



# CLINICAL GUIDELINES

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## Interventional Pain Management Services

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<b>Interventional Pain Management</b>	
<b>CMM-200: Epidural Steroid Injections (ESI)</b>	<b>3</b>
<b>CMM-201: Facet Joint Injections/Medial Branch Blocks</b>	<b>17</b>
<b>CMM-202: Trigger Point Injections</b>	<b>24</b>
<b>CMM-203: Sacroiliac Joint Injections</b>	<b>32</b>
<b>CMM-204: Prolotherapy</b>	<b>38</b>
<b>CMM-207: Epidural Adhesiolysis</b>	<b>41</b>
<b>CMM-208: Radiofrequency Joint Ablations/Denervations</b>	<b>45</b>
<b>CMM-209: Regional Sympathetic Blocks</b>	<b>51</b>
<b>CMM-210: Implantable Intrathecal Drug Delivery Systems</b>	<b>57</b>
<b>CMM-211: Spinal Cord Stimulators</b>	<b>64</b>
<b>CMM-308: Thermal Intradiscal Procedures</b>	<b>65</b>
<b>CMM-310: Manipulation of the Spine Under Anesthesia</b>	<b>70</b>
<b>CMM-400: Anesthesia Services for Interventional Pain Procedures</b>	<b>73</b>

**CMM-200: Epidural Steroid Injections (ESI)**

<b>CMM-200.1: Definitions</b>	<b>4</b>
<b>CMM-200.2: General Guidelines</b>	<b>5</b>
<b>CMM-200.3: Indications: Selective Nerve Root Block (SNRB)</b>	<b>6</b>
<b>CMM-200.4: Indications: Epidural Steroid Injections (Transforaminal, Interlaminar, or Caudal)</b>	<b>6</b>
<b>CMM-200.5: Non-Indications: SNRB</b>	<b>7</b>
<b>CMM-200.6: Non-Indications: ESI</b>	<b>8</b>
<b>CMM-200.7: Procedure (CPT®) Codes</b>	<b>9</b>
<b>CMM-200.8: References</b>	<b>10</b>

## **CMM-200.1: Definitions**

- **Transforaminal epidural steroid injection (TFESI)** is a therapeutic injection of contrast (absent allergy to contrast) performed at a single or multiple spinal levels, followed by the introduction of a corticosteroid and possibly a local anesthetic by inserting a needle into the neuroforamen under fluoroscopic or computed tomography (CT) guidance.
- **Selective Nerve Root Block (SNRB)** is a diagnostic injection of contrast (absent allergy to contrast) of a single nerve root to assist with surgical planning, followed by the introduction of a local anesthetic by inserting a needle into the neuroforamen under fluoroscopic or computed tomography (CT) guidance. SNRBs are erroneously referred to as transforaminal epidural steroid injection (TFESI), although technically SNRBs involve the introduction of anesthetic only and are used for diagnostic purposes.
  - ◆ Selective nerve root blocks (SNRBs) performed for the purpose of treating pain (i.e., repeat SNRB at the same level) may be termed therapeutic selective nerve root blocks. There is insufficient evidence to support the clinical utility of therapeutic selective nerve root blocks (SNRBs).
- **Interlaminar epidural steroid injection (ILESI)** is an injection of contrast (absent allergy to contrast), followed by the introduction of a corticosteroid and possibly a local anesthetic into the epidural space of the spine either through a paramedian or midline interlaminar approach under fluoroscopic guidance.
- **Caudal epidural steroid injection (CESI)** is an injection of contrast (absent allergy to contrast), followed by the introduction of corticosteroids and possibly a local anesthetic into the epidural space of the spine by inserting a needle through the sacral hiatus under fluoroscopic guidance into the epidural space at the sacral canal.
- **Radiculopathy**, for the purpose of this policy, is defined as the presence of pain, dysaesthesia(s), or paraesthesia(s) reported by the individual in a specified dermatomal distribution of an involved named spinal root(s) causing significant functional limitations (i.e., diminished quality of life and impaired, age-appropriate activities of daily living), and **EITHER** of the following:
  - ◆ Documentation of **ONE or MORE** of the following, concordant with nerve root compression of the involved named spinal root(s) demonstrated on a detailed neurologic examination within the prior three (3) months:
    - Loss of strength of specific named muscle(s) or myotomal distribution(s)
    - Altered sensation to light touch, pressure, pin prick or temperature in the sensory distribution
    - Diminished, absent or asymmetric reflex(es)
  - ◆ Documentation of **EITHER** of the following performed within the prior 12 months:
    - A concordant radiologist's interpretation of an advanced diagnostic imaging study (MRI or CT) of the spine demonstrating compression of the involved named spinal nerve root(s)
    - Electrodiagnostic studies (EMG/NCV's) diagnostic of nerve root compression of the involved named spinal nerve root(s).

