. Descalzo, E. Collantes-Estevez, P. Zarco, S. Munoz-Fernandez, l. Carmona and ESPERANZA Study Group, "Performance of the Assessment of Spondyloarthritis International Society criteria for the classification of spondyloarthritis in early spondyloarthritis clinics participating in the ESPERANZA programme," *Rheumatology (Oxford),* pp. 353-360, 2014.

[7] J. Sieper, M. Rudwaleit, X. Baraliakos, J. Brandt, J. Braun, R. Burgos-Bargas, M. Dougados, K.-G. Hermann, R. Landewe, W. Waksymowych and D. van der Heijde, "The Assessment of SpondyloArthritis international," *Ann Rheum Dis,* vol. 68, no. Suppl II, pp. ii1-ii44, 2009.

[8] Z. M. Ashmore, M. M. Bies, J. B. Meiling, R. N. Moman, L. C. Hassett, C. L. Hunt, S. P. Cohen and W. M. Hooten, "Ultrasound-guided lumbar medial branch blocks and intra-

articular facet joint injections: a systematic review and meta-analysis," *Pain Rep,* vol. 7, no. 3, p. e1008, 16 May 2022.

[9] P. Whang, E. Darr, S. Meyer, D. Kovalsky, C. Frank, H. Lockstadt, R. Limoni, A. Redmond, P. Ploska, M. Oh, A. Chowdhary, D. Cher and T. Hillen, " Long-Term Prospective Clinical And Radiographic Outcomes After Minimally Invasive Lateral Transiliac Sacroiliac Joint Fusion Using Triangular Titanium Implants," *Med Devices (Auckl),* vol. 12, pp. 411-422, 26 Sept 2019.

[10] Washington State Health Care Authority, "Spinal Injections," 20 May 2016. [Online]. Available: https://www.hca.wa.gov/about-hca/programs-and-initiatives/health-technology-assessment/spinal-injections; https://www.hca.wa.gov/assets/program/spinal_injections-rr_final_findings_decision_060216.pdf. [Accessed 25 September 2023].

[11] Centers for Medicare & Medicaid Services, "Pain Management," 24 June 2020. [Online]. Available: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=33622&ver=27. [Accessed 26 September 2023].

[12] S. P. Cohen, A. Bhaskar, A. Bhatia, A. Buvanendran, T. Deer, S. Garg, W. M. Hooten, R. W. Hurley, D. J. Kennedy, B. C. McLean, J. Y. Moon, S. Narouze, S. Pangarkar, D. A. Provenzano, R. Rauck, B. T. Sitzman, M. Smuch, J. van Zundert, K. Vorenkamp, M. S. Wallace and Z. Zhao, "Consensus practice guidelines on interventions for lumbar facet joint pain from a multispecialty, international working group," *Reg Anesth Pain Med,* vol. 56, no. 6, pp. 424-467, 2020.

[13] S. P. Cohen, S. Hayek, Y. Semenov, P. F. Pasquina, R. L. Whtie, E. Veizi, J. H. Huang, C. Kurihara, Z. Zhao, K. B. Guthmiller, S. R. Griffith, A. V. Verdun, D. M. Giampetro and Y. Vorobeychik, "Epidural steroid injections, conservative treatment, or combination treatment for cervical radicular pain: a multicenter, randomized, comparative-effectiveness study," *Anesthesiology,* vol. 121, no. 5, pp. 1045-1055, 2014.

[14] A. Qaseem, T. J. Wilt, R. M. McLean, M. A. Forciea, T. D. Denberg, M. J. Barry, C. Boyd, R. D. Chow, N. Fitterman, R. P. Harris, L. L. Humphrey and S. Nijan, "Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians," *Ann Intern Med,* vol. 166, no. 7, pp. 514-530, 2017.

**Reviewed / Approved by NIA Clinical Guideline Committee**

**Disclaimer:** *National Imaging Associates, Inc. (NIA) authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Evolent Health LLC subsidiaries including, but not limited to, National Imaging Associates ("NIA"). The policies constitute only the reimbursement and coverage guidelines of NIA. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. NIA reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.*

| | |
|---|---|
| ***National Imaging Associates, Inc.** | |
| **Clinical guidelines:**<br>**IMPLANTABLE INFUSION PUMP INSERTION** | **Original Date: July 2015** |
| **CPT Codes:**<br>**62350, 62351, 62355, 62360, 62361, 62362** | **Last Revised Date: January 2024** |
| **Guideline Number: NIA_CG_310** | **Implementation Date: July 2024** |

# Table Of Contents



# GENERAL INFORMATION

*It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*

# STATEMENT

An Implantable Infusion Pump (IIP), also referred to as an Implantable Drug Delivery System (IDDS), is a device for the delivery of medication to manage severe, chronic, intractable pain and/or chronic intractable spasm.

