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RMHP Facet Joint Injection

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MCG Health
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Clinical Indications for Procedure

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For Members with **RMHP Medicare (CareAdvantage and Dual Special Needs Plan (DSNP)** plans, the case will be pended for the review team to apply the guidelines from the current Local Coverage Determination (LCD): Facet Joint Interventions for Pain Management (L34892), then the requester will be notified per protocol of the determination.

For Members with **RMHP Individual and Family Plan (IFP) Commercial, CHP Plus, and PRIME (Medicaid)** plans, ***therapeutic*** intra-articular facet joint injections and ***therapeutic*** medial nerve branch blocks are considered experimental; evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit versus harm. See Evidence Summary section under Inconclusive or Non-Supportive Evidence.

- For members with **Individual and Family Plan (IFP) Commercial, CHP Plus** and **PRIME (Medicaid)** Plans, ***diagnostic*** Facet joint injection may be indicated when **ALL** of the following are present(1) :
  - Diagnostic block (medial branch nerve block, intra-articular injection) needed to confirm facet joint as source of spinal pain, as indicated by **1 or more** of the following(2)(3)(4)(5)(6):
    - Initial diagnostic block to diagnose facet pain (dual diagnostic blocks are necessary to diagnose facet pain)
    - Second confirmatory diagnostic block (dual diagnostic blocks are necessary to diagnose facet pain) if documentation indicates first diagnostic block produced 80% or greater relief of primary (index) pain, and duration of relief is consistent with agent employed

- Patient is candidate for facet neurotomy, [A] as indicated by **ALL** of the following(7):
  - Chronic spinal pain (at least 3 months' duration) originating from **1 or more** of the following:
    - Cervical spine (eg, following whiplash injury)(8)(14)
    - Lumbar spine(11)(15)(16)(17)
  - Failure of at least six (6) weeks of nonoperative management, as indicated by **ALL** of the following(18)(19)(20)(21) :
    - Exercise program
    - Pharmacotherapy [B]
    - Documented physical therapy or spinal manipulation therapy completed in the last 24 months
  - Imaging studies and physical examination have ruled out other causes of spinal pain (eg, herniated disk, spinal stenosis, fracture, tumor).(10)(11)
  - Limited number of prior facet neurotomies, [C] as indicated by **1 or more** of the following(25)(12)(26):
    - No prior history of facet neurotomy
    - Prior history of successful facet neurotomy (50% or more reduction in pain documented for at least 3 months) [D]
- No coagulopathy(27)
- No current infection(27)
- The procedure will NOT be done using general anesthesia, conscious sedation or monitored anesthesia care (MAC). See item 2 under Limitations section.

Alternatives to Procedure

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- Nonoperative management may include(28)(7)(29):
  - Cognitive behavioral therapy
  - Exercise program
  - Pharmacotherapy(30)
  - Physical therapy. See Spine Soft Tissue Dysfunction Rehabilitation [AC] for further information.
  - Spinal manipulation therapy. See Spinal Manipulation Therapy (SMT), Chiropractic and Other [AC] for further information.

Evidence Summary

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Background

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A potential source of spinal pain is the posterior zygapophysial joint (facet, Z joint), which adjoins adjacent vertebrae and is innervated by medial branches of the dorsal spinal nerves at 2 levels; however, there is no single history or physical examination finding considered pathognomonic for Z joint syndrome.(31) **(EG 2)**

Fluoroscopic-guided diagnostic medial branch block or intra-articular injection is utilized to identify patients with facet joint pain who are potential candidates for radiofrequency neurotomy. Intra-articular injection is more difficult to perform, and it may have lower prognostic power to determine which patients will respond to neurotomy.(2)(32)(28) **(EG 2)**

Diagnosis of facet joint pain can be made when controlled local anesthetic blockade of the medial branches of the posterior rami of the spinal nerves that supply the putative painful joint(s) provides relief of the target pain. In controlled diagnostic testing, the patient receives an injection of a short-acting anesthetic agent (lidocaine), and those patients who have at least 75% to 80% short-term pain

reduction from baseline pain scores are then injected with a longer-acting agent (bupivacaine). Patients with at least 75% to 80% pain reduction from baseline pain scores after injection of the longer-acting anesthetic agent are considered to be candidates for facet neurotomy.(2)(28)(33)(7) **(EG 2)**