- **Radicular pain** is pain which radiates to the extremity along the course of a spinal nerve root, typically resulting from compression, inflammation and/or injury to the nerve root.
- **Radiculitis** is defined, for the purpose of this policy, as radicular pain without objective neurological findings on physical examination.
- **Spinal stenosis** refers to the narrowing of the spinal canal usually due to spinal degeneration that occurs with aging. It may also be the result of spinal disc herniation, osteoarthritis, or a tumor. Lumbar spinal stenosis results in low back pain as well as pain or abnormal sensations in the legs, thighs, feet or buttocks, or loss of bladder and bowel control. Neurogenic claudication is often a clinical condition that results from spinal stenosis.

### **CMM-200.2: General Guidelines**

- The determination of medical necessity for the performance of a selective nerve root block (SNRB) or a therapeutic epidural steroid injection is always made on a case-by-case basis.
- **Please note:** this guideline does not apply to epidural injections administered for obstetrical or surgical epidural anesthesia.
- An epidural steroid injection should be performed with the use of fluoroscopic or CT guidance and the injection of a contrast, with the exception of an emergent situation or when fluoroscopic/CT guidance or the injection of contrast is contraindicated (e.g., pregnancy).
- The use of an indwelling catheter to administer a continuous infusion/intermittent bolus should be limited to use in a hospital setting only. It is inappropriate to represent the use of a catheter for single episode injection(s) that is/are commonly performed in an outpatient setting as an indwelling catheter for continuous infusion/intermittent bolus.
- There is insufficient scientific evidence to support the scheduling of a “series-of-three” injection in either a diagnostic or therapeutic approach. The medical necessity of subsequent injections should be evaluated individually and be based on the response of the individual to the previous injection with regard to clinically relevant sustained reductions in pain, decreased need for medication and improvement in the individual’s functional abilities.
- When performing transforaminal epidural steroid injections (TFESIs) or selective nerve root blocks (SNRBs), no more than two (2) nerve root levels should be injected during the same session/procedure.
- When medical necessity criteria is met, a total of three (3) epidural steroid injections (ESIs) per episode of pain, per region may be performed in six (6) months, not to exceed four (4) epidural steroid injections (ESIs) per region in 12 months.
- Additionally, when medical necessity criteria are met for a cervical/thoracic interlaminar (ILESIs) and/or a cervical/thoracic transforaminal epidural steroid injection (TFESI), advanced diagnostic imaging should be performed within 12 months prior to the injection.

### **CMM-200.3: Indications: Selective Nerve Root Block (SNRB)**

- A diagnostic selective nerve root block (SNRB), performed at a single nerve root, involving the introduction of anesthetic only, is considered **medically necessary** when attempting to establish the diagnosis of radicular pain (including radiculitis) or radiculopathy when the diagnosis remains uncertain after standard evaluation (neurologic examination, radiological studies and electrodiagnostic studies) in **ANY** of the following clinical situations:
  - ◆ When the physical signs and symptoms differ from that found on imaging studies
  - ◆ When there is clinical evidence of multi-level nerve root pathology
  - ◆ When the clinical presentation is suggestive, but not typical for both nerve root and peripheral nerve or joint disease involvement
  - ◆ When the clinical findings are consistent with radiculopathy in a dermatomal distribution, but the imaging studies do not corroborate the findings (positive straight leg raise test)
  - ◆ When the individual has had previous spinal surgery
  - ◆ For the purposes of surgical planning.
- A diagnostic selective nerve root block (SNRB) at a spinal level other than the initial level is considered **medically necessary** when **ALL** of the following criteria are met:
  - ◆ A response to the prior block of less than 80% relief based on the injectate utilized
  - ◆ Evidence of multilevel pathology
  - ◆ It has been at least 7 days since the prior block

