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Facet Joint Injections and Percutaneous Denervation Procedures (Radiofrequency and Laser Ablation) for Facet-Mediated Joint Pain

MP9448

Covered Service:	Yes
Prior Authorization Required:	Yes, including initial diagnostic intra-articular facet joint injections, medial branch nerve blocks, therapeutic facet denervation procedures, and subsequent facet injections/denervation combinations.
Additional Information:	See MP9466 for sacroiliac (SI) joint injection and sacroiliac joint radiofrequency ablation.

Prevea360 Health Plan Medical Policy:

1.0 **Paravertebral facet joint injections and facet joint denervation** in the cervical, thoracic, lumbar or sacral regions for the treatment of chronic spinal pain **require** prior authorization through the Health Services Division and are considered medically necessary when **ALL** of the following are met and provided at the time of the request:

- 1.1 The medical record includes documentation of the duration of the chronic pain and any conservative therapy that has been attempted; **AND**
- 1.2 Documentation in the member's medical record of the suspected diagnosis of facet joint pathology; **AND**
- 1.3 When the documentation does not support the established criteria for the service requested, the request will be denied as "not medically necessary".

2.0 The number of facet joint injections in the **diagnostic** phase are limited to no more than two (2) sessions, and to no more than three (3) levels whether uni- or bilateral. These injections **require** prior authorization through the Health Services Division and are considered medically necessary when **ALL** the following are met and provided at the time of request:

- 2.1 Member is diagnosed with facet pain resulting in chronic neck or back pain lasting at least three (3) months in duration; **AND**
- 2.2 Failure of three (3) months or more of nonoperative management by **ONE** or more of the following treatment modalities: exercise therapy; pharmacotherapy; physical therapy or spinal manipulation; **AND**
- 2.3 A maximum of six (6) injections are covered under this policy per session; **AND**

2.4 The repeat injection should not occur sooner than within one (1) week of the initial injection; **AND**

2.5 The member must report an 80% or greater improvement in pain and demonstrate the ability to perform previously painful maneuvers to proceed to additional facet injections or denervation.

3.0 In the **therapeutic** phase, no more than four (4) therapeutic facet joint injections per region per member per year are considered medically necessary.

4.0 Cervical, thoracic and lumbar Radiofrequency Ablation (RFA) **requires** prior authorization through the Health Services Division and is considered medically necessary when the member has received effective relief of pain, (e. g 80% or greater relief of pain), from facet joint block(s).

4.1 Only one (1) RFA per level per side in a six (6) month period is considered medically necessary.

4.2 Member has had no prior spinal fusion surgery at the level of the proposed RFA and disc herniation near the location of the proposed RFA has been ruled out.

4.3 A repeat radiofrequency joint denervation/ablation is considered medically necessary when **BOTH** of the following criteria are met:

4.3.1 There is documented pain relief of at least 50% which has lasted for a minimum of 12 weeks; **AND**

4.3.2 The procedure is performed at a minimum of six (6) months following the prior denervation/ablation.

5.0 Occipital Nerve Radiofrequency Ablation **requires** prior authorization through the Health Services Division and is considered medically necessary when the criteria of 5.3 are met **AND** member has received effective relief of pain (e.g. 80% or greater pain relief) from diagnostic anesthetic nerve block:

5.1 Only one (1) RFA per level per side in a six (6) month period is considered medically necessary

5.2 A repeat occipital nerve radiofrequency ablation is considered medically necessary when **BOTH** of the following criteria are met:

5.2.1 There is documented pain relief of at least 50% which has lasted for a minimum of 12 weeks; **AND**

5.2.2 The procedure is performed at a minimum of six (6) months following the prior ablation.

5.3 Occipital radiofrequency ablation is considered medically necessary for **ANY** of the following indication:

5.3.1 Occipital neuralgia/headache

5.3.2 Refractory trigeminal neuralgia

6.0 Genicular Nerve Radiofrequency Ablation **requires** prior authorization through the Health Services Division and is considered medically necessary when the criteria of 6.3 is met **AND** the member has received relief of pain (e.g. 50% or greater pain relief) from diagnostic anesthetic nerve block:

6.1 Only one (1) RFA per level per side in a six (6) month period is considered medically necessary

6.2 A repeat genicular nerve radiofrequency ablation is considered medically necessary when **BOTH** of the following criteria are met:

6.2.1 There is documented pain relief of at least 50% which has lasted for a minimum of 12 weeks; **AND**

6.2.2 The procedure is performed at a minimum of six (6) months following the prior ablation.

6.3 Genicular radiofrequency ablation is considered medically necessary for treatment of severe osteoarthritis for which conservative care (e.g. including. PT, medication therapy as appropriate, and knee injections) have not provided significant relief and **EITHER** of the following criteria apply:

6.3.1 Definitive treatment (e.g. knee surgery or additional revisions of prior knee surgery) is not appropriate as documented by Orthopedic specialist; **OR**

6.3.2 The member is not a candidate for surgical treatment (e.g. BMI does not allow for surgery, uncontrolled comorbid conditions which increase surgical risk, surgical risk unacceptable).

7.0 Peripheral nerve destruction using radiofrequency ablation for **ANY** of the following is considered experimental and investigational, and there for not medically necessary (not an all-inclusive list:

7.1 Foot/heel pain

7.2 Lower extremity pain resulting from **ANY** of the following:

7.2.1 Complex regional pain syndrome

7.2.2 Peripheral nerve entrapment/compression (e.g. tarsal tunnel syndrome)

7.2.3 Peripheral neuropathy

7.3 SI Joint denervation

8.0 All other methods of ablation/denervation for the treatment of chronic neck and spinal/back pain, including but not limited to facet joint (cervical, thoracic, and lumbar) pain or sacroiliac joint pain are considered not medically necessary (not an all-inclusive list):

8.1 Laser denervation,

8.2 Chemical neurolysis (chemodenervation) (e.g. alcohol, phenol, glycerol or hypertonic saline)

8.3 Cryodenervation (cryoablation)

8.4 Pulsed radiofrequency

8.5 Endoscopic radiofrequency ablation

8.6 Intraosseous nerve ablation (e.g. Intracept) for chronic low back pain

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