

Draft LCD for Lumbar Facet Blockade (DL30809)

Draft

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Contractor Information

Draft Draft Draft

Contractor Name

Noridian Administrative Services, LLC

Contractor Number

00821

Contractor Type

Carrier

LCD Information

Draft Draft Draft

LCD ID Number

DL30809

LCD Title

Lumbar Facet Blockade

Contractor's Determination Number

B2010.01

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CMS National Coverage Policy

Section 1862(a)(1)(A) of Title XVIII of the Social Security Act excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) of Title XVIII of the Social Security Act prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

CMS Manual System. Publication 100-2, Medicare Benefit Policy Manual, Chapter 15, §80 describes coverage for physician supervision of diagnostic x-ray, lab and other diagnostic tests.

CMS Manual System. Publication 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Part 1, §30.3 states that acupuncture is not considered a reasonable and necessary service and will not be reimbursed for Medicare beneficiaries.

CMS Manual System. Publication 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Part 2, §150.7 states that prolotherapy is not considered a reasonable and necessary service and will not be reimbursed for Medicare beneficiaries.

Primary Geographic Jurisdiction

Alaska
Oregon
Washington

Oversight Region

Region X

Projected Determination Effective Date

Original Determination Ending Date

Revision Effective Date

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

ABSTRACT:

For the purposes of this policy, a facet joint “level” refers to the zygapophyseal joint or the two medial branch nerves innervating that zygapophyseal joint.

The spinal facet joints are potential generators of low back pain, presumably mediated by the medial branch nerves. The facet or zygapophyseal joint is a paired diarthrodial articulation between posterior elements of adjacent vertebrae. Facet joints are innervated by the medial branches of the dorsal rami of segmental nerves. Two medial branch nerves from two different segmental levels supply each joint. The L5-S1 facet joint is an exception innervated by the L4 medial branch and the L-5 dorsal ramus nerve.

Facet joint blockade is one technique used in the diagnosis and/or management of chronic low back pain (LBP). Lumbar facet block may alleviate low back pain (LBP) associated with:

- Hypertrophic arthropathy of the facet joints that causes pain;
- Back pain following whiplash/post-traumatic injury; and/or
- Back pain associated with suspected motion segment instability/hypermobility or pseudoarthrosis following fusion.

History and physical exam may suggest facet joint arthropathy and involvement in pain production. There are no imaging or other diagnostic tests with findings specific to painful facet arthropathy. Definitive diagnosis requires **double-comparative** local anesthetic blockade of a joint. Both intraarticular blocks (IA) and medial branch blocks (MBB) have been used for diagnosis and treatment of LBP due to facet arthropathy. Radiofrequency thermal denervation has been used after MBB for longer-lasting relief of pain.

The current body of literature on facet joint block (over 30,000 studies in 30 years) does not establish the efficacy of lumbar facet blockade in the treatment of LBP. However, the literature does appear to support the positive patient outcomes documented by our providers associated with specific techniques and related practices and in carefully selected patient populations; albeit, to a limited extent. Based on the specialty societies' commitment to providing an analysis of outcomes with data collection to begin within the next 12 to 18 months, NAS will cover the lumbar facet blocks in accordance with the following Indications of Coverage for a period no greater than five years. Ongoing coverage will be determined by analyses of outcomes.

Providers must maintain and provide on request baseline and follow-up functional and pain assessments for all patients.

INDICATIONS OF COVERAGE

Evaluation of the Patient:

Care of the patient with chronic LBP should be undertaken within the context of a comprehensive, multidisciplinary treatment program. The decision to diagnose or treat chronic pain by invasive or destructive procedures must be based on a thorough evaluation of the patient and include a specific pain history, physical examination, and a systematic assessment of the pathophysiology of the pain. Documentation in the patient's medical record must indicate how the provider arrived at the suspected diagnosis and the provider's intended plan of care for the patient. The medical record must include all the following specific information.