### **CMM-200.4: Indications: Epidural Steroid Injections (Transforaminal, Interlaminar, or Caudal)**

- An epidural steroid injection (ESI) is considered **medically necessary** for **ANY** of the following:
  - ◆ Treatment of presumed radiculopathy when there has been failure of at least six (6) weeks of conservative treatment (e.g., exercise, physical methods including physical therapy and/or chiropractic care, nonsteroidal anti-inflammatory drugs [NSAID's] and/or muscle relaxants).
  - ◆ Treatment of presumed radiculitis or radicular pain when **ALL** of the following criteria are met:
    - Radicular pain, with or without motor weakness, which follows a specified dermatomal distribution of an involved named spinal root(s)
    - A positive straight leg raise, crossed leg raise, and/or Spurling's
    - Failure of at least six (6) weeks of conservative treatment (e.g., exercise, physical methods including physical therapy and/or chiropractic care, NSAID's and/or muscle relaxants).
  - ◆ An initial trial when there is evidence of symptomatic spinal stenosis and **ALL** of the following criteria are met:
    - Diagnostic evaluation has ruled out other potential causes of pain
    - MRI or CT with or without Myelography within the past twelve (12) months demonstrates moderate to severe spinal stenosis at the level to be treated
    - Significant functional limitations resulting in diminished quality of life and impaired, age-appropriate activities of daily living.

- Failure of at least four (4) weeks of conservative treatment (e.g., exercise physical methods including physical therapy and/or chiropractic care, NSAIDS, and/or muscle relaxants)
- A transforaminal epidural steroid injection (TFESI) in addition to an intra-articular facet joint injection with synovial cyst aspiration is considered **medically necessary** when **BOTH** of the following criteria are met:
  - ◆ Advanced diagnostic imaging studies (e.g., MRI CT, CT myelogram) confirm compression or displacement of the corresponding nerve root by a facet joint synovial cyst
  - ◆ Clinical correlation with the individual's signs and symptoms of radicular pain or radiculopathy, based on history and physical examination.
- A repeat epidural steroid injection (ESI) is considered **medically necessary** when at least **TWO** of the following criteria are met for two or more week's duration:
  - ◆ 50% or greater pain relief
  - ◆ Increase in the level of function/physical activity (e.g., return to work)
  - ◆ Reduction in the use of pain medication and/or additional medical services such as physical therapy/chiropractic case

#### **CMM-200.5: Non-Indications: SNRB**

- Diagnostic selective nerve root blocks (SNRBs) are considered **not medically necessary** for any other indication.
- Therapeutic selective nerve root blocks (SNRBs) (i.e., a repeat SNRB at the same level) are considered **experimental, investigational, or unproven** for any indication.
- A diagnostic selective nerve root block (SNRB) at a spinal level other than the initial level is considered **not medically necessary** for **ALL** of the following:
  - ◆ An adequate response to the first block, as determined by the injectate utilized
  - ◆ An absence of multilevel pathology when the first injection is performed under fluoroscopy/CT guidance using contrast
  - ◆ Repeating diagnostic selective nerve root blocks (SNRBs) more frequently than every seven (7) days



### **CMM-200.6: Non-Indications: ESI**

- An epidural steroid injection (ESI) performed with ultrasound guidance is considered **experimental, investigational, or unproven**.
- An epidural steroid injection is considered **not medically necessary** for **ALL** of the following:
  - ◆ When performed without imaging guidance (i.e., CT, fluoroscopy)
  - ◆ Transforaminal epidural steroid injection (TFESI) performed at more than two (2) nerve root levels during the same session/procedure.
  - ◆ An interlaminar epidural steroid injection (ILES), performed at more than a single level during the same session/procedure
  - ◆ Epidural steroid injection (ESI) administered in the same region as other spinal injections on the same day of service with the exception of an epidural steroid injection performed with an intra-articular facet joint injection with synovial cyst aspiration in accordance with criteria in CMM-200.4 above.
  - ◆ Performed in isolation (i.e., without the individual participating in an active rehabilitation program/home exercise program/functional restoration program)
  - ◆ Repeating epidural steroid injections more frequently than every 14 days
  - ◆ More than three (3) epidural steroid injections (ESIs) per episode of pain, per region in 6 months
  - ◆ More than four (4) epidural steroid injections (ESIs) per region, per 12 months
  - ◆ For axial spinal pain (i.e., absence of radiculopathy, myelopathy, myeloradiculopathy)
  - ◆ A caudal epidural steroid injection (CESI) for levels above L4-L5 without supporting clinical rationale for use of alternative approaches (e.g., translaminar, transforaminal)



## CMM-200.7: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only.

Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
62320	Injection(s), of diagnostic or therapeutic substance(s) (e.g., 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) (e.g., 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 (i.e., fluoroscopy or CT)
62322	Injection(s), of diagnostic or therapeutic substance(s) (e.g., 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) (e.g., 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 (i.e., fluoroscopy or CT)
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., 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) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., 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) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural; with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
+64480	Injection(s), anesthetic agent and/or 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 and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
+64484	Injection(s), anesthetic agent 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)

CPT®	Codes Considered Experimental, Investigational or Unproven
0228T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level
0229T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure)
0230T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level
0231T	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure)

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.

