

DRAFT Local Coverage Determination Proposed for Noridian Administrative Services, LLC

DRAFT LCD for Injection Paravertebral Lumbar Facet Joint or Facet Joint Nerve (Lumbar Facet Blocks)/ Paravertebral Lumbar Facet Joint Nerve Destruction by Neurolytic Agent (Lumbar Facet Joint Denervation)

LCD Title	Injection Paravertebral Lumbar Facet Joint Block or Facet Joint Nerve (Lumbar Facet Blocks)/ Paravertebral Lumbar Facet Joint Nerve Destruction by Neurolytic Agent (Lumbar Facet Joint Denervation)
Indications and Limitations of Coverage and/or Medical Necessity	Lumbar Facet Joint Blocks/Facet Joint Denervation <u>Introduction</u> The lumbar facet joints are small, paired joints located posteriorly in the spine that help to stabilize the spine. They are formed by the interlocking of articular processes from two adjacent vertebrae, and are named accordingly (e.g. right and left L3-4 facet joints). Medial branch nerves transmit pain from the facet joints. Two medial branch nerves supply each joint, one from each participating vertebral level. The diagnosis of facet joint pain is considered in patients that have nonspecific low back pain without a strong radicular component or neurologic deficits. Facet joint pain is diagnosed by performing facet nerve (medial branch) anesthetic blocks, as there is no specific history, physical examination, or radiological imaging findings that have been found reliable in diagnosing the condition. Facet joint pain is treated by anesthetic/corticosteroid

injections of the joint, or more commonly by denervation (e.g. radio-frequency thermal ablation) of the lumbar facet joint (medial branch) nerves. The decision to treat facet pain using interventional procedures must be based on a systematic assessment of the location, intensity, and pathophysiology of the pain.

Diagnostic blocks:

Diagnostic lumbar facet nerve (medial branch) blocks are used to assess and localize potentially painful facet joints. Pain relief following local anesthetic injection of the medial branch nerves is used as evidence that a joint is a cause of pain. Immediately prior to the block, the patient must have adequate pain to discern if the pain improves after the diagnostic block. If not, the procedure should be cancelled or postponed.

The total volume of anesthetic used for each medial branch nerve block should be limited to no more than 0.5 cc to avoid spread to adjacent structures. Injection of local anesthetic, with or without steroid, into the joint can be used to diagnose facet joint pain, but is considered less anatomically accurate and reliable than medial branch blocks.

Facet joint blocks must be performed under fluoroscopic or CT guidance to assure accurate placement of the needle and contrast flow in the joint or on the medial branch nerve innervating a specific facet joint.

Appropriate radiographic images of needle placement should be saved and recorded in the patient's medical record.

After the diagnostic block is performed, and prior to discharge, the patient should be examined and should perform maneuvers that typically exacerbate their usual back pain. The magnitude of any elicited pain should be

recorded. Changes in function can also be recorded.

For a minimum of 6 hours after the injection, the patient is required to keep a diary, which must be returned to the physician for review. During the diary time period, the patient should participate in activities that would usually elicit pain. The diary should include a standardized pain rating scale and also document functional improvements.

Diagnostic medial branch blocks of the targeted facet joints are preferably administered on 2 separate sessions, typically at least one week apart. A second block is performed to compensate for an unacceptably high false positive rate associated with single blocks. A second block is indicated when $\geq 80\%$ relief of the patient's primary regional pain (aka "index pain") occurs with the first block. Traditionally, controlled blocks have involved the use of a true placebo (saline) injection, but controlled blocks using two local anesthetics represent a pragmatic alternative. Commonly, a different anesthetic is used for each session, one short acting and one long acting. If the patient experiences a significant ($\geq 80\%$) relief of pain after each set of medial branch blocks, with the duration of relief consistent with the physiological effects of the anesthetic utilized (aka positive controlled medial branch blocks), then the diagnosis of facet pain emanating from the blocked joints is considered established.

Therapeutic Interventions:

Therapeutic facet joint denervation is most commonly performed via radiofrequency (RF) neurotomy of the medial branch nerves innervating the joint. RF neurotomy is performed only after the diagnosis of lumbar facet joint nerve-mediated pain is established by obtaining $\geq 80\%$ pain relief of the patient's index pain following controlled medial branch blocks. In the case of RF denervation of the joint, appropriate pre-lesion

electrical stimulation should be performed to assure safety in performing subsequent thermal denervation in the same tested needle position. RF neurotomy should be performed using a parallel trajectory to the nerve with an adequate lesion volume generated to incorporate the target nerve in its known anatomic location.

