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NIPM 4: APPROPRIATE PATIENT SELECTION FOR DIAGNOSTIC FACET JOINT PROCEDURES

Measurement Period:
January 1, 2018 to December 31, 2018

Measure Developer:
American Society of Interventional Pain Physicians

Description:
Measurement of proportion of patients aged 18 years or older meeting appropriate patient selection criteria for diagnostic facet joint procedures.

Disclaimer:
These performance measures are not standards and do not establish a standard of medical care.

NQS Domain:
Effective Clinical Care

Measure Type:
Process

Stratification:
None

Risk Adjustment Variable:
None
Risk Adjustment Algorithms:

None

Rate Aggregation:

None

Definition(s) of Outcomes:

The percentage of patients undergoing diagnostic facet joint nerve blocks meeting appropriate patient selection criteria defined as:

- At least 3 months of moderate to severe pain with functional impairment inadequately responsive to conservative care such as NSAIDs, acetaminophen, physical therapy (if tolerated).
- Predominant axial pain that is not associated with radiculopathy or neurogenic claudication.
- Absence of non-facet pathology that could explain the source of the patient’s pain, such as fracture, tumor, infection, or significant deformity.
- Clinical assessment that implicates the facet joint as the putative source of pain.

To be considered adherent to patient selection criteria, all 4 indications must be met.

Population:

All patients aged 18 years and older before the start of the measurement period with at least one eligible encounter during the measurement period.

Denominator:

Total number of encounters in which a patient receives a diagnostic facet joint procedure.

ANY of the following CPT Codes: 64490, 64491, 64492, 64493, 64494, 64495 with Quality Code IPM04 to indicate diagnostic intent as opposed to therapeutic intent

Denominator Exclusions:
Numerator:
Total number of encounters in which a patient receives a diagnostic facet joint procedure with documentation either on the day of the procedure or within the preceding 30 days of appropriate patient selection criteria having been met.

Numerator Options:

Performance Met: Quality Code IPM05 (appropriate patient selection criteria met for diagnostic facet joint procedures)

Or

Denominator Exception: Quality Code IPM05-1P (appropriate patient selection criteria not met for diagnostic facet joint procedures for valid medical reasons)

Or

Performance Not Met: Quality Code IPM05-8P (appropriate patient selection criteria not met for diagnostic facet joint procedures for reason not specified)

Numerator Exclusions:
Encounters in which a patient undergoes therapeutic, and not diagnostic, facet joint procedures.

Lumbar Rationale:

Numerous structures in the lower back may be responsible for low back and/or lower extremity pain, including lumbar intervertebral discs, facet joints, sacroiliac joints, and nerve root dura, and may be amenable to diagnostic measures such as imaging and controlled diagnostic blocks (Manchikanti L, et al. Management of lumbar zygapophyseal [facet] joint pain. *World J Orthop* 2016; 7:315-337; Boswell MV, et al. A best-evidence systematic appraisal of the diagnostic accuracy and utility of facet [zygapophyseal] joint injections in chronic spinal pain. *Pain Physician* 2015; 18:E497-E533). Other structures also capable of transmitting pain, including ligaments, fascia, and muscles, may not be diagnosed with accuracy with any diagnostic techniques. Disc-related pathology with disc herniation, spinal stenosis, and radiculitis are diagnosed with reasonable ease and accuracy leading to definitive treatments (Manchikanti L, et al. Management of lumbar zygapophyseal [facet] joint pain. *World J Orthop* 2016; 7:315-337; Manchikanti L, et al. An update of comprehensive evidence-based guidelines for interventional techniques of chronic spinal pain: Part II: Guidance and recommendations. *Pain Physician* 2013; 16:S49-S283). However, low back pain from discs (without disc herniation), lumbar facet joints, and sacroiliac joints is difficult to diagnose accurately by noninvasive measures including imaging. Consequently, no gold standard is generally acknowledged for diagnosing low back pain, irrespective of the source being facet joint(s), intervertebral disc(s), or sacroiliac joint(s), despite the fact that lumbar facet joints, the paired joints that stabilize and guide motion in the spine, have been frequently implicated.


The available evidence is Level I for lumbar facet joint nerve blocks with inclusion of a total of 17 studies with dual diagnostic blocks, with a prevalence of 16% to 41% and false-positive rates of 25% to 44%.

Consequently, it is crucial that appropriate selection criteria are utilized prior to facet joint nerve blocks. Multiple guidelines, systematic reviews, and Medicare policies have described appropriateness criteria and indications as follows:
• At least 3 months of moderate to severe pain with functional impairment inadequately responsive to conservative care such as NSAIDs, acetaminophen, physical therapy (if tolerated).
• Predominant axial pain that is not associated with radiculopathy or neurogenic claudication.
• Absence of non-facet pathology that could explain the source of the patient’s pain, such as fracture, tumor, infection, or significant deformity.
• Clinical assessment that implicates the facet joint as the putative source of pain.

To be considered adherent to patient selection criteria, all 4 indications must be met.

**Improvement Notation:**

Higher compliance score indicates better quality.

**References:**


Thoracic Rationale:


Based on the literature, intervertebral discs, facet joints and nerve root dura have been shown as potential sources of thoracic pain and chest wall pain. Controlled studies have established intervertebral discs and facet joints as sources of thoracic pain. Despite recent advances and multiple publications, apparently...
thoracic facet joint pain may not be diagnosed accurately utilizing conventional clinical and radiological techniques. Consequently, controlled diagnostic blocks have been utilized.

Recent systematic reviews have shown the accuracy for thoracic diagnostic facet joint nerve blocks with controlled diagnostic blocks to have a prevalence of 40% in the thoracic spine with a false-positive rate of 42%, with Level II evidence (Boswell MV, et al. A best-evidence systematic appraisal of the diagnostic accuracy and utility of facet [zygapophysial] joint injections in chronic spinal pain. *Pain Physician* 2015; 18:E497-E533).

Thus, it is crucial that appropriate selection criteria are utilized prior to facet joint nerve blocks. Multiple guidelines, systematic reviews, and Medicare policies have described appropriateness criteria and indications as follows:

- At least 3 months of moderate to severe pain with functional impairment inadequately responsive to conservative care such as NSAIDs, acetaminophen, physical therapy (if tolerated).
- Predominant axial pain that is not associated with radiculopathy.
- Absence of non-facet pathology that could explain the source of the patient’s pain, such as fracture, tumor, infection, or significant deformity.
- Clinical assessment that implicates the facet joint as the putative source of pain.

To be considered adherence to criteria, all 4 indications must be met.

**Improvement Notation:**

Higher compliance score indicates better quality.

**References:**


CGS Administrators, LLC. Local Coverage Determination (LCD). Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L34832). Effective Date: 10/01/2016.

National Government Services, Inc. Local Coverage Determination (LCD). Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L35936). Effective Date: 10/01/2015.