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**CMM-201: Facet Joint Injections/Medial Branch Blocks**

<b>CMM-201.1: Definitions</b>	<b>18</b>
<b>CMM-201.2: General Guidelines</b>	<b>18</b>
<b>CMM-201.3: Indications</b>	<b>19</b>
<b>CMM-201.4: Non-Indications</b>	<b>20</b>
<b>CMM-201.5: Procedure (CPT®) Codes</b>	<b>20</b>
<b>CMM-201.6: References</b>	<b>21</b>

## **CMM-201.1: Definitions**

- **Facet Joint Injections/medial branch blocks** refer to the injection of local anesthetic and possibly a corticosteroid in the facet joint capsule or along the nerves supplying the facet joints from C2-3 to L5-S1. The injection/block applies directly to the facet joint(s) blocked and not to the number of nerves blocked that innervate the facet joint(s). Even though either procedure can be used to diagnose facet joint pain, a medial branch block is generally considered more appropriate. A diagnostic facet joint injection/medial branch block is considered positive when there is at least 80% relief of facet mediated pain for at least the expected minimum duration of the effect of the local anesthetic used.

## **CMM-201.2: General Guidelines**

- The determination of medical necessity for the performance of facet joint injections/medial branch blocks is always made on a case-by-case basis.
- Facet joint injections/medial branch blocks should only be performed for neck pain or low back pain in the absence of an untreated radiculopathy (with the exception of radiculopathy caused by a facet joint synovial cyst).
- A diagnostic facet joint injection/medial branch block may be performed to determine whether spinal pain originates in the facet joint or nerves innervating the facet joint. A second facet joint injection/medial branch block must be performed to confirm the validity of the clinical response of the initial injection and should only be performed with the intent that if successful, a radiofrequency joint denervation/ablation procedure (facet neurotomy, facet rhizotomy) would be considered as an option at the diagnosed level(s).
- More than two facet injections/medial branch blocks at the same level are considered to be therapeutic rather than diagnostic. Following a spinal fusion, a diagnostic facet joint injection/medial branch block may be performed immediately above or below the fused level if a prior injection/block was negative. There is a paucity of published scientific evidence supporting the use of therapeutic facet joint injections/medial branch blocks. Although limited, some anecdotal evidence supports a facet joint injection/medial branch block as an alternative treatment to a radiofrequency ablation/neurotomy for a subset of individuals when the initial facet joint injection/medial branch blocks has resulted in significant pain relief (i.e., > 50%) for at least 12 weeks following the facet joint injection/medial branch block and the individual is not a candidate for a radiofrequency joint denervation/ablation procedure. For this specific subset of individuals a repeat facet joint injection may be considered appropriate, although no sooner than six months from when the prior diagnostic injection was performed.
- It may be necessary to perform the facet joint injection/medial branch block at the same facet joint level(s) bilaterally, however, no more than three (3) facet joint levels should be injected during the same session/procedure.

- Facet joint injections/medial branch blocks are not without risk and can expose patients to potential complications that may be increased when a patient is sedated. As a result, when performing facet joint injections/medial branch blocks, the use of supplemental sedation in addition to local anesthesia is not required and not recommended.

### **CMM-201.3: Indications**

- An initial diagnostic facet joint injection/medial branch block is considered **medically necessary** to determine whether chronic neck or back pain is of facet joint origin when **ALL** of the following criteria are met:
  - ◆ Pain is exacerbated by facet loading maneuvers on physical examination
  - ◆ Pain has persisted despite at least four weeks of appropriate conservative treatment (e.g., physical methods including physical therapy, chiropractic care and exercise, nonsteroidal anti-inflammatory drugs (NSAIDs), and/or analgesics) unless contraindicated and the reason(s) for contraindication(s) is/are documented in the medical record
  - ◆ Clinical findings and imaging studies suggest no other obvious cause of the pain (e.g., central spinal stenosis with neurogenic claudication/myelopathy, foraminal stenosis or disc herniation with concordant radicular pain/radiculopathy, infection, tumor, fracture, pseudoarthrosis, pain related to spinal instrumentation).
  - ◆ The spinal motion segment is not posteriorly fused.
- A second diagnostic facet joint injection/medial branch block, performed to confirm the validity of the clinical response to the initial facet joint injection, is considered **medically necessary** when **ALL** of the following criteria are met:
  - ◆ Administered at the same level as the initial block
  - ◆ The initial diagnostic facet joint injection produced a positive response (i.e., at least 80% relief of facet mediated pain for at least the expected minimum duration of the effect of the local anesthetic)
  - ◆ A radiofrequency joint denervation/ablation procedure is being considered
- An intra-articular facet joint injection performed with synovial cyst aspiration, in addition to a transforaminal epidural steroid injection, is considered **medically necessary** when the following criteria are met:
  - ◆ Advanced diagnostic imaging studies (e.g., MRI, CT, CT myelogram) confirm compression or displacement of the corresponding nerve root by a facet joint synovial cyst
  - ◆ Clinical correlation with the individual's signs and symptoms of radicular pain or radiculopathy, based on history and physical examination.

