EmblemHealth

Pain Management

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Medical Guideline Disclaimer

 The treating physician or primary care provider must submit to EmblemHealth the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request for prior authorization. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. EmblemHealth established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary. If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication. EmblemHealth Services Company LLC, ("EmblemHealth") has adopted the herein policy in providing management, administrative and other services to HIP Health Plan of New York, HIP Insurance Company of New York, Group Health Incorporated and GHI HMO Select, related to health benefit plans offered by these entities. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

Definitions

Neural blockade	The blockade can be used to answer specific questions resulting from a careful pain evaluation and to gain insight into the underlying cause of pain; it consists of a local anesthetic agent or other drug that is locally injected to cause the interruption of neural transmission. Success of the block is determined by the adequacy of nerve function interruption and its effect on pain. The goal of chronic pain management is to achieve optimal pain control, recognizing that a pain-free state may not be achievable, and to minimize adverse outcomes, enhance functional abilities and physical and psychological well-being and enhance the quality of life for patients with chronic pain. (See Exclusions)
Acute pain	Occurs after trauma, surgical interventions and some disease processes, and is elicited by body tissue injury and activation of nociceptive transducers at the site of local tissue damage.
Chronic pain	Has been defined as "persistent or episodic pain of duration or intensity that adversely affects the function or well-being of the patient, attributable to any nonmalignant etiology" (*Practice Guidelines for Chronic Pain Management: A Report by the American Society of Anesthesiologists Task Force on Pain Management, Chronic Pain Section*). In addition, the pain has been refractory to repeated medical management attempts and has usually been present for at least 3–6 months.
Cancer-related pain	(Acute or chronic) that is associated with disease progression and treatment, and which may have multiple causes such as disease progression, treatment (e.g., neuropathic pain resulting from radiation therapy) and co-occurring diseases (e.g., arthritis).
Spinal pain	Generates from multiple structures in the spine; including but not limited to the vertebral bodies, intervertebral discs, spinal cord, nerve roots, facet joints, ligaments, muscles, atlanto-occipital joints, atlanto-axial joints and sacroiliac joints. *(Note: Certain conditions may not be detectable using currently available technology or biochemical studies. However, for a structure to be implicated, it should have been shown to be a source of pain in members using diagnostic techniques of known reliability and validity)*
Postlaminectomy syndrome or pain	This type of pain is becoming an increasingly common entity in modern medicine.

following spinal operative procedures (aka failed management syndrome)	Other spinal conditions causing pain include various degenerative disorders such as spinal stenosis, spondylolysis, spondylolisthesis, degenerative scoliosis, idiopathic vertebrogenic sclerosis, diffuse idiopathic spinal hyperostosis and segmental instability. Degenerative conditions other than disc disruption and facet arthritis may contribute to approximately 5% to 10% of spinal pain.

Related Medical Guidelines

Acupuncture — EmblemHealth Medicare HMO Plans with Acupuncture Benefit
Acupuncture for Chronic Lower Back Pain - Medicare
Dorsal Column Stimulator for Pain Management
Neurotoxins (Botox®, Dysport®, Myobloc® and Xeomin®)
Peripheral Nerve Blocks
Radiofrequency Ablation for Spinal Pain

Guideline Criteria Sets

TRIGGER POINT INJECTIONS
INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS
EPIDURAL AND INTRATHECAL INJECTIONS: INTERLAMINAR AND CAUDAL AND TREATMENT OF SPASTICITY
EPIDURAL INJECTIONS - TRANSFORAMINAL
PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC
PARAVERTEBRAL JOINT/NERVE DENERVATION
SACROILIAC (SI) JOINT INJECTIONS
ACUTE POST-OPERATIVE PAIN MANAGEMENT
LIMITATIONS FOR ALL DIAGNOSTIC AND THERAPEUTIC PAIN MANAGEMENT SERVICES

TRIGGER POINT INJECTIONS FOR CHRONIC PAIN

Myofascial trigger points are self-sustaining hyperirritative foci that may occur in any skeletal muscle in response to strain produced by acute or chronic overload.