- A detailed clinical pain history with prior treatment and response to treatment.
- **Objective measurements** of functional impairment.
- **Duration of pain > 3 months at an average level > 6** on a scale 0 to 10, and
- Evidence of **poor or inadequate response to conservative management, including physical therapy and medications for at least three (3) months.**
- Evidence that pain is primarily axial with or without non-dermatomal referral. Back pain is worse than leg pain. Pain is not associated with neurologic deficit or radiculopathy, spondylolisthesis (> Grade 1), isthmic spondylolysis, spinal stenosis, primary neurogenic claudication associated with stenosis, fracture, tumor, infection, inflammatory disease, or degenerative disease

associated with significant deformity.

- Absence of known or obvious non-facet pathology that could explain LBP.
- A detailed physical examination and review of all pertinent diagnostic tests, including imaging tests performed at any treatment center. Documentation of any joint tenderness to palpation and response to facet loading maneuvers such as hyperextension of the spine.
- Radiological examination required to rule out **other suspected pathology that should be treated primarily before facet block is considered.**

Diagnostic Facet Joint Block:

The primary utility of facet injections in the context of potential multiple pain generators is diagnostic. Definitive diagnosis requires **double-comparative** local anesthetic blockade of a joint under **fluoroscopic or computed tomographic (CT) guidance.** (Films must be available on request). Providers are urged to limit the patient's exposure to ionizing radiation.

- **Pain must be present at the time of the block. Pre-procedural and post-procedural pain scores** (numeric or visual analogue) must be documented and compared. The patient's response(s) shall be monitored and documented with regard to the degree of pain relief, duration of pain relief, and improvement in functional status.
- Blockade may be either by intra-articular injection or injection of the medial branch nerves of the dorsal rami.
- Small volumes of two local anesthetics (LAs), one short and one long-acting, may be injected on separate occasions. With the exception of steroids, no drugs other than local anesthetics (LAs) should be injected. In order to maintain target specificity and avoid extraarticular extravasation, **total injection should not exceed 0.5 ml to 1.0 ml per joint, including contrast.** Larger volumes may be used when performing a facet cyst rupture.
- **Contrast** is required to confirm an actual intra-articular injection of the target joint and confinement to the joint. In MBB, contrast should be used to demonstrate absence of vascular uptake and adequate flow over the target medial branch nerve.
- If after the **first** injection, **80% pain reduction** is documented while the patient engages in activities that typically elicit or aggravate the pain, a second injection may be performed **two or more weeks after the first** injection or later if a longer acting steroid is injected.
- The patient must keep a **pain diary** (or report via equivalent online form), which the physician will review prior to a second injection.
- The second injection may not occur prior to, at least, **50% reduction in pain relief** from the earlier block and a deterioration in functional status.
- Two to three adjacent joints may need to be injected before the precise pathogenic facet joint level is determined; **any additional joint injections on the same side will not be separately paid.**

The diagnosis of facet arthropathy may be presumed when both a) 80% pain relief is achieved following injection of each LA for an appropriate duration and b) there is an appropriate differential response (in the onset and duration of pain relief) to the two different LAs. Relief of pain for a significant period of time suggests that facet joints were the source of the pain. If *complete*, but only temporary pain relief occurs after facet joint/nerve injection, another type of treatment may need to be considered, including RF ablation or another type of block.

Therapeutic Facet Joint Block

Therapeutic IA or MBB may be considered when the diagnosis of facet arthropathy has been established in accordance with the criteria listed under “Diagnostic Facet Joint Blocks” in this LCD. **(Intra-articular blocks are restricted to one diagnosis discussed below.)** Therapeutic blocks must be performed in accordance with all requirements listed in the section, “Diagnostic Facet Joint Blocks”, as well as the following requirements:

- Injections do not exceed a frequency parameter of more than once every three (3) months per joint or four (4) blocks per joint per year;
- initial pain relief of greater than or equal to 80% with the ability to perform previously painful maneuvers and persistent pain relief (for a minimum of six (6) weeks) of 50% with the continued ability to perform previously painful maneuvers; and
- appropriate consideration given to the adverse effects of the block (e.g., adrenal suppression of corticosteroid injections and exposure to radiation).