### **CMM-201.4: Non-Indications**

- Performance of a facet joint injection/medial branch block is considered **not medically necessary** when performed for **ANY** of the following indications:
  - ◆ Without the use of fluoroscopic or CT guidance
  - ◆ In the presence of an untreated radiculopathy (with the exception of radiculopathy caused by a facet joint synovial cyst)
  - ◆ When a radiofrequency joint denervation/ablation procedure (i.e., facet neurotomy, facet rhizotomy) is not being considered
  - ◆ The facet joint injection is performed at a fused posterior spinal motion segment (with the exception of patients with clinically suspected pseudoarthrosis)
  - ◆ On the same day of service when performing other injections (e.g., epidural steroid, sacroiliac) in the same region
  - ◆ Performance of injections/blocks on more than three (3) contiguous spinal joint levels (with the exception of an intervening fused segment)
  - ◆ Additional diagnostic facet joint injection/medial branch blocks at the same level(s) as a prior successful radiofrequency denervation/ablation procedure
- Performance of a facet joint injection/medial branch block is considered **experimental, investigational, or unproven** when performed for **ANY** of the following indications:
  - ◆ Unless performed as a second confirmatory block, all injections subsequent to the initial injection (i.e., therapeutic injections)
  - ◆ When performed under ultrasound guidance

### **CMM-201.5: Procedure (CPT®) Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
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), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal), second level (List separately)
+64492	Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal), third and any additional level(s) (List separately)
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)
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)

CPT®	Codes Considered Experimental, Investigational or Unproven
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

### **CMM-201.6: References**

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**CMM-202: Trigger Point Injections**

<b>CMM-202.1: Definitions</b>	<b>25</b>
<b>CMM-202.2: General Guidelines</b>	<b>25</b>
<b>CMM-202.3: Indications</b>	<b>25</b>
<b>CMM-202.4: Non-indications</b>	<b>26</b>
<b>CMM-202.5: Procedure (CPT®) Codes</b>	<b>26</b>
<b>CMM-202.6: References</b>	<b>27</b>

### CMM-202.1: Definitions

- **Trigger point injections** are defined as an injection of a local anesthetic with or without the addition of a corticosteroid into clinically identified myofascial trigger points.
- **Myofascial trigger point** is defined as a discrete, focal, hyperirritable spot found within a taught band of skeletal muscle or its fascia which when provocatively compressed causes local pain or tenderness as well as characteristic referred pain, tenderness and/or autonomic phenomena. Digital palpation, as well as needle insertion into the trigger point, can often lead to a local twitch response. A local twitch response is a transient visible or palpable contraction of the muscle. The presence of characteristic referred pain, tenderness, muscle shortening and/or autonomic phenomena (e.g., vasomotor changes, pilomotor changes, muscle twitches, etc.) is necessary to render the diagnosis of a myofascial trigger point. Tender points within a muscle or its fascia, which do not refer pain, tenderness and/or autonomic phenomena and lack a local twitch response, cannot be considered a myofascial trigger point.

### CMM-202.2: General Guidelines

- Trigger point injections are not without risk, and can expose patients to potential complications.
- The determination of medical necessity for the use of trigger point injections is always made on a case-by-case basis.

### CMM-202.3: Indications

- Trigger point injections are considered **medically necessary** when **BOTH** of the following criteria are met:
  - ◆ A myofascial trigger point has been identified by the presence of **ONE or MORE** of the following on physical examination:
    - Characteristic referred pain
    - Tenderness
    - Muscle shortening
    - Autonomic phenomena (e.g., vasomotor changes, pilomotor changes, muscle twitches, etc.)
  - ◆ Performed using a local anesthetic with or without steroid (e.g., saline or glucose)
- Repeat trigger point injections are considered **medically necessary** when **BOTH** of the following are documented:
  - ◆ At least 50% pain relief with evidence of functional improvement for a minimum of six (6) weeks following the prior injection(s)
  - ◆ Adequate instruction or supervision in self-management strategies (i.e., therapeutic exercise, ergonomic advice, ADL training, etc.)