These trigger points produce a referred pain pattern characteristic for that individual muscle.

Production of a referred pain pattern differentiates myofascial pain syndrome from tender points and fibromyalgia. Each pattern becomes part of a single muscle myofascial pain syndrome (MPS), and each of these single muscle syndromes is responsive to appropriate treatment, which includes injection therapy.

Injections consist of the administration of agents (e.g., local anesthetics).

Indications

Diagnosis of trigger points requires a detailed history and thorough physical examination. The following clinical features are present most consistently and are helpful in making the diagnosis:

- History of pain onset and its presumed cause (e.g., injury, sprain, etc.)
- Pain distribution pattern consistent with trigger point referral pattern
- Restriction of range of motion with increased sensitivity to stretch
- Muscular deconditioning in the affected area
- Focal tenderness of a trigger point

- Palpable taut muscle band in which trigger point is located
- Local taut response to snapping palpation or needle insertion
- Reproduction of referred pain pattern upon stimulation of the trigger point

The goal is to treat the cause of the pain; not just the symptom, modalities include the following:

- Pharmacologic — including analgesics and medications to induce sleep and relax muscles (e.g., antidepressants, neuroleptics or non-steroidal anti-inflammatory drugs)
- Nonpharmacologic (e.g. osteopathic manual medicine techniques, massage, ultrasonography, application of heat or ice, transcutaneous electrical nerve stimulation, spray and stretch technique)
- Physical therapy — for trigger points in the acute state of formation before additional pathologic changes develop

After myofascial pain syndrome is established as described above, the injection may be indicated when noninvasive medical management is not successful or as 1st line treatment. Additionally, trigger point injection is indicated when the movement of a joint is mechanically blocked as is the case of the coccygeus muscle.

Trigger point injections are considered medically necessary when all the following criteria are met:

- Conservative therapies including pharmacologic therapies such as NSAIDS, muscle relaxants, acetaminophen have been tried and failed
- Symptoms lasting ≥ 3 months
- Trigger point injections are not just provided in isolation but are part of a comprehensive treatment plan including all of the modalities listed above

Limitations

- Dry needle trigger point injections (CPT 20560, 20561) for Commercial and Medicaid members are not considered medically necessary due to insufficient evidence of therapeutic value. (The service is covered for Medicare members in EmblemHealth's Acupuncture for Chronic Lower Back Pain Medical Policy)
- Injections used on a routine basis (e.g., on a regular periodic and continuous basis, for patients with chronic non-malignant pain syndromes) are not considered medically necessary.
- Only injections of local anesthetics and corticosteroids are covered.
- Injections consisting of only saline and/or botanical substances are not supported in the peer-reviewed literature and are not considered medically necessary.

Note: The services represented by CPT codes 76942 and 77022 are considered incidental to injection procedure codes 20550, 20551, 20552 and 20553, and will not be separately reimbursed when submitted with these procedure codes. Modifier 59 will not override this bundling edit. Any combination of trigger point injections (20552, 20553) when billed > 3 times in 90-day period will be denied.

INJECTION OF TENDON SHEATHS, LIGAMENTS, GANGLION CYSTS, CARPAL AND TARSAL TUNNELS

These injections are sometimes indicated to provide pain relief and reduce inflammation when response to conservative measures has failed or is not indicated.

Injection site clarification

Ligament	A band of tissue that connects bones.
Tendon	A fibrous cord of connective tissue attaching a muscle to a bone or other structure. A tendon sheath is the lining enclosing a tendon that facilitates movement around the tendon.
Ganglion cyst	Non-cancerous knot-like masses that are fluid-filled cysts arising from ligaments, joint linings or tendon sheaths.

Carpal tunnel	Passageway from the forearm through the wrist. The median nerve and nine tendons pass through the tunnel.
Tarsal tunnel	Passageway on the medial side of the tarsus. The posterior tibial nerve passes through the tunnel.