Cervical Rationale:

Based on the literature, intervertebral discs, facet joints and nerve root dura have been shown as potential sources of neck pain, headache, and extremity pain. Controlled studies have established intervertebral discs and facet joints as sources of neck pain. Despite recent advances and multiple publications, apparently cervical facet joint pain is not being diagnosed accurately utilizing conventional clinical and radiological techniques (Boswell MV, et al. A best-evidence systematic appraisal of the diagnostic accuracy and utility of facet [zygapophysial] joint injections in chronic spinal pain. *Pain Physician* 2015; 18:E497-E533). Consequently, controlled diagnostic blocks have been utilized.


Consequently, controlled local anesthetic blocks of cervical spinal facet joints or medial branch blocks are employed to diagnose facet joint pain.


Consequently, it is crucial that appropriate selection criteria are utilized prior to facet joint nerve blocks. Multiple guidelines, systematic reviews, and Medicare policies have described appropriateness criteria and indications as follows:
• At least 3 months of moderate to severe pain with functional impairment inadequately responsive to conservative care such as NSAIDs, acetaminophen, physical therapy (if tolerated).
• Predominant axial pain that is not associated with radiculopathy.
• Absence of non-facet pathology that could explain the source of the patient’s pain, such as fracture, tumor, infection, or significant deformity.
• Clinical assessment that implicates the facet joint as the putative source of pain.

To be considered adherence to criteria, all 4 indications must be met.

**Improvement Notation:**

Higher compliance score indicates better quality.

**References:**


CGS Administrators, LLC. Local Coverage Determination (LCD). Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L34832). Effective Date: 10/01/2016.

National Government Services, Inc. Local Coverage Determination (LCD). Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L35936). Effective Date: 10/01/2015.


**NIPM 8: AVOIDING EXCESSIVE USE OF EPIDURAL INJECTIONS IN MANAGING CHRONIC PAIN ORIGINATING IN THE CERVICAL AND THORACIC SPINE**

**Measurement Period:**
January 1, 2018 to December 31, 2018

**Measure Developer:**
American Society of Interventional Pain Physicians

**Description:**
Measurement of percentage of patients aged 18 years and older receiving therapeutic cervical/thoracic epidural injections that do not receive an excessive number of injections during the measurement period.
Disclaimer:

These performance measures are not standards and do not establish a standard of medical care.

NQS Domain:

Efficiency and Cost Reduction

Measure Type:

Process

Stratification:

None

Risk Adjustment Variable:

None

Risk Adjustment Algorithms

None

Rate Aggregation:

None

Definition(s) of Outcomes:

1. The percentage of patients receiving cervical/thoracic epidural injections to treat pain originating in the cervical/thoracic spine who receive cervical/thoracic epidural injections on 5 or less separate encounters during the first 12 months following initial diagnosis.

2. The percentage of patients receiving cervical/thoracic epidural injections to treat pain originating in the cervical/thoracic spine who receive cervical/thoracic epidural injections on 4 or less separate encounters during any 12 month period not within the first year of diagnosis.
Population:
All patients aged 18 years and older before the start of the measurement period with at least one cervical/thoracic epidural injection during the measurement period.

Denominator:
All patients who have received cervical/thoracic epidural injections during the reporting period.

ANY of the following CPT Codes: 62320, 62321, 64479, 64480

Denominator Exclusions:
None

Numerator:
Patients with at least 1 but less than 6 encounters in which a cervical/thoracic epidural injection was performed during the first 12 months following initiation of treatment. Or patients with at least 1 but less than 5 encounters in which a cervical/thoracic epidural injection was performed during subsequent 12 month periods.

ANY of the following CPT Codes: 62320, 62321, 64479, 64480

Numerator Exclusions:
NA

Denominator Exceptions:
Not applicable

Rationale:


Epidural injections have been studied in managing disc herniation, spinal stenosis, post surgery syndrome, and axial or discogenic pain without facet joint pain or radiculitis in the cervical, thoracic, and lumbar regions. The debate continues regarding the efficacy of epidural steroid injections via the various approaches in the 3 regions because of the varying opinions rendered in multiple systematic reviews and guidelines (Kaye AD, et al. Efficacy of epidural injections in managing chronic spinal pain: A best evidence synthesis. *Pain Physician* 2015; 18:E939-E1004).
Kaye et al (Kaye AD, et al. Efficacy of epidural injections in managing chronic spinal pain: A best evidence synthesis. *Pain Physician* 2015; 18:E939-E1004) concluded in a systematic review that there is Level II evidence for long-term management of cervical disc herniation. The evidence is Level II for long-term management of cervical disc herniation with interlaminar epidural injections. The evidence is Level II to III in managing thoracic disc herniation with an interlaminar approach. The evidence is Level II for caudal and lumbar interlaminar epidural injections with Level III evidence for lumbar transforaminal epidural injections for lumbar spinal stenosis. The evidence is Level II for cervical spinal stenosis management with an interlaminar approach. The evidence is Level II for axial or discogenic pain without facet arthropathy or disc herniation treated with caudal or lumbar interlaminar injections in the lumbar region; whereas it is Level II in the cervical region treated with cervical interlaminar epidural injections. The evidence for post lumbar surgery syndrome is Level II with caudal epidural injections and for post cervical surgery syndrome it is Level II with cervical interlaminar epidural injections.

Multiple guidelines and regulations have recommended and systematic reviews have demonstrated the appropriate frequency of epidural injections of 2 procedures initially in the diagnostic phase and thereafter 4 procedures per year with appropriate response of 2½ to 3 months in the therapeutic phase, which starts after the diagnostic phase ends. The guidance is the same for all procedures and all indications.

**Clinical Recommendation Statement:**

ASIPP guidelines and multiple carriers recommend epidural injections may be performed only when patients meet appropriate criteria with documentation of medical necessity and indications. Providers also document appropriate pain relief with improvement in physical and functional status with 2 procedures in the diagnostic phase followed by 4 therapeutic procedures per year, not to exceed 5 total procedures during the first year of treatment, followed by 4 therapeutic procedures per year thereafter following initiation of treatment, based on appropriate pain relief with or without improvement.

**Improvement Notation:**

Higher compliance score indicates better quality.

**References:**


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NIPM 9: AVOIDING EXCESSIVE USE OF THERAPEUTIC FACET JOINT INTERVENTIONS IN MANAGING CHRONIC CERVICAL AND THORACIC SPINAL PAIN

Measurement Period:
January 1, 2018 to December 31, 2018

Measure Developer:
American Society of Interventional Pain Physicians

Description:
Measurement of percentage of patients aged 18 years and older receiving cervical/thoracic facet joint interventions that do not receive an excessive number of procedures during the measurement period, based on the recommendations of the American Society of Interventional Pain Physicians, multiple Medicare carriers, or private insurers.

Disclaimer:
These performance measures are not standards and do not establish a standard of medical care.