### **CMM-202.4: Non-indications**

- Trigger point injections are considered **not medically necessary** for any of the following:
  - ◆ When performed with any substance other than local anesthetic with or without steroid (e.g., saline or glucose)
  - ◆ When performed on the same day of service as other treatments in the same region
  - ◆ When requested for any of the following:
    - Acupuncture
    - Electro-Acupuncture
    - Acupoint injections, aka Biopuncture (saline, sugar, herbals, homeopathic substances)
    - Dry needling
    - Image-guided injection over spinal hardware
- Repeat trigger point injections are considered **not medically necessary** for any of the following:
  - ◆ An isolated treatment modality
  - ◆ An interval of less than two (2) months
  - ◆ More than four (4) trigger point injection sessions per body region per year

### **CMM-202.5: Procedure (CPT®) Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required. Pre- authorization requirements vary by individual payor.

CPT®	Code Description/Definition
<b>20552</b>	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
<b>20553</b>	Injection(s); single or multiple trigger point(s), 3 or more muscle(s)

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the individual payor (health insurance company, etc.) and is based on the member/patient/client/beneficiary's policy or benefit entitlement structure as well as any third party payor guidelines and/or claims processing rules. Providers are strongly urged to contact each payor for individual requirements if they have not already done so.

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**CMM-203: Sacroiliac Joint Injections**

<b>CMM-203.1: Definitions</b>	<b>33</b>
<b>CMM-203.2: General Guidelines</b>	<b>33</b>
<b>CMM-203.3: Indications</b>	<b>34</b>
<b>CMM-203.4: Non-Indications</b>	<b>35</b>
<b>CMM-203.5: Procedure Codes</b>	<b>35</b>
<b>CMM-203.6: References</b>	<b>36</b>

### **CMM-203.1: Definitions**

- The presence of pain over the sacroiliac joint in the absence of radicular findings in and of itself does not substantiate the diagnosis of sacroiliac joint pain. There must also be clinical evidence as described below.
- **Intra-articular sacroiliac joint injection** refers to the injection of contrast (absent allergy to contrast), followed by the introduction of a corticosteroid and/or a local anesthetic into the sacroiliac joint under fluoroscopic guidance.
- **Peri-articular injection** refers to the introduction of a corticosteroid and/or a local anesthetic to one or more sections of the posterior ligamentous structures of the sacroiliac joint.
- **Sacral lateral nerve block** refers to an injection of corticosteroid and/or local anesthetic adjacent to the sacral lateral nerve resulting in the temporary interruption of conduction of impulses for analgesia. Sacral lateral nerve blocks attempt to block pain signals and theoretically provide relief from pain. The duration of the block depends on the dose, concentration and type of pharmacological agent injected.
- **Sacroiliac joint pain** is defined as pain originating from the sacroiliac joint and/or its supporting ligamentous structures as a result of injury, disease or surgery.

### **CMM-203.2: General Guidelines**

- The determination of medical necessity for the performance of sacroiliac joint injections is always made on a case-by-case basis.
- Intra-articular sacroiliac joint injections should be performed using fluoroscopy with injection of contrast (absent allergy to contrast) for guidance, as it is considered the standard of care.
- Peri-articular sacroiliac joint injections may be performed with or without the use of fluoroscopic guidance.
- When sacroiliac joint injections are performed (anesthetic only) for the purpose of diagnosing sacroiliac joint pain, a positive diagnostic response is defined as  $\geq 75\%$  pain relief for the duration of the local anesthetic.
- Sacroiliac injections performed for the purpose of treating sacroiliac pain are termed therapeutic sacroiliac injections. When medical necessity criteria is met, a total of four therapeutic sacroiliac injections for the treatment of sacroiliac pain may be performed per joint during a 12 month period of time, with a minimum of two months duration between each injection, for the recurrence of pain.
- The performance of interventional pain procedures such as a sacroiliac joint injection does not require the need for supplemental anesthesia in addition to local anesthesia.