Indications

To relieve substantial pain and/or significant functional disability resulting from inflammation or other pathological changes:

- Other conservative therapy has not provided acceptable relief, is contraindicated or not appropriate
- There is a reasonable likelihood that injection will significantly improve pain and/or functional disability
- Carpal tunnel injection may be indicated for mild to moderate symptoms when pharmaceutical and other conservative measures have failed or are not otherwise indicated
- Tarsal tunnel Injection may be indicated for conservative management of tarsal tunnel syndrome

EPIDURAL AND INTRATHECAL INJECTIONS: INTERLAMINAR AND CAUDAL AND TREATMENT OF SPASTICITY

Epidural and intrathecal (epidural and subarachnoid) injections are utilized for acute and chronic pain, cancer pain management and the treatment of spasticity. These injections are utilized both for diagnostic and therapeutic purposes.

Indications

1. **Diagnostic** interlaminar/translaminar or caudal epidural steroid injections are seldom used. Although the medication injected can sometimes be confined to a limited area, bilateral effects and spread of injectate to adjacent levels often occurs.

   For diagnostic purposes, a transforaminal epidural injection is given with a low volume of injected local anesthetic.

   Intrathecal diagnostic injections are also used to determine the dose of opioid for pain control, or that no opioid will be effective in any dose, as well as to determine a patient's response to baclofen, clonidine, local anesthetic and other medications.

2. **Therapeutic** intrathecal (subarachnoid) injections and infusions of opioid, local anesthetic, clonidine, and other medications may be used for acute or chronic pain, cancer pain and baclofen for intractable spasticity. Both epidural and intrathecal injections may be used for the following:
   - Acute obstetric, post-traumatic and post-operative pain
   - Advanced cancer pain, primary or metastatic
   - Acute/sub-acute pain syndromes including cervical/thoracic and lumbar pain with radiculopathy and intervertebral disc disease (with neuritis or radiculitis), with or without myelopathy, that has failed to respond to adequate conservative management
   - Nerve root injuries and neuropathic pain, post-surgery and post-traumatic, including post-laminectomy syndrome (failed back syndrome)
   - Spinal cord myelopathy
   - Spinal stenosis
   - Complex regional pain syndrome
   - Epidural scarring from prior infection, hemorrhage and/or surgery
   - Multiple rib fractures
   - Vertebral compression fractures

- Post-herpetic neuralgia and herpes zoster
- Phantom limb pain
- Management of intractable spasticity that has failed medical treatment with oral antispasmodics

The medical record should describe the presence of radicular pain or discogenic pain and the neuropathic diagnosis for the pain being treated. In addition, it should indicate ≥ 1 of the following:

1. Conservative management failure (unless acute disabling and debilitating pain is present)
2. The member is a surgical candidate, but surgery is unacceptable to the member or the member is a poor surgical risk
3. The epidural injection is being performed as a therapeutic adjunct to a conservative therapy program to provide temporary relief and in order to facilitate a more aggressive rehabilitative program

EPIDURAL INJECTIONS - TRANSFORAMINAL

Indications

Transforaminal epidural injection is a selective block of the cervical/thoracic, lumbar or sacral nerve roots of contrast/local anesthetic to the epidural space.

With the aid of fluoroscopic or computed tomography (CT) imaging, local anesthetic is injected in order to perform a diagnostic, reproducible blockade of a specific nerve root (a steroid may be added as a therapeutic measure). (The block may be diagnostic, therapeutic or for both purposes)

1. **Indications for coverage of for a diagnostic injection**
   - Suspected radicular pain and/or neurogenic claudication
   - Low back pain with substantial imaging abnormalities such as central disc herniation, severe degenerative disease, or central spinal stenosis
   - Documented pain rating of 3 or greater on a 10-point scale with functional impairment
   - To differentiate the level of radicular nerve root pain
   - To differentiate radicular from non-radicular pain
   - To evaluate a discrepancy between imaging studies and clinical findings
   - To identify the source of pain in the presence of multi-level nerve root compression
   - To identify the level of pathology at a previous operative site
2. **Therapeutic**
   - Radicular pain resistant to other therapeutic means or when surgery is contraindicated.
   - Post-decompressive radiculitis or post-surgical scarring.
   - Monoradicular pain, confirmed by diagnostic blockade, in which a surgically correctable lesion cannot be identified.
   - Treatment of acute herpes zoster or post-herpetic neuralgia.
   - Spinal stenosis.

PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC

The facet, or zygapophysial, joints are paired diarthrodial articulations between posterior elements of adjacent vertebrae.

Spinal facet joints have been implicated as responsible for spinal pain in patients with low back pain, neck pain and thoracic pain.

Paravertebral facet joint/nerve block is utilized as a diagnostic tool to determine whether a specific facet joint is responsible for chronic spinal pain.

The patient with this condition usually has moderate-to-severe back pain that does not have a strong radicular component. There is no associated neurologic deficit; the pain is typically aggravated by hyperextension of the spine and there is typically tenderness to palpation of the spine at the level of the suspected joint. Back or neck pain is typically worse than leg or arm pain respectively (e.g., pain is primarily axial; not radicular).

Facet joint arthropathy (joint disease) is diagnosed through a **double-comparative** local anesthetic blockade of a joint, either by intra-articular injection of a **small volume** of local anesthetic (0.5 to 1.0 ml), or blockade of the medial branch nerves of the dorsal rami innervating the joint with a small volume of local anesthetic (0.5 to 1.0 ml).

A single block has been implicated to be a source of false-positive results. The diagnosis can be made by a positive but differential response to local anesthetics of different durations of action injected on separate occasions.

After a needle is placed into the facet joint or adjacent to the target medial branch nerve under fluoroscopic or computed tomography (CT) imaging guidance, a small volume of local anesthetic agent with or without steroid is injected. The patient is then asked to engage in activities that typically elicit or aggravate the pain.

Relief of pain for a significant period of time suggests that facet joints were the source of the pain. Pre-procedural and post-procedural pain scores (numeric or Visual Analogue) should be documented and then compared.

If significant pain relief occurs after the injection (a positive response), the patient's response should be monitored and documented with regards to the degree and duration of pain relief, as well as the improvement in functional status.

A repeat block may be performed only if the patient's pain returns and functional status starts to deteriorate. If significant relief is noted with improvement in functional status, but the pain returns after a period of relief, a second block may be performed at a later date with local anesthetic of a different duration of action in order to rule out a false-positive response.

If double-comparative paravertebral facet joint /nerve blocks provide significant pain relief lasting several weeks to months, therapeutic facet joint/nerve blocks may be considered. If double-comparative paravertebral facet joint/nerve blocks provide significant pain relief that is not long-lasting, then facet joint denervation may be considered.

Indications

Diagnostic or therapeutic injections/nerve blocks may be required for the management of chronic pain. It may take multiple nerve blocks targeting different anatomic structures to establish the etiology of the chronic pain in a given patient.

1. **Diagnostic**

   Appropriate if all of the following criteria are met

   - Back and neck pain that is not improving with at least 3 months of conservative therapy (e.g., NSAIDs, physical therapy)
   - Predominantly axial pain without radiculopathy or neurogenic claudication
   - Clinical assessment points to facet pain as likely source (other clear sources of non-facet pain such as fractures, tumors, infection, or deformity have been ruled out)
   - Patient's pain level is at least 6 on a 10-point scale and has been recurrent or constant
   - Pain is causing functional limitation for the patient

   Repeat injection would be considered medically necessary only upon subsequent return of pain and deterioration in functional status. As noted in the above, if pain returns after a satisfactory response it

may be necessary to give a second injection on a different date of service to determine the etiology of the pain and effectiveness of the injection. Two-to-three adjacent joint levels may need to be injected before the level(s) is (are) determined.

2. **Therapeutic**

   When a patient has relief of pain with controlled diagnostic blocks with a combined response from two blocks of several weeks to months, he/she may be considered a candidate for therapeutic facet joint/nerve nerve blocks. When a patient has relief of pain (positive response), but an insufficient duration of symptom relief with controlled diagnostic blocks, he/she should be considered for a more definitive procedure such as denervation (unless the diagnosis is in error).