Criteria

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For diagnostic block, The goal of facet joint injection is to make a diagnosis of facet joint pain to determine if a patient is a candidate for facet neurotomy. In controlled diagnostic testing, the patient receives an injection of a short-acting anesthetic agent (eg, lidocaine); those patients who have at least 75% to 80% short-term pain reduction from baseline pain scores are then injected with a longer-acting agent (bupivacaine). Patients with at least 75% to 80% pain reduction from baseline pain scores after injection of the longer-acting anesthetic agent are candidates for facet neurotomy. Diagnostic injection of the local anesthetic agent is either performed via blockade of the medial branches of the posterior rami of the spinal nerves that supply the putative painful joint(s), or alternatively via intra-articular injection; medial branch block is associated with a better prediction of success of neurotomy compared with intra-articular injection.(2)(32)(28)(7) **(EG 2)** Single diagnostic blocks carry a false-positive rate of between 25% and 41%.(28)(25) **(EG 2)** For diagnosis of cervical facet joint pain, a systematic review of 10 studies (1192 patients) evaluating the diagnostic accuracy of facet joint injections (using 75% or more pain relief as a criterion standard) found there was good evidence to support their use and that the false-positive rate was 27% to 63%.(34) **(EG 1)** For diagnosis of lumbar facet joint pain, a systematic review of 14 studies (2804 patients) evaluating the diagnostic accuracy of facet joint injections (using 75% or more pain relief as a criterion standard) found there was good evidence to support their use and that the false-positive rate was 17% to 49%.(34) **(EG 1)** An evidence-based guideline states that there is moderate evidence that the diagnosis of lumbar facet-mediated back pain can be established with the use of a medial nerve double-injection technique that results in a greater than 80% pain improvement threshold; the results are predictive of a good response to facet neurotomy.(35) **(EG 2)** A multispecialty consensus practice guideline recommends that a 50% or more reduction in pain be used to define a positive diagnostic block, acknowledging that the exact amount of pain reduction for a positive block remains uncertain; further studies are needed to identify optimal response criteria.(24) **(EG 2)** For diagnosis of thoracic facet joint pain, a systematic review of 3 studies from the same research group (183 patients) evaluating the diagnostic accuracy of facet joint injections (using 80% or more pain relief as a criterion standard) found there was good evidence for their use and that the false-positive rate was 42% to 58%.(34) **(EG 1)**

Inconclusive or Non-Supportive Evidence

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For therapeutic intra-articular facet joint injection, An evidence-based technology assessment found limited evidence to suggest that facet joint corticosteroid injections are not effective for presumed facet joint pain.(36) **(EG 1)** A systematic review of cervical intra-articular facet joint injection identified only 2 randomized trials that reported conflicting outcomes (one reported negative outcomes, and the other reported indeterminate results); these studies had significant structural problems, which included lack of placebo controls, confounding variables of trigger point and botulinum toxin injection, and a withdrawal rate of greater than 20%. The authors concluded that the evidence supporting cervical intra-articular facet joint injection was of moderate or low quality.(37) **(EG 1)** A randomized double-blind controlled study of 28 patients with lumbar Z joint pain confirmed by medial branch block comparing intra-articular fluoroscopic-guided corticosteroid injection with saline injection found no significant difference in the average time to, or percentage of patients receiving, subsequent radiofrequency ablation. The study was terminated early because more than 75% of patients in both groups underwent radiofrequency ablation by the first study follow-up visit at 6 weeks. The authors advise larger, adequately powered analyses.(38) **(EG 1)** For lumbar intra-articular facet joint injection, a systematic review of 5 randomized controlled trials found that the evidence supporting its use was of moderate or low quality.(37) **(EG 1)** Another systematic review of 6 randomized controlled trials (434 patients) evaluating the efficacy of therapeutic lumbar intra-articular facet joint injections with active drug found that there is insufficient high-quality evidence to support their use over sham procedure, placebo injection, or conservative therapy.(39) **(EG 1)** An evidence-based guideline states that there is moderate evidence suggesting the lack of a role for intra-articular facet joint injections for treatment of facet-mediated chronic low back pain without radiculopathy in patients with degenerative disease of the lumbar spine.(35) **(EG 2)** For thoracic intra-articular facet joint injection, a systematic review revealed

that there was no available literature investigating its efficacy.(37) **(EG 1)** A consensus practice guideline recommends against the routine use of therapeutic medial branch blocks and intra-articular injections but offers there may be a role for these interventions for certain populations, such as patients with contraindications to radiofrequency ablation.(24) **(EG 2)**