**PURPOSE**
The purpose of this guideline is to address criteria for intraspinal drug trials as well as the permanent placement of an implantable infusion pump.

**NOTE:** There are no medical indications for intrathecal treatments except chronic pain and intractable spasticity.

## INDICATIONS FOR IMPLANTABLE INFUSION PUMP INSERTION

**INTRASPINAL DRUG TRIAL**
For the treatment of chronic intractable pain in non-terminal individuals (**ALL** the following criteria must be met):

- Pain causing functional disability that significantly interferes with activities of daily living including ability to work and overall quality of life; **OR** persistent pain level of ≥ 6 on a scale of 0 to 10 despite treatment
- Failure to respond to non-operative conservative therapy* targeting the requested spinal region for a minimum of 12 weeks unless the medical reason this treatment cannot be done is clearly documented

For the treatment of spasticity in non-terminal individuals (**ALL** the following must be met):

- Intractable spasticity that results in the individual's inability to maintain an upright posture, severely impairs balance in ambulation, or significantly interferes with activities of daily living related to **ONE** of the following conditions [1]:
    - Spinal cord injury
    - Multiple sclerosis
    - Stiff person syndrome
    - Other medical conditions causing intractable spasms
- Failure to respond to a minimum of 12 weeks of non-operative conservative therapy (e.g., oral medications, physical therapy, etc.)

**Additional Trials**
A second intraspinal drug trial is indicated when documentation of the first trial of intraspinal (intrathecal or epidural) medication administered as a bolus or by continuous infusion resulted in one of the following:

- Less than 50% pain relief
- Intolerable side effects

Limit of two intraspinal drug trials for preliminary consideration of chronic intractable pain or spasticity management with permanent implantable device in non-terminal individuals.

**NOTE:** Intrathecal trials are not indicated in opioid-naïve individuals

**PERMANENTLY IMPLANTED INFUSION PUMP**

For the treatment of chronic intractable pain in non-terminal individuals (**ALL** the following must be met):

- Pain causing functional disability that significantly interferes with activities of daily living, including ability to work and overall quality of life; **OR** persistent pain level of ≥ 6 on a scale of 0 to 10 despite treatment
- Failure to respond to non-operative conservative therapy* targeting the requested spinal region for a minimum of 12 weeks unless the medical reason this treatment cannot be done is clearly documented
- At least 12 weeks of oral or transdermal opioid or nonopioid pain medications
- Documentation of a successful trial of intraspinal (intrathecal or epidural) medication administered as a bolus or by continuous infusion providing at least 50% pain relief with tolerable side effects
- Documentation of a completed psychological assessment prior to permanent pump insertion that documents the individual's cognitive ability, physical capability, and willingness to participate in implanted infusion pump therapy

For the treatment of spasticity in non-terminal individuals (**ALL** of the following must be met):

- Intractable spasticity that results in the individual's inability to maintain an upright posture, severely impairs balance in ambulation, or significantly interferes with activities of daily living related to **one** of the following conditions [1];
    - Spinal cord injury
    - Multiple sclerosis
    - Stiff person syndrome
    - Other medical conditions causing intractable spasms
- Failure to respond to a minimum of 12 weeks of conservative therapy (e.g., oral medications, physical therapy, etc.)
- Documentation of a successful trial of intraspinal (intrathecal or epidural) antispasmodic medication administered as a bolus or by continuous infusion providing at least 50% spasm relief with tolerable side effects
- Documentation of a completed psychological assessment prior to permanent pump insertion that documents the individual's cognitive ability, physical capability, and willingness to participate in implanted infusion pump therapy

**NOTE:** Failure of conservative treatment is defined as one of the following:

- Lack of meaningful improvement after a full course of treatment; **OR**
- Progression or worsening of symptoms during treatment; **OR**
- Documentation of a medical reason the member is unable to participate in treatment (*Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute "inability to complete" treatment)*

**PUMP REPLACEMENT, REVISION AND REMOVAL**

Replacement, revision, or removal of an Implanted Infusion Pump is indicated with one of the following:

- Loss of effectiveness (e.g., battery depletion)
- Intolerance by the individual
- Infection
- Painful generator site
- Patient demand
- Documentation of pump or catheter malfunction impairing function or safety
- **Other medical reason deemed appropriate for replacement, revision, or removal**

**NOTE:** If the pump is programmable, the pump analysis report should accompany the request for replacement.

## CONTRAINDICATIONS FOR IMPLANTED INFUSION PUMP

- Active systemic or spinal infection
- Body habitus that is insufficient to support the weight and bulk of the device