   Therapeutic facet joint/nerve block injections may be considered provided that all of the following are applicable:

   - Injections do not exceed a frequency parameter of > once every two (2) months for a specific region (cervical/thoracic, lumbosacral)
   - Initial pain relief is ≥ 80%-90% 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
   - Appropriate consideration is given to the adverse effects (e.g., adrenal suppression of corticosteroid injections)

PARAVERTEBRAL JOINT/NERVE DENERVATION

Non-pulsed radiofrequency ablation denervation is covered if appropriate criteria are met (See Radiofrequency Ablation for Spinal Pain)

Non-thermal RF modalities for medial branch ablation including chemical, low-grade thermal, or pulsed radiofrequency ablation (CPT 64625) are not covered.

SACROILIAC (SI) JOINT INJECTIONS

The sacroiliac (SI) joint is a diarthrodial synovial joint which is formed by the articular surfaces of the sacrum and iliac bones. The SI joints bear the weight of the trunk and as a result are subject to the development of strain and/or pain.

Indications

Sacroiliac (SI) joint injections would be considered medically reasonable and necessary for the diagnosis and/or treatment of chronic low back pain that is considered to be secondary to suspected sacroiliac joint dysfunction.

Diagnostic and therapeutic injections of the SI joint would not likely be performed unless conservative therapy and noninvasive treatments (i.e., rest, physical therapy, NSAIDs, etc.) have failed.

Diagnostic SI joint blocks can be performed to determine whether it is the source of low back pain. Arthropathy (joint disease) is diagnosed through a double-comparative local anesthetic blockade of the joint by the intra-articular injection of a small volume of local anesthetics (2 — 3 ml) of different durations of actions. A positive response should demonstrate initial pain relief of at least 75% and the ability to perform previously painful maneuvers. Steroids may be injected in addition to the local anesthetic.

Therapeutic SI joint injections of an anesthetic and/or steroid to block the joint for immediate, and potentially long lasting, pain relief are considered medically reasonable and necessary if it is determined that the SI joint is the source of the lower back pain.

Limitations

If previous diagnostic or therapeutic SI injections of an anesthetic and/or steroid to block the joint for immediate, and potentially long lasting, pain relief have not effectively relieved the pain, further injections would **not** be considered medically necessary.

ACUTE POST-OPERATIVE PAIN MANAGEMENT

Management of acute pain (obstetric, post-operative, or secondary to major trauma not requiring an operative procedure) in the hospital may be provided by several means: oral and parenteral administration of analgesics, intravenous patient controlled analgesia (PCA) and by the administration of epidural opiates or anesthetics.

Epidural analgesia may be provided by single injection or continuous infusion and may be provided before or after a surgical procedure, but the advantage to pre-operative placement is that the patient is able to cooperate with the procedure, is not sedated from the operation and therefore is able to report any accompanying paresthesias, the catheter can be properly tested prior to surgery, and the patient will be able to receive pain medications via the epidural space prior to emergence from general anesthesia and may receive benefit from preemptive analgesia.

Epidural anesthesia/analgesia commonly employs, in combination or as single agents: local anesthetics, opiates and opioids. Occasionally clonidine is used. Catheters are usually left in place for ≤ 3 days as the patients have usually recovered sufficiently to allow for removal. Patients with major abdominal or thoracic procedure may require longer infusion periods.

Indications

Any:

1. Major non-operative trauma.
2. Obstetrical care.
3. Post major thoracic, intra-abdominal, radical pelvic cancer, aortic, retroperitoneal or orthopedic surgeries (hip and knee).