NQS Domain:
Efficiency and Cost Reduction

Measure Type:
Process

Stratification:
None
Risk Adjustment Variable:
None

Risk Adjustment Algorithms:
None

Rate Aggregation:
None

Definition(s) of Outcomes:

1. Percentage of patients undergoing therapeutic cervical/thoracic facet joint injections who receive 4 or less treatments per year, with treatment defined as single level or multiple levels, either unilaterally or bilaterally.

2. Percentage of patients undergoing therapeutic cervical/thoracic facet joint denervation who receive 2 or less denervation treatments per year, with treatment defined as single level or multiple levels, either unilaterally or bilaterally.

Population:
Initial population, all patients undergoing therapeutic cervical/thoracic facet joint interventions with at least one eligible encounter during the measurement period.

Denominator:
All patients undergoing therapeutic cervical/thoracic facet joint interventions.

ANY of the following CPT Codes: 64633, 64634

Or
ANY of the following CPT Codes: 64490, 64491, 64492 with Quality Code IPM03 to indicate therapeutic intent as opposed to diagnostic intent

Denominator Exclusions:
Encounters in which diagnostic cervical/thoracic facet joint procedures are performed.

Numerator:
Patients who underwent at least 1 but less than 5 therapeutic cervical/thoracic facet joint treatments during the measurement year (CPT Codes: 64490, 64491, 64492 with Quality Code IPM03 to indicate therapeutic intent as opposed to diagnostic intent). Or patients with at least 1 but less than 3 therapeutic cervical/thoracic facet joint denervation treatments during the measurement year (CPT Codes: 64633, 64634). Bilateral treatments that are performed unilaterally on separate days within 14 calendar days are considered a single treatment.

ANY of the following CPT Codes: 64633, 64634

Or

ANY of the following CPT Codes: 64490, 64491, 64492 with Quality Code IPM03 to indicate therapeutic intent as opposed to diagnostic intent

Numerator Exclusions:
Encounters in which diagnostic cervical/thoracic facet joint procedures are performed.

Denominator Exceptions:
Not applicable

Rationale:
The therapeutic spinal facet joint interventions generally used for the treatment of axial spinal pain of facet joint origin are intraarticular facet joint injections, facet joint nerve blocks, and radiofrequency

Based on the systematic reviews and best evidence synthesis of their effectiveness for the management of spinal facet joint pain, the evidence for long-term improvement is Level II for lumbar and cervical radiofrequency neurotomy, and therapeutic facet joint nerve blocks in the cervical, thoracic, and lumbar spine; Level III for lumbar intraarticular injections; and Level IV for cervical intraarticular injections and thoracic radiofrequency neurotomy (Manchikanti L, et al. A systematic review and best evidence synthesis of the effectiveness of therapeutic facet joint interventions in managing chronic spinal pain. Pain Physician 2015; 18:E535-E582).

Various guidelines exist for performing these procedures with ASIPP guidelines and some Medicare carriers and others describing 4 facet joint injections, either intraarticular injection or facet joint nerve block, per year, per region, or 2 radiofrequency neurotomies in the therapeutic phase, with documentation of 2½ to 3 months of pain relief for facet joint injections and facet joint nerve blocks, and 4 to 6 months of relief with radiofrequency neurotomy.

Clinical Recommendation Statement:

ASIPP guidelines and other guidelines, Medicare guidance, and guidance from multiple insurers provide utilization criteria.

Improvement Notation:

References:


**NIPM 10: COMMUNICATING CONCURRENT OPIOID AND BENZODIAZEPINE PRESCRIBING TO OTHER PRESCRIBERS**

**Measurement Period:**

January 1, 2018 to December 31, 2018

**Measure Developer:**

American Society of Interventional Pain Physicians
Description:
Percentage of patients 18 years of age and older who are prescribed opioids and have a letter or other communication sent to another clinician who is prescribing benzodiazepines. This measure is reported by the clinician who prescribes opioids to a patient already taking benzodiazepines. Communication must occur at the time of initial opioid prescribing and following any gaps in prescribing of greater than 6 months, or once per reporting year for patients on continuous chronic opioid and benzodiazepine therapy.

Disclaimer:
These performance measures are not standards and do not establish a standard of medical care.

NQS Domain:
Patient Safety

Measure Type:
Process

Stratification:
None

Risk Adjustment Variable:
N/A

Risk Adjustment Algorithms
N/A

Rate Aggregation:
None
Definition(s) of Outcomes:

1. The percentage of patients 18 years of age and older who are prescribed opioids and have a letter or other communication sent to another clinician who is prescribing benzodiazepines. This measure is reported by the clinician who prescribes opioids to a patient already taking benzodiazepines.

Population:

All patients aged 18 years and older who receive a new prescription for opioids and are also currently prescribed benzodiazepines by another clinician.

Denominator:

All patients aged 18 years and older who are prescribed both opioids and benzodiazepines from separate clinicians.

Quality Code IPM14 to indicate encounters in which an opioid is prescribed to a patient who is also prescribed benzodiazepines.

Denominator Exclusions:

None

Numerator:

Percentage of patients 18 years of age and older who are prescribed opioids and have a letter or other communication sent to another clinician who is prescribing benzodiazepines. This measure is reported by the clinician who prescribes opioids to a patient already taking benzodiazepines. Communication must occur at the time of initial opioid prescribing and following any gaps in prescribing of greater than 6 months, or once per reporting year for patients on continuous chronic opioid and benzodiazepine therapy.

Numerator Options:

Performance Met: Quality Code IPM16 (communication was sent to the benzodiazepine prescriber, indicating co-prescribing of opioids)
Denominator Exception: Quality Code IPM16-1P (communication is not necessary since opioids and benzodiazepines are prescribed by the same prescriber OR communication has already been sent to the co-prescriber within the appropriate timeframe as defined by the measure)

Performance Not Met: Quality Code IPM16-8P (communication was not sent to the benzodiazepine prescriber)

Numerator Exclusions:
None

Rationale:
pain management showed 94% of patients were on long-term opioids and 35% were on benzodiazepines with 29.3% of the patients with combined opioid and benzodiazepine prescriptions on a long-term basis.

A number of studies have showed the relationship between opioid and benzodiazepine co-abuse and adverse consequences. Overall, combined prescriptions increase emergency department visits, as well as overdose death rates. Opioids are most commonly and extensively used drugs in managing acute, chronic cancer and non-cancer pain. Benzodiazepine medications are most commonly prescribed to treat anxiety and mood disorders such as depression and insomnia. These drugs are also used to treat seizures. The FDA showed that the number of individuals who were prescribed both opioids and benzodiazepines grew by 41% or 2.5 million between 2002 and 2014. In February of 2016, 41 public health officials from across the United States submitted a petition to the FDA calling for the agency to add “black box” warnings about the potentially fatal combination of opioids and benzodiazepines to the drugs. Consequently, on September 1, 2016, the FDA announced new label requirements for prescription opioids and benzodiazepines to include “black box” warnings detailing that the drugs can be fatal if taken together. The FDA provided a drug safety communication warning about risks and death when combining opioid or cough medicines with benzodiazepines.