**POLICY HISTORY**

| Date | Summary |
|---|---|
| January 2024 | • Added criteria for additional intrathecal trials<br>• Expanded pump criteria to include non-opioid medical trials<br>• Expanded replacement indications to also include revision and removal<br>• Edited background |
| May 2023 | Removed language 'A life expectancy of at least 3 months' |
| May 2022 | • Reorganized and reworded indications for clarity and uniformity<br>• Under permanent implanted infusion pump for treatment of chronic pain:<br>  ○ Added OR persistent pain levels 6 or greater on a 10-point scale despite treatment<br>  ○ Added requirement of minimum of 12 weeks of oral or transdermal opiate pain medications<br>• Simplified indications for pump replacement<br>• Updated Contraindications |

## REFERENCES


[1] A. McIntyre, R. Mays, S. Mehta, S. Janzen, A. Townson, J. Hsieh, D. Wolfe and R. Teasell, "Examining the effectiveness of intrathecal baclofen on spasticity in individuals with chronic spinal cord injury: A systematic review," *The Journal of Spinal Cord Medicine,* vol. 37, no. 1, 2014.

[2] Annals of Internal Medicine, "Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians," 2017. [Online].

[3] The American College of Radiology, *ACR Appropriateness Criteria Low Back Pain: 2021 Update,* 2021.

**Reviewed / Approved by NIA Clinical Guideline Committee**

**Disclaimer:** *National Imaging Associates, Inc. (NIA) authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Evolent Health LLC subsidiaries including, but not limited to, National Imaging Associates ("NIA"). The policies constitute only the reimbursement and coverage guidelines of NIA. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. NIA reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.*

| *National Imaging Associates, Inc. | |
|---|---|
| **Clinical guidelines:**<br>**Spinal Cord Stimulation** | **Original Date: August 2020** |
| **CPT Codes:**<br>**63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688** | **Last Revised Date: January 2023** |
| **Guideline Number: NIA_CG_405** | **Implementation Date: July2024** |

# Table of Contents

# GENERAL INFORMATION

*It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*

# INDICATIONS

### SPINAL CORD STIMULATION (SCS) [1, 2, 3, 4, 5]

A spinal cord stimulation trial is appropriate when **ALL** the following criteria are met:

- Pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10
- Failure to respond to non-operative conservative therapy* for a minimum of 6 months unless the medical reason this treatment cannot be done is clearly documented
- A completed psychological assessment that documents the following: [6, 7, 8, 9]
    - Pain is not due to psychiatric disorders such as depression, anxiety, somatic symptom disorder, or sequelae of substance use
    - Satisfactory management of personality disorders
    - Satisfactory management of substance use disorder in recovery
    - Demonstration of cognitive ability to manage the stimulator
- Pain caused by at least **ONE** of the following:
    - Failed spine surgery syndrome (FSSS) or post-laminectomy syndrome [10]
    - Complex regional pain syndrome (CRPS), type I or type II, characterized by **ALL** of the following:
        - Unilateral vasomotor changes
            - Changes in skin color; cyanotic, or mottled;
            - Changes in skin temperature; **OR**
            - Unilateral edema
        - Unilateral sudomotor changes
            - Skin is dry; **OR**
            - Skin is moist
        - Unilateral trophic changes
            - Skin is smooth or shiny;
            - Soft issue atrophy;
            - Joint stiffness, with decreased passive ROM;
            - Nail changes; **OR**
            - Hair growth changes
    - Chronic neuropathic pain of certain origins that falls into **ONE** of the following diagnoses:
        - Lumbosacral arachnoiditis
        - Post herpetic neuralgia

- Radiculopathy
- Chronic ischemic leg pain
- Diabetic peripheral neuropathy [11]
- Phantom limb syndrome (stump pain)
- Peripheral neuropathy
- Chronic back pain (neuropathic pain) and not a surgical candidate
- Chronic, refractory angina pectoris, characterized by **ALL** the following:
    - Continued angina after percutaneous coronary intervention or coronary artery bypass graft
    - Not a candidate for further revascularization
    - Angina is NYHA (New York Heart Association) III (less than ordinary physical activity causes symptoms) or IV (symptoms present at rest)
    - Optimal pharmacotherapy for at least one month with failure to tolerate medications in indicated dosage or failure to respond adequately to indicated medications

**PERMANENT SPINAL CORD STIMULATOR [3, 12]**
Appropriate when **ALL** the following criteria are met:

- Documentation of a successful trial of the temporary SCS device providing at least 50% reduction in pain
- Significant functional improvement for a minimum duration of 3 days
- The type of stimulator device used for temporary trial will be the same used for permanent spinal cord stimulator placement

**REVISION OR REMOVAL OF SPINAL CORD STIMULATOR DEVICE**
Indicated with **ONE** of the following:

- Migration of lead(s)
- Loss of effectiveness
- Intolerance by the individual
- Infection
- Painful generator site
- Development of neurological deficits
- Patient demand

## CONTRAINDICATIONS [4]

- Active systemic or spinal infection
- Body habitus that is insufficient to support the weight and bulk of the device

## BACKGROUND [13]

The most common indication for spinal cord stimulator (SCS) placement is chronic pain from failed spine surgery syndrome. SCS is a minimally invasive, non-opioid alternative therapy used for the treatment of chronic neuropathic pain or ischemic pain. SCS has been well established as a safe and effective treatment of pain derived from a wide variety of etiologies. For individuals with chronic pain who have failed conservative approaches, SCS should be considered among other options before prescribing long-term opioids.