Intraarticular Blocks (IA). Emerging evidence suggests that some elderly patients who suffer from **symptomatic degenerative facet joint disease and** have a posterior spinal fusion or synovial cyst or spinal cord stimulator or cardiac pacemaker may benefit from palliative treatment with IA blocks. An initial “diagnostic” block, with or without steroid, may alleviate pain for prolonged periods of time or indefinitely. Additionally, in patients with symptomatic facet joint cysts, evidence suggests that purposeful iatrogenic synovial cyst rupture via an IA injection and joint space over-pressurization may be beneficial.

Lumbar Medial Branch Radiofrequency Neurotomy. Thermocoagulation with radiofrequency energy may achieve long-lasting pain relief via axonotmesis of the sensory afferent nerve (medial branch). If double-comparative MBB provides at least 80% pain relief but relief is not long-lasting, facet joint denervation with radiofrequency (RF) neural ablation may be considered. Intra-articular blocks cannot establish the utility and/or medical necessity of RF Neurotomy. Comparative MBB is the only validated prognostic test for thermal RF Neurotomy.

Pre-lesion electrical stimulation should be performed to assure safety in performing subsequent thermal denervation in the same tested needle position. Under local anesthesia and with fluoroscopic guidance, a needle or radiofrequency cannula is placed adjacent and must be **parallel** to each of the two medial branch nerves innervating the target joint. Neurolysis is performed with radiofrequency lesion volumes sufficient to incorporate the target nerve in its anatomic location. Large gauge (16 & 18G) electrodes more reliably capture the target nerve than smaller gauge (21G) and usually require multiple placements to allow for variation in the location of the nerve. Lesions should be placed along the maximal length of the nerve in order to optimize duration of effect.

The effects of appropriately performed denervation **should last nine (9) months or more** and, in some cases, are permanent. Repeat denervation procedures of the same joint will only be considered medically necessary when the patient had significant improvement that lasted at least 9 months. Neurotomy of a single facet joint is limited to two times per year.

LIMITATIONS OF COVERAGE:

- Radiculopathy secondary to nerve root involvement must be ruled

out by physical/electrophysiological examination. Presence of radiculopathy precludes coverage of facet blockade.

- Low back pain may also be associated with “myofascial pain syndrome” or a soft-tissue source of pain in which case no facet joint/nerve pathology exists. Therefore, a therapeutic facet joint/nerve block injection would be ineffective and non-covered.
- Provision of multiple modalities such as epidural block, bilateral sacroiliac joint injections, and lumbar sympathetic blocks on the same day as facet joint blocks or providing more than three levels of facet joint blocks on the same day is not considered medically necessary. We would not expect to see other pain management modalities performed on the same date of service as facet joint blocks. Therefore, only one of these procedures is allowed on a given day with the following exceptions.

o Pain relief is incomplete following an adequately assessed non-facet injection, and any potential residual effects from the injection may be reliably known to have dissipated. It otherwise would be impossible to determine which injection resulted in pain relief; and/or

o Multiple LBP generators are present and diagnoses are clearly documented in a patient on anticoagulants, requiring the anticoagulants to be stopped for the injections.

- Monitored anesthesia care (MAC) is usually not necessary for facet joint blocks and will therefore be denied as not medically necessary without supporting documentation.
- Facet joint nerve injections for the treatment of acute back pain (<3 months’ duration) are considered not medically necessary.
- Chemical, thermal, electrical means of denervation (not including thermal RF) as well as pulsed RF are not covered for facet joint denervation.
- Prolotherapy is non-covered.

Coding Information



Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

CPT/HCPCS Codes

64493	Inj paravert f jnt l/s 1 lev
64494	Inj paravert f jnt l/s 2 lev
64495	Inj paravert f jnt l/s 3 lev

ICD-9 Codes that Support Medical Necessity

716.98	UNSPECIFIED ARTHROPATHY INVOLVING OTHER SPECIFIED SITES
724.2	LUMBAGO
724.8*	OTHER SYMPTOMS REFERABLE TO BACK
733.82*	NONUNION OF FRACTURE
847.2	LUMBAR SPRAIN
733.82* PSEUDOARTHROSIS ONLY	
724.8* FACET SYNDROME ONLY	

Diagnoses that Support Medical Necessity

See above list of ICD-9-CM codes that support medical necessity and reasonableness.