### **CMM-203.3: Indications**

- The performance of a diagnostic sacroiliac joint injection for localized, sacroiliac joint pain resulting from disease, injury or surgery is considered **medically necessary** when **ALL** of the following criteria are met:
  - ◆ Pain primarily experienced between the upper level of the iliac crests and the gluteal fold (the pain can refer distally, even below the knee)
  - ◆ Clinical findings and imaging studies suggest no other obvious cause of the pain (e.g., central spinal stenosis with neurogenic claudication/myelopathy, foraminal stenosis or disc herniation with concordant radicular pain/radiculopathy, infection, tumor, fracture, pseudoarthrosis, pain related to spinal instrumentation).
  - ◆ Reproduction of pain using at least three (3) of the following provocative tests:
    - Distraction or “Gapping” or FABER/Patrick’s Test
    - Thigh Thrust or Posterior Pelvic Pain Provocational Test
    - Gaenslan’s Test
    - Sacroiliac Joint Compression Test
    - Sacral Thrust or Yeoman’s Test.
- Pain persists despite **BOTH** of the following:
  - ◆ A minimum of four (4) weeks of noninvasive conservative therapy (e.g., exercise, physical therapy, chiropractic care, nonsteroidal anti-inflammatory drugs [NSAIDs] and analgesics)
  - ◆ Ongoing, active participation in rehabilitative/therapeutic exercise program
- A therapeutic sacroiliac joint injection for the treatment of sacroiliac joint pain is considered **medically necessary** following a diagnostic injection with  $\geq 75\%$  reduction in the reported pain.
- A repeat therapeutic sacroiliac joint injection for the treatment of sacroiliac joint pain is considered **medically necessary** following a therapeutic injection with  $\geq 75\%$  reduction in the reported pain and **BOTH** of the following are met:
  - ◆ **EITHER** of the following:
    - Increase in the individual’s level of function (i.e., return to work)
    - Reduction in the use of pain medication and/or additional medical services such as physical therapy/chiropractic care
  - ◆ A minimum of two months since the prior injection

### **CMM-203.4: Non-Indications**

- Ultrasound guidance for a sacroiliac joint injection, for any indication, is considered **experimental, investigational, or unproven**.
- Sacral lateral nerve branch blocks and/or ablations/neurotomies for the diagnosis and/or treatment of sacroiliac joint mediated pain is considered **experimental, investigational, or unproven**.
- A sacroiliac joint injection is considered **not medically necessary** for **ANY** of the following:
  - ◆ Sacroiliac joint injections performed without fluoroscopic or other alternative guidance, with the exception of ultrasound as noted above
  - ◆ When performed on the same of service as a facet joint block, epidural steroid injection, or lumbar sympathetic chain block
  - ◆ When performed in isolation (i.e., without the individual participating in an active rehabilitation program, home exercise program, or functional restoration program)
  - ◆ As a subsequent diagnostic block when the initial diagnostic block does not produce a positive response of  $\geq 75\%$  pain reduction
  - ◆ Therapeutic sacroiliac joint injections performed at a frequency greater than once every two (2) months for the treatment of sacroiliac pain
  - ◆ More than four (4) injections per SI joint performed within a 12 month period

### **CMM-203.5: Procedure Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

<b>CPT®</b>	<b>Code Description/Definition</b>
<b>27096</b>	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
<b>G0259</b>	Injection procedure for sacroiliac joint; arthrography
<b>G0260</b>	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.



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**CMM-204: Prolotherapy**

<b>CMM-204.1: Definition</b>	<b>39</b>
<b>CMM-204.2: General Guidelines</b>	<b>39</b>
<b>CMM-204.3: Procedure (CPT®) Codes</b>	<b>39</b>
<b>CMM-204.4: References</b>	<b>40</b>

### **CMM-204.1: Definition**

**Prolotherapy** is defined as an injection or a series of injections designed to strengthen weak or lax ligaments, tendons or joints by injecting various proliferating agents (sclerosing solutions) directly into the proposed damaged or stretched ligaments or tendons or into a joint or its adjacent structures to create scar tissue in an effort to stabilize the joint or tendon. Agents used with prolotherapy have included zinc sulfate, psyllium seed oil, combinations of dextrose, glycerin and phenol, or dextrose alone.

### **CMM-204.2: General Guidelines**

Based on the lack of conclusive scientific evidence demonstrating the clinical efficacy of prolotherapy combined with the potential to expose individuals to adverse side effects or complications, the use of prolotherapy in the treatment of musculoskeletal pain and/or instability (e.g., laxity, weakness) is considered **experimental, investigational or unproven**.

### **CMM-204.3: Procedure (CPT®) Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Codes Considered Experimental, Investigational , or Unproven
<b>M0076</b>	Prolotherapy

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.

## CMM-204.4: References

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**CMM-207: Epidural Adhesiolysis**

<b>CMM-207.1: Definition</b>	<b>42</b>
<b>CMM-207.2: General Guidelines</b>	<b>42</b>
<b>CMM-207.3: Procedure (CPT®) Codes</b>	<b>42</b>
<b>CMM-207.4: References</b>	<b>43</b>

### **CMM-207.1: Definition**

**Epidural adhesiolysis** is also known as epidural neurolysis, epidural decompressive neuroplasty, and Racz neurolysis. It is defined as a treatment for back pain that involves disruption, reduction, and/or elimination of fibrous tissue from the epidural space, which is carried out by either catheter manipulation or the injection of saline or other adhesiolytic agents. A catheter is used to enter the epidural space through a caudal, interlaminar, or transforaminal approach. The goal is to free the nerve root of adhesions and allow introduction of medications to the affected nerve root. An anesthetic along with a glucocorticosteroid may also be injected as part of the procedure. These procedures may also involve spinal endoscopy to visually address the adhesions.