SCS is used to treat some common indications to include, but not limited to, failed spine surgery syndrome (FSSS), complex regional pain syndrome, painful peripheral vascular disease, and intractable angina. Limited literature suggests that SCS may also be beneficial for individuals with visceral abdominal and perineal pain and for painful diabetic neuropathy.

Based primarily on differences in clinical observations, SCS therapies can be categorized into at least two modalities to include paresthesia SCS (classical SCS) and sub-perception SCS (e.g., burst, kHz). Paresthesia SCS is generally characterized by programming stimulation parameters (including electric field configuration) between metal contacts residing in the epidural space such that the individual experiences paresthesia and the paresthesia topography overlaps the pain topography as much as possible.

***CONSERVATIVE TREATMENT [14, 15, 5]**

Non-operative treatment should include a multimodality approach consisting of at least one (1) active and one (1) inactive component targeting the affected spinal region.

- Active components
  - Physical Therapy
  - Physician-supervised home exercise program**
  - Chiropractic Care
- Inactive Modalities
  - Medications (e.g., NSAIDs, steroids, analgesics)
  - Injections (e.g., epidural steroid injection, selective nerve root block)
  - Medical Devices (e.g., TENS unit, bracing)

****HOME EXERCISE PROGRAM (HEP) [14, 16]**

The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor

  **AND**

- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (e.g., increased pain or inability to physically perform exercises).

## POLICY HISTORY

| Date | Summary |
|---|---|
| January 2023 | • Adjusted psychological section to address pain is not due to psychiatric disorders, personality disorders and substance use disorders are being managed<br>• Adjusted conservative treatment language in body and background sections<br>• Reduced Background section<br>• Added table of contents<br>• Updated references |
| May 2023 | • No Change |
| May 2022 | • Reorganized and reworded indications for clarity and uniformity<br>• Clarified average pain on 10-point scale<br>• Clarified pain causing functional disability<br>• Added Contraindications section |

## References


[1] S. Thomson, F. Huygen, S. Prangnell, J. De Andres, G. Baranidharan, H. Belaid, N. Berry, B. Billet, J. Cooil, G. De Carolis, L. Demartini, S. Eldabe, S. Gatzinsky, J. W. Kallewaard, K. Meier, M. Paroli, A. Stark, M. Winkelmuller and H. Stoevelaar, "Appropriate referral and selection of patients with chronic pain for spinal cord stimulation: European consensus recommendations and e-health tool," *Eur J Pain,* vol. 24, no. 6, pp. 1169-1181, 2020.

[2] B. T. Sitzman and D. A. Provenzano, "Best Practices in Spinal Cord Stimulation," *Spine (Phila Pa 1976),* vol. 42, no. Suppl 14, pp. S67-S71, 2017.

[3] H. Shanthanna, S. Eldabe, D. A. Provenzano, B. . Bouche, E. Buchser, R. Chadwick, T. L. Doshi, R. Duarte, C. Hunt, F. J. Huygen, J. Knight, L. Kohan, R. North, J. Rosenow, C. J. Winfree and S. Narouze, "Evidence-based consensus guidelines on patient selection and trial stimulation for spinal cord stimulation therapy for chronic non-cancer pain," *Reg Anesth Pain Med,* vol. 48, no. 6, pp. 273-287, 2023.

[4] K. Garcia, J. K. Wray and S. Kumar, "Spinal Cord Stimulation," 24 April 2023. [Online]. Available: https://www.ncbi.nlm.nih.gov/books/NBK553154/. [Accessed 26 September 2023].

[5] T. R. Deer, M. Russo, J. S. Grider, J. Pope, J. M. Hagedorn, J. Weisbein, A. Abd-Elsayed, R. Benyamin, L. J. Raso, K. V. Patel, D. Provenzano and P. S. Kim, "The Neurostimulation Appropriateness Consensus Committee (NACC): Recommendations on Best Practices for Cervical Neurostimulation [published correction appears in Neuromodulation," *Neuromodulation,* vol. 25, no. 1, pp. 35-52, 2022.

[6] American Psychiatric Association, DSM-5 Task Force, Diagnostic and statistical manual of mental disorders: DSM-5™ (5th ed.), Washington: American Psychiatric Publishing, Inc, 2013.

[7] D. Marazziti, F. Mungai, L. Vivarelli, S. Presta and B. Dell'Osso, "2. Marazaaiti, D. (2006 November). Pain and psychiatry: a critical analysis and pharmacological review," *Clinical Practice and Epidemiology in Mental Health,* vol. 2, no. 31, 6 Nov 2006.