Consequently, health care professionals should limit prescribing opioids with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medications are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect.

Patients and caregivers should be warned about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. In addition, patients and caregivers must be of the overdoses and
increased risk of overdose and deaths. Patients should be educated and counseled to manage anxiety with multiple other measures including antidepressant therapy, psychotherapy, and a referral to psychologist or psychiatrist may be initiated whenever feasible.

Various side effects include the following: dizziness, lightheadedness, sleepiness, slow or difficult breathing, non-responsiveness.

Consequently, it is crucial that all providers involved in care are aware of concurrent opioid and benzodiazepine prescribing. Thus, providers should communicate concurrent opioid and benzodiazepine prescribing to other prescribers.

**Clinical Recommendation Statement:**
Concurrent opioid and benzodiazepine prescribing by multiple prescribers must be communicated to all providers to prevent adverse reactions related to co-prescription of opioids and benzodiazepines.

**Improvement Notation:**
High compliance rate shows improvement in clinical care.

**References:**


Jones CM et al. Emergency department visits and overdose deaths from combined use of opioids and benzodiazepines.


**NIPM 11: PATIENT COUNSELING REGARDING RISKS OF CO-PRESCRIBED OPIOIDS AND BENZODIAZEPINES**

**Measurement Period:**
January 1, 2018 to December 31, 2018

**Measure Developer:**
American Society of Interventional Pain Physicians

**Description:**
Percentage of patients 18 years of age and older who are prescribed both opioids and benzodiazepines and receive either written or verbal education regarding the risks of concurrent opioid and benzodiazepine use. Education and counseling must occur at the time of initial co-prescribing, and following any gap of greater than 6 months of co-prescribing, or at least once per reporting period for patients taking chronic concurrent opioid and benzodiazepine therapy.

**Disclaimer:**
These performance measures are not standards and do not establish a standard of medical care.

**NQS Domain:**
Patient Safety

**Measure Type:**
Process
Stratification:
None

Risk Adjustment Variable:
N/A

Risk Adjustment Algorithms
N/A

Rate Aggregation:
None

Definition(s) of Outcomes:

2. The percentage of patients 18 years of age and older who are prescribed both opioids and benzodiazepines and receive either written or verbal education regarding the risks of concurrent opioid and benzodiazepine use.

Population:
All patients aged 18 years and older who are concurrently prescribed both opioids and benzodiazepines.

Denominator:
All patients aged 18 years and older who are prescribed both opioids and benzodiazepines.

Quality Code IPM14 to indicate encounters in which an opioid is prescribed to a patient who is also prescribed benzodiazepines.

Denominator Exclusions:
None

Numerator:

All patients aged 18 years and older who are concurrently prescribed both opioids and benzodiazepines and receive either written or verbal education regarding the risks of concurrent opioid and benzodiazepine use. Education and counseling must occur at the time of initial co-prescribing, and following any gap of greater than 6 months of co-prescribing, or at least once per reporting period for patients taking chronic concurrent opioid and benzodiazepine therapy.

Numerator Options:

Performance Met: Quality Code IPM15 (patient received either written or verbal education regarding the risks of concurrent opioid and benzodiazepine use)

Or

Performance Not Met: Quality Code IPM15-8P (patient did not receive either written or verbal education regarding the risks of concurrent opioid and benzodiazepine use)

Numerator Exclusions:
None

Denominator Exceptions:
Not applicable

Rationale:

Drug overdose deaths are widely considered to represent a national epidemic (Manchikanti L et al. Responsible, safe, and effective prescription of opioids for chronic non-cancer pain: American Society of Interventional Pain Physicians (ASIPP) guidelines. Pain Physician 2017: 20: 25:S3-S92). Opioid analgesics and benzodiazepine are the 2 most common drug classes involved in prescription drug overdose deaths. The concurrent use of opioids and benzodiazepines appears to be growing, in part, due to the large number of prescriptions written in the US for these medications, as well as increasing availability of heroin
A number of studies have showed the relationship between opioid and benzodiazepine co-abuse and adverse consequences. Overall, combined prescriptions increase emergency department visits, as well as overdose death rates. Opioids are most commonly and extensively used drugs in managing acute, chronic cancer and non-cancer pain. Benzodiazepine medications are most commonly prescribed to treat anxiety and mood disorders such as depression and insomnia. These drugs are also used to treat seizures. The FDA showed that the number of individuals who were prescribed both opioids and benzodiazepines grew by 41% or 2.5 million between 2002 and 2014. In February of 2016, 41 public health officials from across the United States submitted a petition to the FDA calling for the agency to add “black box” warnings about the potentially fatal combination of opioids and benzodiazepines to the drugs. Consequently, on September 1, 2016, the FDA announced new label requirements for prescription opioids and benzodiazepines to include “black box” warnings detailing that the drugs can be fatal if taken together. The FDA provided a drug safety communication warning about risks and death when combining opioid or cough medicines with benzodiazepines.

FDA reviewed several studies showing that serious risks are associated with the combined use of opioids and benzodiazepines and other drugs that depress the CNS or alcohol (Food and Drug Administration Safety Announcement: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning. September 20, 2017. https://www.fda.gov/Drugs/DrugSafety/ucm518473.htm; Hwang CS et al. Trends in the concomitant...

Consequently, health care professionals should limit prescribing opioids with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medications are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect.

Patients and caregivers should be warned about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. In addition, patients and caregivers must be of the overdoses and increased risk of overdose and deaths. Patients should be educated and counseled to manage anxiety with multiple other measures including antidepressant therapy, psychotherapy, and a referral to psychologist or psychiatrist may be initiated whenever feasible.

Various side effects include the following: dizziness, lightheadedness, sleepiness, slow or difficult breathing, non-responsiveness.

**Clinical Recommendation Statement:**

Patients and caregivers must be warned to report if they experience symptoms of unusual dizziness or lightheadedness, extreme sleepiness, slowed or difficult breathing, or unresponsiveness. The caregivers and patients must also be warned about the increased risk of abuse, overuse, misuse, addiction, and death.

**Improvement Notation:**

High rate of compliance with counseling regarding risks of co-prescribed opioids and benzodiazepines provides high level of care.
References:


Jones CM et al. Emergency department visits and overdose deaths from combined use of opioids and benzodiazepines.


**NIPM 12: FUNCTIONAL STATUS ASSESSMENT AND IMPROVEMENT FOLLOWING SPINAL CORD STIMULATOR IMPLANTATION**

**Measurement Period:**
January 1, 2018 to December 31, 2018

**Measure Developer:**
American Society of Interventional Pain Physicians

**Description:**
Percentage of patients 18 years of age and older who undergo spinal scord stimulator implantation who completed baseline and follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline. Follow-up functional assessment must be completed within 90 days following the procedure.
Disclaimer:

These performance measures are not standards and do not establish a standard of medical care.