LIMITATIONS FOR ALL DIAGNOSTIC AND THERAPEUTIC PAIN MANAGEMENT SERVICES

1. Low back pain may also be associated with "**myofascial pain syndrome**" or a soft-tissue source of pain in which case no nerve root pathology exists, so interlaminar/translaminar, caudal, or transforaminal epidural injection would be ineffective. If the diagnosis is in question, the diagnosis of radiculopathy should be confirmed by electrophysiological studies, radiological studies, or a diagnostic transforaminal selective epidural/selective nerve root injection. A paravertebral joint/nerve or sacroiliac joint injection would also not be indicated for pain associated with "myofascial pain syndrome."
2. Nerve blocks may be used for diagnostic and therapeutic purposes. Therapeutic blocks include the use of anesthetic, antispasmodic, and/or anti-inflammatory substances for the long-term control of pain. **There is no role for a "series" of injections**. Each injection should be individually evaluated for diagnostic/therapeutic clinical efficacy. If complete, but only temporary pain relief occurs after the injections, another type of treatment should be considered. (Note: Peripheral nerve blocks for the purpose of treating diabetic neuropathy is not supported by the current peer reviewed, published, evidence-based scientific literature nor by specialty society guidelines and is therefore not considered medically necessary)
3. **Other interventional pain management procedures done on the same day** as paravertebral facet joint blocks should be rare.

In certain circumstances a patient may present with both facet and sacroiliac problems. In this case, it is appropriate to perform both facet injections and SI injection at the same session assuming that these are therapeutic injections and that prior diagnostic injections (blocks) have demonstrated that both structures contribute to pain generation. The medical record must clearly support both procedures.

It is usually not appropriate to provide an interlaminar epidural/intrathecal injection, a transforaminal selective epidural (or selective nerve root injection), facet joint/nerve block, sacroiliac joint injection, lumbar sympathetic block or other nerve block on the same day. Therefore, only one of these procedures is allowed on a given day, unless conditions are met as described immediately above for paravertebral and sacroiliac joints or one of the following conditions occur and are documented in the medical record.

- If > 1 type of diagnostic injection is performed on the same day, the anesthetic response to the first injection must be assessed and demonstrate incomplete pain relief prior to proceeding with the additional injection. Otherwise it would be impossible to determine which injection resulted in pain relief
- Multiple pain generators are present and are clearly documented in a patient on anticoagulants, requiring the anticoagulants to be stopped for the injection(s)

4. **Epidural steroids** should be used only in the presence of radiculopathy unless the pain is discogenic in origin (see below for covered indications).

   The standard of care for all transforaminal epidural injections for paravertebral facet joint/nerve injection and denervation, and sacroiliac joint injections requires that these procedures be performed under fluoroscopic or CT-guided imaging. Therefore, injections performed without imaging guidance will be considered inappropriate and not reasonable or necessary. The rationale for accepted medically necessary use of CT rather than fluoroscopy must be documented.

   Failure to obtain appropriate response to blind interlaminar or caudal epidurals may indicate improper delivery of the drug and/or presence of a pain generator, which is non-responsive to epidural injection. Thus, subsequent epidural injections after a failed or inadequate response, if performed, should be under fluoroscopic visualization.

   The following indications are covered for epidural steroid injections:

   - Suspected radicular pain and/or neurogenic claudication
   - Low back pain with significant imaging abnormalities indicating a discogenic origin for the pain (e.g, central disc herniation, severe degenerative disc disease, or central spinal stenosis). For a patient with low back pain, if imaging only shows a simple disc bulge or annular fissure, another indication must be met to justify the use of an epidural steroid injection
   - Pain rating ≥3/10 with functional impairment in activities of daily living
   - Failure of 6 weeks of conservative therapy (non-surgical, non-injection therapy) unless there is:
     - Significant functional loss
     - Severe pain unresponsive to medical management
     - Inability to tolerate non-surgical, non-injection therapies due to comorbidities
     - Prior successful epidural steroid injection for same condition

5. Specific to epidural and facet injections, sedation and/or Monitored Anesthesia Care (MAC) services are not generally required for pain management procedures. Anesthesia services will be denied (unless substantiated as being medically necessary) when reported with a pain management service. Modifier 59 will not override this edit.