[8] J. Katz, B. Rosenbloom and S. Fashler, "Chronic Pain, Psychopathology, and DSM-5 Somatic Symptom Disorder," *Can J Psychiatry,* vol. 60, no. 4, pp. 160-7, Apr 2015.

[9] Substrance Abuse and Mental Health Services Administration, "CH 3 Chronic Pain Management," in *Managing Chronic Pain in Adults with or in Recovery from Substance Use Disorders. Treatment Improvement Protocol (TIP) Series 54.*, Rockville, MD: HHS, 2011, p. 34.

[10] J. S. Grider, L. Manchikanti, A. Carayannopoulos, M. Lal Sharma, C. C. Balog, M. E. Harned, V. Grami, R. Justiz, K. H. Nouri, S. M. Hayek and R. Vallejo, "Effectiveness of Spinal Cord Stimulation in Chronic Spinal Pain: A Systematic Review," *Pain Physician,* vol. 19, no. 1, pp. E33-E54, 2016.

[11] E. A. Petersen, T. G. Stauss, J. A. Scowscroft, E. S. Brooks, J. L. White, S. M. Sills, K. Amirdelfan, M. N. Guirguis, J. Xu, C. Yu, A. Nairizi, D. G. Patterson, K. C. Toulfas, M. J. Creamer, V. Galan, R. Bundschu, N. D. Mehta, D. . Sayed, S. P. Lad, D. J. DiBenedetto, K. A. Sethi, J. H. Goree, M. T. Bennett, N. J. Harrison, A. F. Israel, P. Chang, P. W. Wu, C. E. Argoff, C. E. Nasr, R. S. Taylor, D. L. Caraway and N. A. Mekhail, "Durability of High-Frequency 10-kHz Spinal Cord Stimulation for Patients With Painful Diabetic Neuropathy Refractory to Conventional Treatments: 12-Month Results From a Randomized Controlled Trial," *Diabetes Care,* vol. 45, no. 1, pp. e3-e6, 2022.

[12] A. M. Dydyk and P. Tadi, "Spinal Cord Stimulator Implant," 3 July 2023. [Online]. Available: https://www.ncbi.nlm.nih.gov/books/NBK555994/. [Accessed 26 September 2023].

[13] N. Mekhail, O. Visnjevac, G. Azer, D. S. Mehanny, P. Agrawal and V. Foorsov, "Spinal Cord Stimulation 50 Years Later: Clinical Outcomes of Spinal Cord Stimulation Based on Randomized Clinical Trials-A Systematic Review," *Reg Anesth Pain Med,* vol. 43, no. 4, pp. 391-406, 2018.

[14] S. P. Cohen, A. Bhaskar, A. Bhatia, A. Buvanendran, T. Deer, S. Garg, W. M. Hooten, R. W. Hurley, D. J. Kennedy, B. C. McLean, J. Y. Moon, S. Narouze, S. Pangarkar, D. A. Provenzano, R. Rauck, B. T. Sitzman, M. Smuch, J. van Zundert, K. Vorenkamp, M. S. Wallace and Z. Zhao, "Consensus practice guidelines on interventions for lumbar facet joint pain from a multispecialty, international working group," *Reg Anesth Pain Med,* vol. 56, no. 6, pp. 424-467, 2020.

[15] S. P. Cohen, S. Hayek, Y. Semenov, P. F. Pasquina, R. L. Whtie, E. Veizi, J. H. Huang, C. Kurihara, Z. Zhao, K. B. Guthmiller, S. R. Griffith, A. V. Verdun, D. M. Giampetro and Y. Vorobeychik, "Epidural steroid injections, conservative treatment, or combination treatment for cervical radicular pain: a multicenter, randomized, comparative-effectiveness study," *Anesthesiology,* vol. 121, no. 5, pp. 1045-1055, 2014.

[16] A. Qaseem, T. J. Wilt, R. M. McLean, M. A. Forciea, T. D. Denberg, M. J. Barry, C. Boyd, R. D. Chow, N. Fitterman, R. P. Harris, L. L. Humphrey and S. Nijan, "Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians," *Ann Intern Med,* vol. 166, no. 7, pp. 514-530, 2017.