NQS Domain:

Person and care-giver centered experience and outcome

Measure Type:

Outcome

Stratification:

None

Risk Adjustment Variable:

N/A

Risk Adjustment Algorithms

N/A

Rate Aggregation:

None

Definition(s) of Outcomes:

1. Percentage of patients 18 years of age and older who undergo spinal cord stimulator implantation who completed baseline and follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline. Follow-up functional assessment must be completed within 90 days following the procedure.

Baseline and follow-up functional status can be assessed directly within the registry platform through completion of a patient survey OR documented within the medical record using custom quality codes FXN00 through FXN99, with FXN00 representing 0% disability and FXN99 representing 99% disability as calculated from a validated, scaled functional assessment.
**Population:**

All patients aged 18 years and older who undergo surgical implantation of a spinal cord stimulator with implantable pulse generator, excluding replacement or revision of existing spinal cord stimulation systems.

**Denominator:**

All patients aged 18 years and older who undergo surgical implantation of a spinal cord stimulator with implantable pulse generator, excluding replacement or revision of existing spinal cord stimulation systems.

ALL of the following CPT Codes in the same encounter: 63650, 63685

**Denominator Exclusions:**

Patients undergoing revision or replacement of pulse generator: 63688

Patients undergoing temporary placement of neuroelectrodes: 63650 without 63685

Patients undergoing revision or replacement of existing neuroelectrodes: 63663

**Numerator:**

Percentage of patients 18 years of age and older who undergo spinal scord stimulator implantation who completed baseline and follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline. Follow-up functional assessment must be completed within 90 days following the procedure.

**Numerator Exclusions:**

Patients in whom the neuroelectrodes and/or pulse generator were revised or explanted during the 90-day post-operative period: 63661, 63663, 63688

**Denominator Exceptions:**
Rationale:


For recalcitrant pain after failure of various modalities of treatments, spinal cord stimulation has been used frequently (Grider JS et al. Effectiveness of spinal cord stimulation in chronic spinal pain: A systematic review. *Pain Physician* 2016; 19:E33-E54). Multiple systematic reviews have been performed assessing the effectiveness of spinal cord stimulation in managing chronic spinal and other neuropathic pain. However, it is most commonly performed for management of chronic persistent pain with disability after failed surgical interventions. A Cochrane review in 2004 (Mailis-Gagnon A et al. Spinal cord stimulation for chronic pain. *Cochrane Database Syst Rev* 2004; 3:CD003783) suggested that spinal cord stimulation showed promise in the treatment of neuropathic pain and that had proven refractory to other treatment options. Subsequent multiple randomized controlled trials, accompanied by reviews, have shown significant evidence showing the effectiveness of spinal cord stimulation. Grider et al (Grider JS et al. Effectiveness of spinal cord stimulation in chronic spinal pain: A systematic review. *Pain Physician* 2016; 19:E33-E54) performed a systematic review in 2016 with inclusion of multiple randomized controlled trials, as well as cost effectiveness studies. Based on a best evidence synthesis with 3 high quality randomized controlled trials, the evidence of efficacy for spinal cord stimulation in lumbar failed back surgery syndrome was Level I to II. There is also evidence of high frequency stimulation (Kapural L et al. Novel 10-kHz high frequency therapy (HF10 Therapy) is superior to traditional low-frequency spinal cord stimulation for the treatment of chronic back and leg pain: The SENZARCT randomized controlled trial. *Anesthesiology* 2015; 123:851-860; Harrison C et al. The efficacy and safety of dorsal root ganglion stimulation as a treatment for neuropathic pain: A literature review. Neuromodulation 2017 [Epub ahead of print]), as well as dorsal root ganglion stimulation, and adaptive stimulation (Schultz DM et al. Sensor-


Multiple guidelines and regulations have been recommended and systematic reviews based on high quality relevant randomized controlled trials have shown efficacy of spinal cord stimulation, along with cost effectiveness.

Basic guidelines and multiple carriers recommend consideration of spinal cord stimulation therapy as a late option after more conservative attempts such as medications, physical therapy, psychological therapy, or other modalities have been tried.

For spinal cord stimulation trial and subsequent implantation, patients must have undergone careful screening, evaluation and diagnosis by physicians, as well as psychologists. In addition, guidelines also recommend that prior to selecting a patient for a trial, patient:

- Must not have active substance abuse issues
- Must undergo prior patient education discussion and disclosure including an extensive discussion of the risks and benefits of this therapy
- Must undergo appropriate psychological screening

It is expected that accurate patient selection will lead to most patients going on to receive permanent implants. Only patients who experience a positive response to a trial should proceed to a permanent implantation. A successful trial should be associated with at least 50% reduction of target pain, or 50% reduction of analgesic medications, and show some element of functional improvement.

Patients should be monitored for improvement functional status after the permanent implantation. Functional status improvement is measured utilizing various outcome measures of function including, but

**Clinical Recommendation Statement:**

Improvement in functional status following permanent implant may be measured with assessment by Oswestry Disability Index (ODI) scores in low back pain and Neck Disability Index scoring in the neck pain.

**Improvement Notation:**

High compliance score indicates better quality.

**References:**


Kapural L et al. Novel 10-kHz high frequency therapy (HF10 Therapy) is superior to traditional low-frequency spinal cord stimulation for the treatment of chronic back and leg pain: The SENZARCT randomized controlled trial. *Anesthesiology* 2015; 123:851-860.


[http://www.mvltca.net/Presentations/mvltca.pdf](http://www.mvltca.net/Presentations/mvltca.pdf)


**NIPM 13: FUNCTIONAL STATUS ASSESSMENT AND IMPROVEMENT FOLLOWING LUMBAR MEDIAL BRANCH RADIOFREQUENCY ABLATION**

**Measurement Period:**
January 1, 2018 to December 31, 2018

**Measure Developer:**
American Society of Interventional Pain Physicians

**Description:**
Percentage of patients 18 years of age and older with lumbar medial branch radiofrequency ablation who completed baseline and follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline. Follow-up functional assessment must be completed within 90 days following the procedure.

**Disclaimer:**
These performance measures are not standards and do not establish a standard of medical care.

**NQS Domain:**
Person and care-giver centered experience and outcome

**Measure Type:**
Outcome
Stratification:
None

Risk Adjustment Variable:
N/A

Risk Adjustment Algorithms
N/A

Rate Aggregation:
None

Definition(s) of Outcomes:

1. Percentage of patients 18 years of age and older with lumbar medial branch radiofrequency ablation who completed baseline and follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline.

Baseline and follow-up functional status can be assessed directly within the registry platform through completion of a patient survey OR documented within the medical record using custom quality codes FXN00 through FXN99, with FXN00 representing 0% disability and FXN99 representing 99% disability as calculated from a validated, scaled functional assessment.