Despite apparently correct needle placement, a thermal radiofrequency neurolysis may not work in a small percentage of patients, and the procedure may need to be repeated with technical modifications.

In some cases, repetitive therapeutic facet blocks are a reasonable approach to palliate pain in patients who are not candidates for RF neurotomy or when such therapy is unavailable or undesired by the patient. Such therapeutic blocks should not be performed if the relief from previous therapeutic procedure for that specific joint did not last at least 3 months. Therapeutic blocks must only be performed with either CT or fluoroscopic guidance, with appropriate radiographic images of the procedure stored in the patient's medical record and available for review.

Special Circumstances:

Occasionally, intra-articular facet joint injections and/or aspirations are indicated to obtain synovial fluid for the evaluation of potential infection or abscess of the facet joint. Additionally, intra-articular facet joint needle placement can be used to rupture or aspirate a facet joint synovial cyst which is causing nerve root compression and radicular pain.

Limitations

No more than three diagnostic/therapeutic facet joint injection procedures and two neurotomies (e.g. RF neurotomy) may be performed on any individual facet

joint (level) in any given year without prior authorization by the Carrier. Documentation justifying each procedure is required. However, If a procedure were discontinued prior to completion (e.g. vaso-vagal reaction, vascular injection, etc.), the procedure would not be counted against the yearly limit.

Injections into the paravertebral musculature should NOT be billed as facet joint nerve blocks. These constitute trigger point injections, and should be billed as such, if appropriate.

Injections performed in any location without fluoroscopic or CT guidance should NOT be billed utilizing the facet injection CPT codes or facet joint neurolysis codes (64622-64623).

Currently, the level of medical literature is insufficient to support the efficacy or safety of ultrasound (US) guidance or magnetic resonance imaging (MRI) guidance in the performance of diagnostic or therapeutic facet procedures (joint injections, facet nerve blocks, RF neurotomies, etc.). Therefore, facet interventions utilizing these imaging modalities will not be covered or paid separately.

Patients who receive diagnostic and therapeutic facet joint procedures (e.g. medial branch blocks, RF neurotomy) must have the results of those procedures evaluated and documented in the medical record. This includes pain logs/visual analog scores and documentation of functional improvement. Maintenance of detailed records, including images, documenting the use of fluoroscopic or CT guidance with each patient is mandatory and such records must be made available to CMS upon request. Failure to use and document fluoroscopic or CT guidance will subject claims to denial upon post-pay review.

A lumbar epidural (62311), lumbar transforaminal

	<p>epidural or selective nerve root block (64483, 64484), sacroiliac joint injection (27906), or lumbar sympathetic block (64520) should not be routinely performed on the same day as facet joint nerve block injections. If such therapy is not supported by documentation in the medical record of a pain problem separate and in addition to the facet-generated pain, the additional codes will be denied as not medically necessary. If a therapeutic procedure is performed, adequate time should be allowed to determine the effectiveness of that specific therapy.</p> <p>Note: Since each facet joint is supplied by two medial branch nerves (or the L4 medial branch and the L5 dorsal ramus nerve for the L5-S1 facet joint), blocking one facet joint requires injecting both nerves. Despite the fact that 2 anesthetic injections are required to block one joint level, only one facet joint injection code should be billed to the Medicare carrier (CPT Codes 64475, 64476). However, for facet neurolysis / radiofrequency denervation (CPT codes 64622, 64623), each nerve treated (each neurolysis) should be billed.</p>
<p>Coverage Topic</p>	<p>Doctor Office Visits Hospital Care (Inpatient) Outpatient Hospital Services</p>
<p>CPT/HCPCS Codes</p>	<p>Italicized and/or quoted material is excerpted from the American Medical Association <i>Current Procedural Terminology (CPT)</i> codes.</p> <p>CPT/HCPCS Codes for Paravertebral Facet Joint Interventions</p> <p>64475 INJECTION, ANESTHETIC AGENT AND/OR STEROID, PARAVERTEBRAL FACET JOINT OR FACET JOINT NERVE; LUMBAR OR</p>