**Reviewed / Approved by NIA Clinical Guideline Committee**

**Disclaimer:** *National Imaging Associates, Inc. (NIA) authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Evolent Health LLC subsidiaries including, but not limited to, National Imaging Associates ("NIA"). The policies constitute only the reimbursement and coverage guidelines of NIA. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. NIA reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.*

| *National Imaging Associates, Inc. | |
|---|---|
| **Clinical guideline:**<br>**SYMPATHETIC NERVE BLOCKS** | **Original Date: November 2020** |
| **CPT Codes: 64510, 64517, 64520, 64530** | **Last Revised Date: January 2024** |
| **Guideline Number: NIA_CG_404** | **Implementation Date: July 2024** |

# TABLE OF CONTENTS

## GENERAL INFORMATION

*It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*

## STATEMENT

Sympathetically maintained pain is a symptom of neuropathic pain. The pain is driven by overactivity of the sympathetic nervous system with or without an identifiable injury and is notably characterized as a clinical syndrome called complex regional pain syndrome (CRPS); but may also occur from neuropathic pain syndromes of different etiologies. Sympathetic nerve blocks provide diagnostic value in the identification of sympathetically maintained pain and the focused location of nerves along the spinal column provide a targeted advantage. These blocks are widely used in both acute and chronic management of sympathetically maintained pain of visceral, ischemic, and neuropathic etiologies.

### PURPOSE

This guideline focuses on the utilization management of sympathetic nerve blocks for the diagnosis and acute and chronic management of sympathetically maintained pain for specific indications.

## SPECIAL NOTE

### NEW EPISODES OF CARE

Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **INITIAL** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

## GENERAL INDICATIONS

- Acute or chronic noncancer pain causing functional disability or average pain level of ≥ 6 on a scale of 0 to 10 prior to injection **AND** continuation of pain or functional disability after the relief period due to the block
- Cancer pain affecting quality of life prior to injection and continuation after the relief period due to the block [1]

**NOTE:** It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service (e.g., diagnostic block and neurolytic procedure)

**NOTE:** Each block must be performed under image guidance [2, 3]

## INDICATIONS FOR STELLATE GANGLION BLOCK

Applies to face, upper extremities and upper thoracic region [4]

**DIAGNOSTIC EVALUATION OR ACUTE MANAGEMENT OF SYMPATHETICALLY MAINTAINED PAIN RESULTING FROM:**

- Acute Herpes Zoster (shingles) for prevention of postherpetic neuralgia [5], **AND**
    - Pain duration less than 4 weeks, **AND**
    - Active antiviral therapy regimen or documented medical reason unable to tolerate
- Frostbite, hyperhidrosis, chronic nonsurgical neuropathic pain syndromes, cancer pain, phantom limb pain, or nonsurgical vascular pain due to insufficiency, arterial embolism, vasospasm [2], **AND**
    - Failure to respond to nonoperative conservative treatment pertinent to the diagnosis or a clearly documented medical reason the conservative treatment cannot be done
- **Posttraumatic stress disorder (psychiatrist)[2], refractory angina, refractory ventricular electrical storm, AND assessment and clearance by a licensed, physician specialist in the management of the indication**
- Up to 6 sympathetic blocks may be performed per 12 months.
    - For the treatment of posttraumatic stress disorder (PTSD), up to 3 blocks in the first 12 weeks, with **NO** more than 6 blocks per year
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic

**DIAGNOSTIC EVALUATION, ACUTE OR CHRONIC MANAGEMENT OF SYMPATHETICALLY MAINTAINED PAIN RESULTING FROM:**

- Complex regional pain syndrome types I [6] and II [7], meeting Budapest criteria, **AND**
    - Active participation in a multimodal, multidisciplinary pain rehabilitation plan with a focus on functional restoration which may include physical therapy, occupational therapy, or pain psychology modalities (e.g., desensitization, range of motion, biofeedback, etc.) or a clearly documented medical reason the patient is unable participate [2]

- During the initial treatment phase, a total of 6 blocks may be performed within the first 12 weeks
- Following the initial treatment phase, a maximum of 4 sympathetic nerve blocks may be performed in a 12-month period
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic

**GENERAL LIMITATIONS**

- It has been at least one week since the prior injection in the same or different region
- Bilateral stellate ganglion blocks will not be performed on the same day of service

**CONTRAINDICATIONS**

- Patient refusal
- Local or systemic infection
- Coagulopathy or recent myocardial infarction
- Contralateral pneumothorax or severe emphysema
- Contralateral palsy of recurrent laryngeal nerve or phrenic nerve
- Allergy to anesthetic medication

## INDICATIONS FOR THORACIC OR LUMBAR SYMPATHETIC BLOCK

Applies to thoracic region and lower extremities [4]

**FOR THE DIAGNOSTIC EVALUATION OR ACUTE MANAGEMENT OF SYMPATHETICALLY MAINTAINED PAIN RESULTING FROM:**

- Acute Herpes Zoster (shingles) for prevention of postherpetic neuralgia [8], **AND**
    - Pain duration less than 4 weeks, **AND**
    - Active antiviral therapy regimen or documented medical reason unable to tolerate
- Frostbite, hyperhidrosis, chronic nonsurgical neuropathic pain syndromes, cancer pain, phantom limb pain, or nonsurgical ischemic limb pain [2], **AND**
    - Failure to respond to nonoperative conservative treatment pertinent to the diagnosis or a clearly documented medical reason the conservative treatment cannot be done
- Up to 6 sympathetic blocks may be performed per 12 months.
- The previous block resulted in at least 50% pain relief, significant documented functional improvement, or 50% reduction in PTSD symptoms for at least the duration of the anesthetic