Population:
All patients aged 18 years and older who undergo lumbar medial branch radiofrequency ablation.

Denominator:
All patients aged 18 years and older who undergo lumbar medial branch radiofrequency ablation.
ANY of the following CPT Codes in the same encounter: 64635, 64636

**Denominator Exclusions:**
None

**Numerator:**
Percentage of patients 18 years of age and older with lumbar medial branch radiofrequency ablation who completed baseline and follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline. Follow-up functional assessment must be completed within 90 days following the procedure.

**Numerator Exclusions:**
None

**Denominator Exceptions:**
Not applicable

**Rationale:**
Multiple structures in the low back responsible for low back and/or lower extremity pain include lumbar intervertebral discs, facet joints, sacroiliac joints, and nerve root dura. Facet joints have been shown to be amenable to diagnostic measures such as controlled diagnostic blocks (Manchikanti L, et al. Management of lumbar zygapophysial (facet) joint pain. *World J Orthop* 2016; 7:315-337; Boswell MV, et al. A best-evidence systematic appraisal of the diagnostic accuracy and utility of facet (zygapophysial) joint injections in chronic spinal pain. *Pain Physician* 2015; 18:E497-E533). Based on neuroanatomic, neurophysiologic, biomechanical studies, and controlled diagnostic facet joint nerve blocks, lumbar facet joints have been recognized as a potential cause of low back pain as well as referred lower extremity pain patients who have chronic low back pain. Lumbar facet joints are well innervated the medial branches of the dorsal rami, with presence of free and encapsulated nerve endings, as well as nerves containing substance P and calcitonin gene-related peptide.


Established guidelines, systematic reviews, and local coverage determinations dictate appropriate documentation of functional status improvement.

Functional status improvement is measured utilizing various outcome measures of function including, but not limited to Oswestry Disability Index (ODI) scoring (Fairbank JC, et al. The Oswestry Disability Index. *Spine (Phila Pa 1976)* 2000; 25:2940-2952). In addition, return to work or self-rated improvement in functional status are also considered.

**Clinical Recommendation Statement:**
ASIPP guidelines, Medicare LCDs, and guidance from multiple insurers provide utilization criteria based on outcomes with appropriate pain relief and functional status improvement.

**Improvement Notation:**

A high score indicates better quality and appropriate utilization of the procedure.

**References:**


NIPM 14: FUNCTIONAL STATUS ASSESSMENT AND IMPROVEMENT FOLLOWING CERVICAL MEDIAL BRANCH RADIOFREQUENCY ABLATION

**Measurement Period:**
January 1, 2018 to December 31, 2018

**Measure Developer:**
American Society of Interventional Pain Physicians

**Description:**
Percentage of patients 18 years of age and older with cervical medial branch radiofrequency ablation who completed baseline and follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline. Follow-up functional assessment must be completed within 90 days following the procedure.

**Disclaimer:**
These performance measures are not standards and do not establish a standard of medical care.

**NQS Domain:**
Person and care-giver centered experience and outcome

**Measure Type:**
Outcome

**Stratification:**
None

**Risk Adjustment Variable:**
N/A
Risk Adjustment Algorithms

N/A

Rate Aggregation:

None

Definition(s) of Outcomes:

1. Percentage of patients 18 years of age and older with cervical medial branch radiofrequency ablation who completed baseline and follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline. Follow-up functional assessment must be completed within 90 days following the procedure.

Baseline and follow-up functional status can be assessed directly within the registry platform through completion of a patient survey OR documented within the medical record using custom quality codes FXN00 through FXN99, with FXN00 representing 0% disability and FXN99 representing 99% disability as calculated from a validated, scaled functional assessment.

Population:

All patients aged 18 years and older who undergo cervical medial branch radiofrequency ablation.

Denominator:

All patients aged 18 years and older who undergo cervical medial branch radiofrequency ablation.

ANY of the following CPT Codes in the same encounter: 64633, 64634

Denominator Exclusions:

None

Numerator:
Percentage of patients 18 years of age and older with cervical medial branch radiofrequency ablation who completed baseline and follow-up patient-reported functional status assessments, and achieved at least a 10% improvement in functional status score from baseline. Follow-up functional assessment must be completed within 90 days following the procedure.

**Numerator Exclusions:**

None

**Denominator Exceptions:**

Not applicable

**Rationale:**


Various guidelines exist in reference to measurement of pain relief after radiofrequency neurotomy. Pain relief may be assessed with Numeric Rating Scale (NRS) or Visual Analog Scale (VAS) on a scale of 0 to 10
Various guidelines exist in reference to measurement of improvement in functional status following radiofrequency neurotomy of cervical and thoracic spine. Functional status improvement is measured utilizing various outcome measures of function including, but not limited to, Neck Disability Index (NDI) scoring (Cleland JA, et al. Psychometric properties of the Neck Disability Index and Numeric Pain Rating Scale in patients with mechanical neck pain. Arch Phys Med Rehabil 2008; 89:69-74). In addition, return to work or self-rated improvement in functional status are also considered.

Clinical Recommendation Statement:

ASIPP guidelines, Medicare LCDs, and guidance from multiple insurers provide utilization criteria based on outcomes with appropriate pain relief and functional status improvement.

Improvement Notation:

A high score indicates better quality and appropriate utilization of the procedure.

References:


**NIPM 15: REDUCTION IN PATIENT REPORTED PAIN FOLLOWING SPINAL CORD STIMULATOR IMPLANTATION FOR FAILED BACK SURGERY SYNDROME**

**Measurement Period:**
January 1, 2018 to December 31, 2018

**Measure Developer:**
American Society of Interventional Pain Physicians

**Description:**
Measurement of reduction in pain as reported by patients aged 18 years and older following implantation of a spinal cord stimulator and implantable pulse generator for the indication of failed back surgery syndrome

**Disclaimer:**
These performance measures are not standards and do not establish a standard of medical care.

**NQS Domain:**
Person and care-giver centered experience and outcome

**Measure Type:**
Outcome

**Stratification:**
None

**Risk Adjustment Variable:**
None

**Risk Adjustment Algorithms**
None

**Rate Aggregation:**
None

**Definition(s) of Outcomes:**

1. The percent reduction in pain score on a visual analog scale (VAS 0-10) in the area targeted for treatment by spinal cord stimulation, comparing pre-implantation pain (recorded within 90 days prior to surgical implantation) and post-implantation pain (recorded within 90 days following surgical implantation) OR
2. The reduction in pain as reported by the patient as a percent reduction in pain in the area targeted for treatment by spinal cord stimulation, comparing pre-procedure pain and post-procedure pain. Percent reduction in pain must be reported within 90 days following surgical implantation.

Average baseline and follow-up VAS pain scores can be documented directly within the registry platform by clinicians OR by patients through patient reported outcome survey response OR documented within the medical record using custom quality codes VAS00 through VAS10.