For therapeutic medial branch nerve block, For cervical facet joint pain, a systematic review identified only one randomized controlled trial and one observational study (from the same research group) supporting the short-term and long-term effectiveness of medial branch block; limitations of the studies included lack of a placebo group in the randomized controlled trial and lack of randomization in the observational study.(37) **(EG 1)** A randomized double-blind controlled trial of 120 patients with cervical facet joint pain who received medial branch nerve block with local anesthetic with or without steroids found, at 2-year follow-up, that although both groups had significant improvement in pain scores and functional assessment, there was no significant difference between the groups. In addition, although both groups showed a decrease in opioid intake, the difference was not significant. The authors noted that the study lacked a placebo group and recommended larger, placebo-controlled studies to validate the findings.(40) **(EG 1)** For lumbar facet joint pain, a systematic review identified only 2 randomized controlled studies of moderate to good-quality evidence supporting the use of lumbar facet nerve block.(9) **(EG 1)** A randomized double-blind controlled trial of 120 patients with lumbar facet joint pain who received medial branch nerve block with local anesthetic with or without steroids found, at 2-year follow-up, that although both groups had significant improvement in pain scores and functional assessment, there was no significant difference between the groups. In addition, although both groups showed a decrease in opioid intake, the difference was not significant. The authors noted that the study lacked a placebo group and recommended larger, placebo-controlled studies to validate the findings.(41) **(EG 1)** For osteoporotic compression fracture, a retrospective study of 53 patients who underwent therapeutic medial branch block found that there was significant improvement in pain and disability scores at 12-month follow-up. The study was structurally limited by performance of a single diagnostic block and lack of a placebo control group. Additional double-blind randomized controlled studies were recommended.(42) **(EG 2)** For thoracic facet joint pain, a systematic review identified only one randomized trial and one observational study (from the same research group) supporting the use of thoracic facet joint nerve block.(37) **(EG 1)** A randomized double-blind controlled trial of 100 patients with thoracic facet joint pain who received medial branch nerve block with local anesthetic with or without steroids found, at 2-year follow-up, that although both groups had significant improvement in pain scores and functional assessment, there was no significant difference between the groups. In addition, although both groups showed a decrease in opioid intake, the difference was not significant. The authors noted that the study lacked a placebo group and recommended larger, placebo-controlled studies to validate the findings.(43) **(EG 1)**

Reviewer Guidance

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For **CareAdvantage and Dual Special Needs Plan (DSNP) Medicare** plans - apply the current Local Coverage Determination and Article (LCD/LCA). See References for full titles.

For **Individual and Family Plan (IFP) Commercial, CHP Plus** and **PRIME (Medicaid)** plans, ***therapeutic*** facet joint injections and ***therapeutic*** medial nerve branch blocks are experimental per MCG and are not a benefit of any of these plans. See Evidence Summary section under Inconclusive or Non-Supportive Evidence.

Policy History

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History Summary: 6/3/2020 adopted MCG with MC LCD and retired RMHP 2016-2019 policy - implemented 6/17/2020. 6/8/2021 Annual review and LCD/LCA revision reference update. 3/27/2022 Update to 25th edition with Medicare LCD/LCA guidance. 7/11/2022 Annual internal review, clarified non-operative therapies and limitations. 2022 Annual review by committee hierarchy approval completed 12/29/2022 by MAC.

6/23/2023 Annual review and updated plan names.

References

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The Center for Medicare and Medicaid Services (CMS) Local Coverage Determination (LCD): Facet Joint Interventions for Pain Management (L34892) Original Effective Date 10/01/2015 (for services on or after 4/25/2021). Reviewed 6/23/2023.

The Center for Medicare and Medicaid Services (CMS) Local Coverage Article (LCA) Billing and Coding: Facet Joint Interventions for Pain Management (A56670) Original Effective Date 7/11/2019, Revision Effective Date 1/1/2023. Reviewed 6/23/2023.

Limitations

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1. Facet joint interventions done without CT or fluoroscopic guidance are considered not medically reasonable and necessary. This includes facet joint interventions done without any guidance, performed under ultrasound guidance,or with Magnetic Resonance Imaging (MRI).

2. General anesthesia is considered not medically reasonable and necessary for facet joint interventions. Neither conscious sedation nor Monitored Anesthesia Care (MAC) is routinely necessary for intraarticular facet joint injections or medial branch blocks and are not routinely considered medically reasonable and necessary. Individual consideration may be given on redetermination (appeal) for payment in rare, unique circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record. Frequent reporting of these services together may trigger focused medical review.