6. Peripheral nerve stimulation (PNS) and peripheral nerve field stimulation (PNFS) are considered experimental, investigational or unproven for chronic pain (e.g., Moventis PNS, SPRINT PNS System [the

Smartpatch is marketed under the name SPRINT], StimQ PNS System [formerly marketed as Smartpatch], StimRouter Neuromodulation System, Reactiv8 Implantable Neurostimulation System for pain associated with multifidus muscle dysfunction, IB-Stim percutaneous electrical nerve field stimulation [PNFS] for irritable bowel syndrome [IBS] pain) (CPT 64555, 64575, 64585, 64590, 64595, 64999)

7. Axon Therapy for chronic nerve pain is considered experimental, investigational or unproven (CPT 64999)

Exclusions

The plan does not consider the following procedures to be medically necessary, as there is insufficient evidence in the peer-reviewed literature to substantiate therapeutic value:

1. Acupuncture (with the exception of Medicare Dual Eligible and Medicare VIP Essential members)
2. Joint sclerotherapy
3. Ligamentous injections with sclerosing agents
4. Nerve block injections for primary or secondary headache (e.g., cluster, migraine, cervicogenic [i.e., occipital neuralgia], posttraumatic, etc.) (Note: Injections given for occipital headache [ICD-10 code M53.81] will be covered only for Medicare members when billed with CPT codes 64490 and 64633) (See also NGS Medicare Peripheral Nerve Block Local Coverage Determination)
5. Prolotherapy

Revision History

8/12/2022	Amended Limitations/Exclusions to convey that Axon Therapy for chronic nerve pain is considered investigational
7/8/2022	Amended Limitations/Exclusions to convey that PFS and PFNS are considered investigational
7/21/2020	Amended noncoverage note for dry needle trigger point injections (CPT 20560, 20561) to communicate applicability to Commercial and Medicaid members only Added link to EmblemHealth's Acupuncture for Chronic Lower Back Pain policy where the service is covered for Medicare members
11/11/2016	Added note re trigger point injections stating that any combination of trigger point injections (CPT 20552, 20553) when billed > 3 times in 90-day period will be denied
7/15/2016	Note added depicting Medicare coverage of injections given for occipital headache
6/10/2016	Diagnostic SI joint injection trial changed from demonstration of 80-90% pain reduction to at least 75%
11/13/2015	Added clinical criteria parameters for trigger point injections, diagnostic epidural nerve block injections and epidural steroid injections
6/15/2015	Amended Limitations/Exclusions to convey that nerve blocks for diabetic neuropathy are considered investigational

Applicable Procedure Codes

01996	Daily hospital management of epidural or subarachnoid continuous drug administration
20526	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar ''fascia'')
20551	Injection(s); single tendon origin/insertion
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553	Injection(s); single or multiple trigger point(s), 3 or more muscle(s)

20612	Aspiration and/or injection of ganglion cyst(s) any location
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
28899	Unlisted procedure, foot or toes
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
64479	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level.
64480	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic each additional level (list separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
64484	Injection(s), anesthetic agent(s) and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), cervical or thoracic; second level (list separately in addition to code for primary procedure)

64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), cervical or thoracic; third and any additional level(s) (list separately in addition to code for primary procedure)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), lumbar or sacral; second level (list separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), lumbar or sacral; third and any additional level(s) (list separately in addition to code for primary procedure)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure
64999	Unlisted procedure, nervous system
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)
77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation
G0068	Professional services for the administration of antiinfective, pain management, chelation, pulmonary hypertension, and/or inotropic infusion drug(s) for each infusion drug administration calendar day in the individual's home, each 15 minutes (Eff. 01/01/2019)
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography
J0475	Injection, baclofen, 10 mg
J0476	Injection, baclofen, 50 mcg for intrathecal trial
J0735	Injection, clonidine hydrochloride, 1 mg
J1170	Injection, hydromorphone, up to 4 mg
J2278	Injection, ziconotide, 1 microgram
J3010	Injection, fentanyl citrate, 0.1 mg
J3490	Unclassified drugs

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