**Population:**
All patients aged 18 years and older who undergo surgical implantation of a spinal cord stimulator with implantable pulse generator for the indication of failed back surgery syndrome, excluding replacement or revision of existing spinal cord stimulation systems.
Denominator:

All patients aged 18 years and older who undergo surgical implantation of a spinal cord stimulator with implantable pulse generator for the indication of failed back surgery syndrome, excluding replacement or revision of existing spinal cord stimulation systems.

Patient population includes ALL of the following CPT Codes in the same encounter: 63650, 63685

Denominator Exclusions:

Patients undergoing revision or replacement of pulse generator: 63688

Patients undergoing temporary placement of neuroelectrodes: 63650 without 63685

Patients undergoing revision or replacement of existing neuroelectrodes: 63663

Numerator:

1. The percent reduction in pain score on a visual analog scale (0-10) in the area targeted for treatment by spinal cord stimulation, comparing pre-implantation pain (recorded within 90 days prior to surgical implantation) and post-implantation pain (recorded within 90 days following surgical implantation) OR

2. The reduction in pain as reported by the patient as a percent reduction in pain in the area targeted for treatment by spinal cord stimulation, comparing pre-procedure pain and post-procedure pain. Percent reduction in pain must be reported within 90 days following surgical implantation.

Numerator Exclusions:

Patients in whom the neuroelectrodes and/or pulse generator were revised or explanted during the 90-day post-operative period: 63661, 63663, 63688

Denominator Exceptions:

Not applicable

Rationale:

As illustrated by multiple reports worldwide, the impact of chronic pain is enormous, and continues to increase. Burden of diseases, injuries, and risk factors showed that morbidity and chronic disability now account for nearly half of the US health burden from 1999-2010, with increasing life expectancy despite substantial progress and improvement in health (US Burden of Disease Collaborators. The state of US

For recalcitrant pain after failure of various modalities of treatments, spinal cord stimulation has been used frequently (Grider JS et al. Effectiveness of spinal cord stimulation in chronic spinal pain: A systematic review. Pain Physician 2016; 19:E33-E54). Multiple systematic reviews have been performed assessing the effectiveness of spinal cord stimulation in managing chronic spinal and other neuropathic pain. However, it is most commonly performed for management of chronic persistent pain with disability after failed surgical interventions. A Cochrane review in 2004 (Mailis-Gagnon A et al. Spinal cord stimulation for chronic pain. Cochrane Database Syst Rev 2004; 3:CD003783) suggested that spinal cord stimulation showed promise in the treatment of neuropathic pain and that had proven refractory to other treatment options. Subsequent multiple randomized controlled trials, accompanied by reviews, have shown significant evidence showing the effectiveness of spinal cord stimulation. Grider et al (Grider JS et al. Effectiveness of spinal cord stimulation in chronic spinal pain: A systematic review. Pain Physician 2016; 19:E33-E54) performed a systematic review in 2016 with inclusion of multiple randomized controlled trials, as well as cost effectiveness studies. Based on a best evidence synthesis with 3 high quality randomized controlled trials, the evidence of efficacy for spinal cord stimulation in lumbar failed back surgery syndrome was Level I to II. There is also evidence of high frequency stimulation (Kapural L et al. Novel 10-kHz high frequency therapy (HF10 Therapy) is superior to traditional low-frequency spinal cord stimulation for the treatment of chronic back and leg pain: The SENZARCT randomized controlled trial. Anesthesiology 2015; 123:851-860; Harrison C et al. The efficacy and safety of dorsal root ganglion stimulation as a treatment for neuropathic pain: A literature review. Neuromodulation 2017 [Epub ahead of print]), as well as dorsal root ganglion stimulation, and adaptive stimulation (Schultz DM et al. Sensor-driven position adaptive spinal cord stimulation for chronic pain. Pain Physician 2012; 15:1-12) as a treatment for a neuropathic pain.

Multiple guidelines and regulations have been recommended and systematic reviews based on high quality relevant randomized controlled trials have shown efficacy of spinal cord stimulation, along with cost effectiveness.

Basic guidelines and multiple carriers recommend consideration of spinal cord stimulation therapy as a late option after more conservative attempts such as medications, physical therapy, psychological therapy, or other modalities have been tried.

For spinal cord stimulation trial and subsequent implantation, patients must have undergone careful screening, evaluation and diagnosis by physicians, as well as psychologists. In addition, guidelines also recommend that prior to selecting a patient for a trial, patient:

- Must not have active substance abuse issues
- Must undergo prior patient education discussion and disclosure including an extensive discussion of the risks and benefits of this therapy
- Must undergo appropriate psychological screening

It is expected that accurate patient selection will lead to most patients going on to receive permanent implants. Only patients who experience a positive response to a trial should proceed to a permanent implantation. A successful trial should be associated with at least 50% reduction of target pain, or 50% reduction of analgesic medications, and show some element of functional improvement.

After permanent implant, the patient should be monitored for pain relief utilizing Numeric Pain Rating Scale (NRS) or Visual Analog Scale (VAS) on a scale of 0 to 10. Both measures have shown to be valid (National Institutes of Health. Warren Grant Magnuson Clinical Center. Pain Intensity Instruments, July 2003. http://www.mvlteca.net/Presentations/mvlteca.pdf).

**Clinical Recommendation Statement:**

The patient should be monitored for pain relief utilizing Numeric Pain Rating Scale (NRS) or Visual Analog Scale (VAS) on a scale of 0 to 10.

**Improvement Notation:**
High compliance score indicates better quality.

References:


Kapural L et al. Novel 10-kHz high frequency therapy (HF10 Therapy) is superior to traditional low-frequency spinal cord stimulation for the treatment of chronic back and leg pain: The SENZARCT randomized controlled trial. *Anesthesiology* 2015; 123:851-860.


Kumar K et al. The effects of spinal cord stimulation in neuropathic pain are sustained: A 24-month follow-up of the prospective randomized controlled multicenter trial of the effectiveness of spinal cord stimulation. *Neurosurgery* 2008; 63:762-770.


[http://www.mvltna.net/Presentations/mvltna.pdf](http://www.mvltna.net/Presentations/mvltna.pdf)

**NIPM 16: REDUCTION IN PATIENT REPORTED PAIN FOLLOWING LUMBAR MEDIAL BRANCH RADIOFREQUENCY ABLATION**

**Measurement Period:**
January 1, 2018 to December 31, 2018

**Measure Developer:**
Description:
Measurement of reduction in pain as reported by patients aged 18 years and older following lumbar medial branch radiofrequency ablation

Disclaimer:
These performance measures are not standards and do not establish a standard of medical care.