3. It is not expected that patients will present with pain in both cervical/thoracic and lumbar spinal regions. Therefore, facet joint interventions (both diagnostic and therapeutic) are limited to one spinal region per session.

4. It is not routinely necessary for multiple blocks (e.g., epidural injections, sympathetic blocks, trigger point injections, etc.) to be provided to a patient on the same day as facet joint procedures. Multiple blocks on the same day could lead to improper or lack of diagnosis. If performed, the medical necessity of each injection (at the same or a different level[s]) must be clearly documented in the medical record. For example, the performance of both paravertebral facet joint procedures and a transforaminal epidural steroid injection (TFESI) at the same or close spinal level at the same encounter would not be expected unless a synovial cyst is compressing the nerve root. In this situation, TFESI may provide relief for the radicular pain, while the facet cyst rupture allows nerve root decompression. Frequent reporting of multiple blocks on the same day may trigger a focused medical review.

5. Facet joint intraarticular injections and medial branch blocks may involve the use of anesthetic, corticosteroids, anti-inflammatories and/or contrast agents and do not include injections of biologicals or other substances not FDA designated for this use.

6. One to two levels, either unilateral or bilateral, are allowed per session per spine region. The need for a three or four-level procedure bilaterally may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal. A session is a time period, which includes all procedures (i.e., MBB, IA, facet cyst ruptures, and RFA ablations) that are performed during the same day.

7. If there is an extended period of time, two years or more, since the last RFA and/or there is a question as to the source of the recurrent pain then diagnostic procedures must be repeated.

8. Therapeutic intraarticular facet injections are not considered medically reasonable and necessary unless there is documentation explaining why RFA cannot be performed.

9. Facet joint procedures in patients for the indication of generalized pain conditions (such as fibromyalgia) or chronic centralized pain syndromes are considered not medically reasonable and necessary. Individual consideration may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal.

10. In patients with implanted electrical devices, providers must follow manufacturer instructions and extra planning as indicated to ensure safety of procedure.

The following are considered not medically reasonable and necessary:

1. Intraarticular and extraarticular facet joint prolotherapy.

2. Non-thermal modalities for facet joint denervation including chemical, low-grade thermal energy (less than 80 degrees Celsius), laser neurolysis, and cryoablation.

3. Intra-facet implants.

4. Facet joint procedure performed after anterior lumbar interbody fusion (ALIF).

5. Definitive clinical and/or imaging findings pointing to a specific diagnosis other than facet joint syndrome.

6. Diagnostic injections or MBB at the same level as the previously successful RFA procedure.

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Footnotes

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[A] Following diagnostic medial branch nerve block, a practice guideline recommends cervical or lumbar radiofrequency neurotomy for patients with chronic nonradicular spinal pain of at least 3 months' duration who have failed conservative care, who lack evidence of other spinal pathology (eg, herniated disk), and who experience at least 75% pain relief from baseline with diagnostic local anesthetic blockade of the medial branches of the posterior rami of the spinal nerves that supply the putative painful joint(s).(7) A systematic review of one randomized sham-controlled and 5 observational studies found fair evidence supporting the use of cervical radiofrequency neurotomy for facet joint pain.(8) A systematic review of 9 randomized controlled trials found moderate to high-quality evidence supporting the use of lumbar radiofrequency neurotomy for facet joint pain.(9) Observational studies found that although radiofrequency neurotomy improves pain, disability, and quality of life for up to 6 months, its efficacy diminishes over time. Retreatment can be performed in selected patients.(10)(11)(12)(13) [A in Context Link 1]

[B] There is some evidence to support the short-term benefit of opioids for mild to moderate pain, but the evidence for improvement in function is inconsistent. Given that chronic opioid therapy for noncancer pain often begins with acute opioid prescriptions, clinicians should provide the lowest effective dose necessary to alleviate pain when giving prescriptions for acute pain; in most instances, a maximum course of 3 days of medication should be sufficient, and a prescription for 7 or more days is only rarely justifiable.(22) [B in Context Link 1]

[C] Successful longer-term pain relief with diagnostic medial branch nerve block is one criterion used to determine appropriateness for facet neurotomy. Another criterion for performance of facet neurotomy is that the patient has either undergone no prior neurotomy or has previously undergone a successful facet neurotomy.(23)(24)(25) [C in Context Link 1]

[D] Expert consensus guidelines recommend repeating radiofrequency ablation in individuals who experience 3 to 6 months of successful pain relief (defined as 50% or greater relief) no more frequently than every 6 months.(23)(24) [D in Context Link 1]

Codes

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