**FOR THE DIAGNOSTIC EVALUATION, ACTUE OR CHRONIC MANAGEMENT OF SYMPATHETICALLY MAINTAINED PAIN RESULTING FROM:**

- Complex regional pain syndrome types I and II [9], meeting Budapest criteria, **AND**
    - Active participation in a multimodal, multidisciplinary pain rehabilitation plan with a focus on functional restoration which may include physical therapy, occupational therapy, or pain psychology modalities (e.g., desensitization, range of motion, biofeedback, etc.) or a clearly documented medical reason the patient is unable participate [2]
- During the initial treatment phase, a total of 6 blocks may be performed within the first 12 weeks
- Following the initial treatment phase, a maximum of 4 sympathetic nerve blocks may be performed in a 12-month period The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic

**GENERAL LIMIATIONS**

- It has been at least one week since the prior injection in the same or different region
- Bilateral thoracic or lumbar sympathetic blocks will not be performed on the same day
- Imaging modalities do not include ultrasound guidance

**CONTRAINDICATIONS**

- Patient refusal
- Local or systemic infection
- Coagulopathy, hypotension or recent myocardial infarction
- Contralateral pneumothorax
- Allergy to anesthetic medication

## INDICATIONS FOR CELIAC PLEXUS BLOCK

Applies to the upper abdomen [4]

**FOR THE DIAGNOSTIC EVALUATION OF SYMPATHETICALLY MAINTAINED VISCERAL PAIN**

- Upper abdominal pain associated with malignancy [9]
    - Conservative treatment is not required
- Up to two diagnostic blocks may be performed in the initial diagnostic phase for a planned neurolysis procedure

**FOR THE ACUTE OR CHRONIC MANAGEMENT OF SYMPATHECIALLY MAINTAINED VISCERAL PAIN RESULTING FROM:**

- Acute pancreatitis, **OR**
- Chronic, relapsing pancreatitis [2], **AND**

    - Failure to respond to nonoperative conservative treatment pertinent to the diagnosis or a clearly documented medical reason the conservative treatment cannot be done
- If the first injection is unsuccessful, a second initial injection may be performed in the initial phase for a maximum of 2 injections.
- After the initial phase, a therapeutic block may be performed every 3 months in a 12-month period
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic
- Each therapeutic block resulted in at least 50% relief for a duration of 3 months

**GENERAL LIMITATIONS**

- At least one week between diagnostic blocks or injections performed in the initial phase

**CONTRAINDICATIONS**

- Patient refusal
- Local or systemic infection
- Coagulopathy, hypotension or recent myocardial infarction
- Contralateral pneumothorax
- Allergy to anesthetic medication
- Abnormal anatomy

## INDICATIONS FOR SUPERIOR HYPOGASTRIC BLOCK

Applies to the pelvic and rectal regions [4]

**FOR THE DIAGNOSTIC EVALUATION OF SYMPATHETICALLY MAINTAINED VISCERAL PAIN**

- Pelvic or rectal pain associated with malignancy
    - Conservative treatment is not required
- Up to two diagnostic blocks may be performed in the initial diagnostic phase for a planned neurolysis procedure

**FOR THE ACUTE OR CHRONIC MANANGEMENT OF SYMPATHETICALLY MAINTAINED VISCERAL PAIN RESULTING FROM:**

- Chronic noncancer pain of pelvic and rectal viscera, **AND**
    - Failure to respond to nonoperative conservative treatment pertinent to the diagnosis or a clearly documented medical reason the conservative treatment cannot be done
- If the first injection is unsuccessful, a second initial injection may be performed in the initial phase for a maximum of 2 injections.

- After the initial phase, a therapeutic block may be performed every 3 months in a 12-month period
- The previous block resulted in at least 50% relief or significant documented functional improvement for at least the duration of the anesthetic
- Each therapeutic block resulted in at least 50% relief for a duration of 3 months

**GENERAL LIMITATIONS**

- At least one week between diagnostic blocks or injections performed in the initial phase
- Imaging modalities do not include ultrasound guidance

**CONTRAINDICATIONS**

- Patient refusal
- Local or systemic infection
- Coagulopathy, hypotension or recent myocardial infarction
- Contralateral pneumothorax
- Allergy to anesthetic medication
- Abnormal anatomy

## EXCLUSIONS

These requests are excluded from consideration under this guideline;

- Sphenopalatine ganglion block
- Ganglion impar block
- Other parasympathetic ganglion blocks
- Inferior hypogastric block

## BACKGROUND

****HOME EXERISE PROGRAM (HEP)**

The following two elements are required to meet guidelines for completion of conservative therapy:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor [10, 11]

  **AND**

- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (e.g., increased pain or inability to physically perform exercises). Closure of medical offices, closure of therapy offices, patient inconvenience, or noncompliance without explanation does not constitute “inability to complete” HEP [10].