	<p style="text-align: center;">SACRAL, SINGLE LEVEL</p> <p>64476 INJECTION, ANESTHETIC AGENT AND/OR STEROID, PARAVERTEBRAL FACET JOINT OR FACET JOINT NERVE; LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</p> <p>64622 DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; LUMBAR OR SACRAL, SINGLE LEVEL</p> <p>64623 DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</p>
<p>Does the CPT 30% Coding Rule Apply?</p>	<p>No</p>

**ICD-9 Codes that
Support Medical
Necessity**

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

These ICD-9-CM codes apply to the CPT/HCPCS Codes 64470, 64472, 64475, 64476, 64622, 64623, 64626, 64627.

720.0 ANKYLOSING SPONDYLITIS

721.3 LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY

721.42 SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION

722.52 DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC

724.2 LUMBAGO

738.4 ACQUIRED SPONDYLOLISTHESIS

724.8 FACET SYNDROME

847.2 LUMBAR SPRAIN

Documentation Requirements

1. All documentation, including permanent radiographic images, one of which portrays contrast flow (excluding those cases in which using contrast is contra-indicated, such as patients with documented contrast allergies), the patient's identification information and date of the procedure should be documented on or with the saved images and must be stored in the patient's medical record or other appropriate venue so as to be available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.
3. The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.
4. The drugs injected, the doses or volumes used, the site of the injection, any significant complications and the response to the procedure(s) should be documented in the patient's medical record.

Specific Documentation Requirements for Lumbar Facet Joint Injections:

1. The patient's medical record must indicate the medical necessity of services for each date of service billed. This must include the patient's history and chief complaint, relevant physical examination and documentation specific to

	<p>patient response to the facet procedures. Assessment of patient’s response to a facet intervention may include information about use of analgesics, other therapeutic interventions (e.g. treatments from other providers), and appropriate functional changes (such as return to work, improved ambulation, etc.).</p> <p>2. Documentation in the medical record should support the performance of any diagnostic or therapeutic facet procedure and include the subsequent results of the procedure (e.g. VAS changes, etc.). All documentation must be available to Medicare upon request.</p>		
<p>Appendices</p>	<p>N/A</p>		
<p>Utilization Guidelines</p>	<p>In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.</p> <p>Evidence-based practice guidelines indicate the following descriptions of the frequency of facet joint interventions:</p> <div data-bbox="634 1514 1352 1675" style="background-color: #e0e0e0; padding: 10px; text-align: center;"> <p>Lumbar Paravertebral Facet Joint Blocks</p> </div> <table data-bbox="634 1682 1352 1766"> <tr> <td style="padding-right: 20px;">Diagnostic/Therapeutic</td> <td>Three (3) procedures maximum per joint/per year</td> </tr> </table>	Diagnostic/Therapeutic	Three (3) procedures maximum per joint/per year
Diagnostic/Therapeutic	Three (3) procedures maximum per joint/per year		

	<p>Injections:</p> <p>Facet joint neurolysis (e.g. RF) Two (2) procedure maximum per joint/per year, provided there is $\geq 80\%$ relief of the patient's primary pain noted by prior controlled medial branch blocks.</p> <p>Diagnostic or therapeutic facet joint injections/blocks in excess of more than three (3) injections/side/per joint (level)/per year will be reviewed on an individual consideration basis.</p> <p>This contractor may request records when it is apparent that patients are requiring a significant number of injections to manage their pain.</p>
<p>Sources of Information and Basis for Decision</p>	<p>Other Contractor's Policies</p> <ol style="list-style-type: none"> 1. Bogduk N, Dreyfuss P, Govind J: A Narrative Review of Thermal Lumbar Medial Branch Neurotomy for the Treatment of Chronic Zygapophysial Joint Pain. Pain Medicine. Online Publication. DOI: 10.1111/j.1526-4637.2009.00692.x 2. Bogduk N, Macintosh J, Marsland A: Technical limitations to the efficacy of radiofrequency neurotomy for spinal pain. Neurosurgery 1987; 20:529-535, 3. Levin JH, Prospective, double-blind, randomized placebo-controlled trials in interventional spine: what the highest quality

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