NQS Domain:
Person and care-giver centered experience and outcome

Measure Type:
Outcome

Stratification:
None

Risk Adjustment Variable:
None

Risk Adjustment Algorithms
None

Rate Aggregation:
None

Definition(s) of Outcomes:
3. The percent reduction in pain score on a visual analog scale (0-10), comparing pre-procedure pain (recorded within 90 days prior to the procedure) and post-procedure pain (recorded within 90 days following the procedure) in the area targeted for treatment by lumbar medial branch radiofrequency ablation OR

4. The reduction in pain as reported by the patient as a percent reduction in pain in the area targeted for treatment by lumbar medial branch radiofrequency ablation, comparing pre-procedure and post-procedure pain. Percent reduction in pain must be reported within 90 days following the procedure.

Average baseline and follow-up VAS pain scores can be documented directly within the registry platform by clinicians OR by patients through patient reported outcome survey response OR documented within the medical record using custom quality codes VAS00 through VAS10.

**Population:**

All patients aged 18 years and older who undergo lumbar medial branch radiofrequency ablation.

**Denominator:**

All patients aged 18 years and older who undergo lumbar medial branch radiofrequency ablation.

Patient population includes ANY of the following CPT Codes: 64635, 64636

**Denominator Exclusions:**

None

**Numerator:**

1. The percent reduction in pain score on a visual analog scale (0-10), comparing pre-procedure pain (recorded within 90 days prior to the procedure) and post-procedure pain (recorded within 90 days following the procedure) in the area targeted for treatment by lumbar medial branch radiofrequency ablation OR

2. The reduction in pain as reported by the patient as a percent reduction in pain in the area targeted for treatment by lumbar medial branch radiofrequency ablation, comparing pre-procedure and post-procedure pain. Percent reduction in pain must be reported within 90 days following the procedure.

**Numerator Exclusions:**
Denominator Exceptions:

Not applicable

Rationale:


Multiple structures in the low back responsible for low back and/or lower extremity pain include lumbar intervertebral discs, facet joints, sacroiliac joints, and nerve root dura. Facet joints have been shown to be amenable to diagnostic measures such as controlled diagnostic blocks (Manchikanti L, et al. Management of lumbar zygapophysial (facet) joint pain. World J Orthop 2016; 7:315-337; Boswell MV, et al. A best-evidence systematic appraisal of the diagnostic accuracy and utility of facet (zygapophysial) joint injections in chronic spinal pain. Pain Physician 2015; 18:E497-E533). Based on neuroanatomic, neurophysiologic, biomechanical studies, and controlled diagnostic facet joint nerve blocks, lumbar facet joints have been recognized as a potential cause of low back pain as well as referred lower extremity pain patients who have chronic low back pain. Lumbar facet joints are well innervated the medial branches of the dorsal rami, with presence of free and encapsulated nerve endings, as well as nerves containing substance P and calcitonin gene-related peptide.

With appropriate diagnosis, accurate and evidence-based treatment may be expected to achieve reasonable outcomes; however, outcomes must be monitored and documented for appropriate


Established guidelines, systematic reviews, and local coverage determinations dictate appropriate documentation of pain relief. Pain relief is measured by Numeric Pain Rating Scale (NRS) or Visual Analog Scale (VAS) on a scale of 0 to 10 (National Institutes of Health. Warren Grant Magnuson Clinical Center. Pain Intensity Instruments, July 2003. [http://www.mvlte.net/Presentations/mvltca.pdf](http://www.mvlte.net/Presentations/mvltca.pdf)).

**Clinical Recommendation Statement:**

ASIPP guidelines, Medicare LCDs, and guidance from multiple insurers provide utilization criteria based on outcomes with appropriate pain relief and functional status improvement.

**Improvement Notation:**

A high score indicates better quality and appropriate utilization of the procedure.

**References:**


**NIPM 17: REDUCTION IN PATIENT REPORTED PAIN FOLLOWING CERVICAL/THORACIC MEDIAL BRANCH RADIOFREQUENCY ABLATION**

**Measurement Period:**
January 1, 2018 to December 31, 2018

**Measure Developer:**
American Society of Interventional Pain Physicians

**Description:**
Measurement of reduction in pain as reported by patients aged 18 years and older following cervical/thoracic medial branch radiofrequency ablation

**Disclaimer:**
These performance measures are not standards and do not establish a standard of medical care.
NQS Domain:
Person and care-giver centered experience and outcome

Measure Type:
Outcome

Stratification:
None

Risk Adjustment Variable:
None

Risk Adjustment Algorithms
None

Rate Aggregation:
None

Definition(s) of Outcomes:
5. The percent reduction in pain score on a visual analog scale (0-10), comparing pre-procedure pain (recorded within 90 days prior to the procedure) and post-procedure pain (recorded within 90 days following the procedure) in the area targeted for treatment by cervical/thoracic medial branch radiofrequency ablation OR
6. The reduction in pain as reported by the patient as a percent reduction in pain in the area targeted for treatment by cervical/thoracic medial branch radiofrequency ablation, comparing pre-procedure and post-procedure pain. Percent reduction in pain must be reported within 90 days following the procedure.

Average baseline and follow-up VAS pain scores can be documented directly within the registry platform by clinicians OR by patients through patient reported outcome survey response OR documented within the medical record using custom quality codes VAS00 through VAS10.
Population:
All patients aged 18 years and older who undergo cervical/thoracic medial branch radiofrequency ablation.

Denominator:
All patients aged 18 years and older who undergo cervical/thoracic medial branch radiofrequency ablation.

Patient population includes ANY of the following CPT Codes: 64633, 64634

Denominator Exclusions:
None

Numerator:
1. The percent reduction in pain score on a visual analog scale (0-10), comparing pre-procedure pain (recorded within 90 days prior to the procedure) and post-procedure pain (recorded within 90 days following the procedure) in the area targeted for treatment by cervical/thoracic medial branch radiofrequency ablation OR
2. The reduction in pain as reported by the patient as a percent reduction in pain in the area targeted for treatment by cervical/thoracic medial branch radiofrequency ablation, comparing pre-procedure and post-procedure pain. Percent reduction in pain must be reported within 90 days following the procedure.

Numerator Exclusions:
None

Denominator Exceptions:
Not applicable

Rationale:
The therapeutic spinal facet joint interventions generally used for the treatment of axial spinal pain of facet joint origin are intraarticular facet joint injections, facet joint nerve blocks, and radiofrequency neurotomy. Despite interventional procedures being common as treatment strategies for facet joint


Various guidelines exist in reference to measurement of pain relief after radiofrequency neurotomy. Pain relief may be assessed with Numeric Rating Scale (NRS) or Visual Analog Scale (VAS) on a scale of 0 to 10 (National Institutes of Health. Warren Grant Magnuson Clinical Center. Pain Intensity Instruments, July 2003. [http://www.mvltc.net/Presentations/mvltica.pdf](http://www.mvltc.net/Presentations/mvltica.pdf)).

**Clinical Recommendation Statement:**

ASIPP guidelines, Medicare LCDs, and guidance from multiple insurers provide utilization criteria based on outcomes with appropriate pain relief and functional status improvement.

**Improvement Notation:**

A high score indicates better quality and appropriate utilization of the procedure.

**References:**