**POLICY HISTORY**

| Date | Summary |
|---|---|
| January 2024 | • Expanded criteria to enumerate individual block types<br>• Added exclusions<br>• Clarified language on application for treatment of PTSD and emphasized need for psychiatric referral and care |
| May 2023 | • Statement added for clinical indication<br>• Adjusted treatment for chronic pain<br>• Adjusted non-operative conservative therapy<br>• Adjusted frequency of repeat injections<br>• Adjusted background (conservative therapy removed)<br>• Types of sympathetic nerve blocks covered was removed |
| May 2022 | • Added note to clarify when **INITIAL** injection requirements must be met for approval<br>• Reorganized and reworded indications for clarity and uniformity<br>• Under treatment for chronic pain, updated non-operative conservative therapy<br>• Clarified frequency of injections for treatment of PTSD versus other indications<br>• Clarified lack of medical necessity of performing multiple pain procedures on same DOS<br>• Added Contraindications section<br>• Added region-specific wording to conservative treatment requirement (e.g., conservative therapy targeting the requested spinal region) |

## REFERENCES


[1] M. M. Aman, A. Mahmoud, T. Deer, D. Sayed, J. M. Hagedorn, S. E. Brogan, V. Singh, A. Gulati, N. Strand, J. Weisbein, J. H. Goree, F. Xing, A. Valimahomed, D. J. Pak, A. El Helou, P. Ghosh, K. Shah, V. Patel, A. Escobar, K. Schmidt, J. Shah, V. Varshney, W. Rosenberg and S. Narang, "The American Society of Pain and Neuroscience (ASPN) Best Practices and Guidelines for the Interventional Management of Cancer-Associated Pain," *Journal of Pain Research,* vol. 2021, no. 14, pp. 2139-64, 2021.

[2] "An Updated Report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine*," Anesthesiology, 2010.

[3] J. Li and A. Szabova, "Ultraasound-Guided Nerve Blocks in the Head and Neck for Chronic Pain Management: The Anatom, Sonoanatomy, and Procedure," *Pain Physician,* vol. 2021, no. 24, pp. 533-48, 2021.

[4] M. Doroshenko, O. Turkot and D. B. Horn, "Sympathetic Nerve Block," in *StatPearls [Internet]*, Treasure Island, FL: StatPearls Publishing, 2022.

[5] M. Y. Makharita, Y. M. Amr and Y. El-Bayoumy, "Effect of Early Stellage Ganglion Blockade for Facial Pain from Acute Herpes Zoster and Incidence of Postherpetic Neuralgia," *Pain Physician,* no. 15, pp. 467-74, 2012.

[6] I. Yucel, Y. Demiraran, K. Ozturan and E. Degirmenci, "Complex regional pain syndrome type I: efficacy of stellate ganglion blockade," *Journal of Orthopaedics and Traumatology,* no. 10, pp. 179-83, 2009.

[7] R. Datta, J. Agrawal, A. Sharma, V. Rathore and S. Datta, "A study of the eficacy of stellate ganglion blocks in complex regional pain syndromes of the upper body," *Journal of Anaesthesiology Clinical Pharmacology,* no. 33, pp. 534-40, 2017.

[8] T. C. Bagaphou, D. Santonastaso, E. Gargaglia, L. Norgiolini, C. Tiburzi, S. Cristallini, V. Cerotto and F. Gori, "Case Report: Ultrasound Guided Continuous Sciatic Nerve Block for Acute Herpetic Neuralgia," *Case Reports in Anesthesiology,* 2019.

[9] O. H. Gunduz and O. Kenis-Coskun, "Ganglion blocks as a treatment of pain: current perspectives," *Journal of Pain Research,* no. 10, pp. 2815-26, 2017.

[10] Annals of Internal Medicine, "Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians," 2017. [Online].

[11] The American College of Radiology, *ACR Appropriateness Criteria Low Back Pain: 2021 Update,* 2021.

[12] L. Manchikanti, N. Knezevic, A. Navani, P. J. Christo, G. Limerick and A. K. Calodney, "Epidural Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines," *Pain Physician,* vol. 24, pp. S27-208, 2021.

**Reviewed / Approved by NIA Clinical Guideline Committee**

**Disclaimer:** *National Imaging Associates, Inc. (NIA) authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment and/or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Evolent Health LLC subsidiaries including, but not limited to, National Imaging Associates ("NIA"). The policies constitute only the reimbursement and coverage guidelines of NIA. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. NIA reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.*