

Interventional Pain Management

Origination: 05/21/08	Revised: 10/30/08	Annual Review: 12/15/11
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Purpose:

The Medical Technology Assessment Committee will review published scientific literature and information from appropriate government regulatory bodies (when available) related to Interventional Pain Management in order to determine inclusion in the benefit plan.

Recommendation:

A recommendation was made by the MTAC following discussion by committee members based on current literature:

Eligibility Criteria

The following procedures are considered medically necessary after the following criteria are met:

A.) Facet joint injections: considered appropriate in the management of chronic back or neck pain (pain lasting more than three [3] months despite appropriate conservative treatment) when used either as a diagnostic trial to determine the origin of the Member's pain; to establish the effectiveness of the facet injections in relieving the Member's pain; or to achieve a therapeutic effect.

Frequency: If approved, a set of facet joint injections, up to six (6) injections per sitting, can be authorized and this can be repeated up to four (4) times per year with intervals of 2-3 months or longer between injections, provided that >50% relief is obtained for six (6) weeks.

Facet joint injections are not covered for any other indications.

B.) Trigger point injections: Considered appropriate for treating chronic neck or back pain or myofascial pain syndrome, when *all* of the following section criteria are met:

- Trigger points have been identified by palpation, *and*
- Symptoms have persisted for more than three (3) months, *and*
- Conservative therapies such as bed rest, exercises, heating or cooling modalities, massage, and medications such as non-steroidal anti-inflammatory medications, muscle relaxants, non-narcotic analgesics should have been tried and failed.

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Recommendation, continued:

Eligibility Criteria, continued

The following procedures are considered medically necessary after the following criteria are met, continued:

B.) Trigger point injections: Considered appropriate for treating chronic neck or back pain or myofascial pain syndrome, when *all* of the following section criteria are met, continued:

Frequency: up to four (4) sets of injections are considered medically necessary to diagnose the origin of a Member's pain and achieve a therapeutic effect but should not be performed more frequently than once every two (2) months up to a maximum of six (6) times per year, provided that >50% relief is obtained for six (6) weeks.

Trigger point injections are not covered for any other indications.

C.) Sacroiliac joint injections: Considered appropriate to relieve lumbosacral pain present for more than three (3) months.

Frequency: It is rarely medically necessary to repeat sacroiliac injections more than frequently than once every two (2) months. If approved, can authorize up to two (2) sacroiliac injections as considered medically necessary to diagnose the Member's pain and achieve a therapeutic effect but should not be performed more frequently than once every two (2) months for a maximum of six (6) times over a one(1) year period provided that >50% relief is obtained for six (6) weeks.

Sacroiliac joint injections are not covered for any other indications.

D.) Epidural injections: Considered appropriate in the outpatient setting for management of back or neck pain when *all* of the following are met:

- Intraspinial tumor or other space-occupying lesion, or non-spinal origin for pain has been ruled out as the cause of pain; *and*
- Member has failed to improve after two (2) or more weeks of conservative measures (e.g., rest, systemic analgesics, and/or physical therapy); *and*

Frequency: Up to three (3) epidural injections are considered medically necessary to diagnose and achieve a therapeutic effect. It is rarely medically necessary to repeat epidural injections more frequently than once every two (2) months. If approved, can authorize up to three (3) injections over a six (6) month period provided that >50% relief is obtained for at least six (6) weeks.

Epidural injections are not covered for any other indications.

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Recommendation, continued:

Eligibility Criteria, continued

The following procedures are considered medically necessary after the following criteria are met, continued:

E.) Chemonucleolysis: Considered appropriate for the treatment of sciatica due to a herniated disc when *all* of the following are met:

- Leg pain worse than low back pain; *and*
- Radicular symptoms reproduced by sciatic stretch tests; *and*
- Only a single level herniated disc with nerve root impingement at clinically suspected level demonstrated by MRI, CT, or myelography; *and*
- Objective neurologic deficit; *and*
- Pain not relieved by at least six (6) weeks of conservative therapy.

Frequency: If approved, can authorize one (1) treatment procedure per level per side as considered medically necessary in a six (6) month period.

Chemonucleolysis is not covered for any other indications.

F.) Radiofrequency facet denervation (i.e., neurotomy, rhizotomy, rhizolysis): Considered appropriate for treatment of intractable cervical or back pain with or without sciatica in the outpatient setting when *all* of the following are met:

- Severe pain limiting activities of daily living for at least six (6) months; *and*
- No prior spinal fusion surgery; *and*
- Neuroradiologic studies are negative or fail to confirm disc herniation; *and*
- No significant narrowing of the vertebral canal or spinal instability requiring surgery; *and*
- Failure of conservative treatment such as bed rest, physiotherapy, back bracing, as well as medication s(e.g., anti-inflammatory agents, analgesics and muscle relaxants); *and*
- Trial of facet joint injections has been successful in relieving the pain.

Frequency: If approved, can authorize one (1) treatment procedure per level per side as considered medically necessary in a six (6) month period provided that >50% relief is obtained for 10-12 weeks.

Radiofrequency facet denervation is not covered for any other indications.

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Recommendation, continued:

Exclusions

Experimental and Investigational Procedures:

The following injections or procedures are considered experimental and investigational and are not a covered benefit. This includes, but is not limited to:

1. Intradiscal Electrothermal Therapy (IDET) and Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), also known as percutaneous radiofrequency thermomodulation, Coblation percutaneous disc decompression or Nucleoplasty (CPT codes 22526, 22527).
2. Radiofrequency lesioning of dorsal root ganglia.
3. Radiofrequency lesioning of terminal (peripheral) nerve endings.
4. Epiduroscopy, also known as epidural spinal endoscopy, spinal endoscopy, myeloscopy, and epidural myeloscopy (CPT codes 62263, 62264, 0027T).
5. Epidural injections of lytic agents (e.g., hypertonic saline, hyaluronidase) or mechanical lysis.
6. Yeung Endoscopic Spinal Surgery System (Y.E.S.S.) also known as Arthroscopic Microdiscectomy or Percutaneous Endoscopic Discectomy with or without laser, or SMART Endoscopic Spine System.
7. Microsurgical anterior foraminotomy for cervical spondylotic myelopathy or other indications.
8. Sacroiliac fusion for the treatment of low back pain due to sacroiliac joint syndrome.
9. Sacroplasty for osteoporotic sacral insufficiency fractures and other indications.
10. Racz procedure epidural adhesiolysis with the Racz catheter.
11. Microendoscopic discectomy (MED) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications.
12. Dynamic stabilization (e.g., Dynesys Dynamic Neutralization System).
13. Endoscopic laser formaminoplasty.
14. Piriformis muscle resection.

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Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed Health Plans' benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed Health Plans makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed Health Plans service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.