ICD-9 Codes that DO NOT Support Medical Necessity

Any diagnosis codes other than those listed in the covered ICD-9-CM codes will be denied as not reasonable and necessary and will be denied provider liable unless a non-coverage notice has been issued to the beneficiary prior to the test. Screening diagnoses will be denied as routine services.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

General Information



Documentation Requirements

The patient's medical record should contain documentation that fully supports the medical necessity for paravertebral facet joint/nerve injections as they are covered by Medicare (please see "Indications and Limitations of Coverage and/or Medical Necessity"). This documentation includes, but is not limited to, relevant medical history, physical examination, results of pertinent diagnostic tests or procedures.

Medical documentation in the patient's medical record should substantiate the suspected diagnosis. As an example, "The patient had back pain without a strong radicular component, no associated neurologic deficit, and the pain was aggravated by hyperextension of the spine." Medical documentation should also demonstrate that the patient's pain has been refractory to repeated attempts at medical management. The following lists some specific criteria that should be documented in the medical record:

- Complete initial evaluation including history and physical examination;
- Physiological and functional assessment, as necessary and feasible;
- Description of indications and medical necessity, as follows:
 - o Suspected organic problem;
 - o Pain and disability of moderate-to-severe degree;
 - o No evidence of contraindications such as severe spinal stenosis resulting in intraspinal obstruction, infection, or predominantly psychogenic pain;
 - o Nonresponsiveness to conservative modalities of treatment;
 - o Repeating interventions only upon return of pain and deterioration in functional status; and/or
 - o Responsiveness to prior interventions with improvement in physical and functional status for repeat blocks or other interventions.

Document the total amount of injectate for all medications used, **not** to exceed 0.5 to 1 mL per facet joint or medial branch nerve.

The standard of care for all facet joint/nerve injections requires that these procedures be performed under fluoroscopic- or CT-guided imaging. An image (plain radiograph with conventional film or specialized paper) documenting the needle position must be obtained whenever a substance is injected. A hard or digital copy of the needle placement should be retained to document accurate placement and must be made available on request.

Appendices

Utilization Guidelines

See Indications & Limitations

Sources of Information and Basis for Decision

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Advisory Committee Meeting Notes

This medical policy was presented at the Medicare Part B Open Public Meeting held on 05/11/2010. It was again discussed at the following Carrier Advisory Committee meetings on the following dates:

Alaska 06/24/2010

Oregon 06/19/2010

Washington 05/25/2010

This policy does not reflect the sole opinion of the contractor or the Contractor Medical Directors. Although the final decision rests with the contractor, this policy was developed in cooperation with several provider advisory groups, including Part B Carrier Advisory Committee(CAC) and Part A workgroups. In addition, many individual providers contributed references and practice outcomes data.

The Section titled "Does the 'CPT 30% Rule' apply?" needs clarification. This rule comes from the AMA (American Medical Association), the organization that holds the copyrights for all CPT codes. The rule states that if, in a given section (e.g., surgery) or subsection (e.g., surgery, integumentary) of the CPT Manual, more than 30% of the codes are listed in the LCD, then the short descriptors must be used rather than the long descriptors found in the CPT Manual.

This policy is subject to the reasonable and necessary guidelines and the limitation of liability provision.

Start Date of Comment Period

05/11/2010

End Date of Comment Period

08/23/2010

Start Date of Notice Period

Revision History Number

Revision History Explanation

Reason for Change

Last Reviewed On Date

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.

Draft Contact

Noridian Administrative Services LLC Contractor Medical Director(s) - policyb.drafts@noridian.com
Policy Development - Medicare Part B - Drafts
900 42nd Street S.

All Versions



Updated on 01/08/2010 with effective dates N/A - N/A