### **CMM-207.2: General Guidelines**

There is insufficient scientific evidence to support the use of epidural adhesiolysis, performed by catheter or endoscopically, as a treatment for back pain. It is considered **experimental, investigational or unproven**.

### **CMM-207.3: Procedure (CPT®) Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Codes Considered Experimental, Investigational or Unproven
<b>62263</b>	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
<b>62264</b>	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
<b>62280</b>	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid
<b>62281</b>	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic
<b>62282</b>	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.



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<b>CMM-208: Radiofrequency Joint Ablations/Denervations</b>	
<b>CMM-208.1: Definitions</b>	<b>46</b>
<b>CMM-208.2: General Guidelines</b>	<b>46</b>
<b>CMM-208.3: Indications</b>	<b>46</b>
<b>CMM-208.4: Non-Indications</b>	<b>47</b>
<b>CMM-208.5: Procedure (CPT®) Codes</b>	<b>48</b>
<b>CMM-208.6: References</b>	<b>48</b>

### CMM-208.1: Definitions

- **Radiofrequency joint denervation/ablation** (i.e., facet neurotomy, facet rhizotomy) refers to the insertion of a radiofrequency probe towards the medial branch of the posterior primary rami, which supplies the innervation to the facet joints under fluoroscopic guidance. The radiofrequency electrode is then utilized to create a “continuous” heat lesion by coagulating the nerve supplying the joint with the intention of providing pain relief by denervating the painful facet joint. The injection/block applies directly to the facet joint(s) blocked/ablated and not to the number of nerves blocked/ablated that innervate the facet joint(s).

### CMM-208.2: General Guidelines

- The determination of medical necessity for the performance of radiofrequency joint denervations/ablations is always made on a case-by-case basis.
- When performing radiofrequency joint denervations/ablations, it may be necessary to perform the procedure at the same level(s) bilaterally; however, no more than three (3) levels should be performed during the same session/procedure.
- When performing a repeat radiofrequency joint denervation/ablation at the same spinal level(s) as a prior successful denervation/ablation procedure, further diagnostic facet joint injections/medial branch blocks at that spinal level(s) are not necessary.

### CMM-208.3: Indications

- A radiofrequency joint denervation/ablation is considered **medically necessary** for facet mediated pain resulting from disease, injury, or surgery when **ALL** of the following are met:
  - ◆ Clinical findings and imaging studies suggest no other obvious cause of the pain (e.g., central spinal stenosis with neurogenic claudication/myelopathy, foraminal stenosis or disc herniation with concordant radicular pain/radiculopathy, infection, tumor, fracture, pseudoarthrosis, pain related to spinal instrumentation).
  - ◆ Failure of at least three (3) months of conservative therapy (e.g., exercise, physical methods including physical therapy, chiropractic care, nonsteroidal anti-inflammatory drugs [NSAID’s] and/or analgesics) unless contraindicated and the reason(s) for the contraindication(s) is/are documented in the medical record
  - ◆ Two positive diagnostic facet joint injections/medial branch blocks as evidenced by at least 80% relief of facet mediated pain for at least the expected minimum duration of the effect of the local anesthetic used.
- For an individual with a prior spinal fusion, radiofrequency joint denervation/ablation is considered **medically necessary** when the above criteria are met and the procedure is performed at an unfused spinal segment located either above or below the fused spinal segment.

- A repeat radiofrequency joint denervation/ablation when **BOTH** of the following criteria are met:
  - ◆ There is documented pain relief of at least 50% which has lasted for a minimum of 12 weeks
  - ◆ The procedure is performed at a minimum of six months following the prior denervation/ablation.

### **CMM 208.4: Non-Indications**

- Performance of a radiofrequency joint denervation/ablation for **ANY** of the following indications is considered **not medically necessary**:
  - ◆ When performed without the use of fluoroscopic guidance
  - ◆ Performing more than two procedures at the same level(s) during a 12 month period of time
  - ◆ In the absence of two sequential positive diagnostic facet joint injections/medial branch blocks at the same level(s) for an initial radiofrequency treatment, or for a repeat radiofrequency treatment in the absence of at least 50% relief of facet mediated pain for at least 6 months from a previous radiofrequency treatment at the same level(s).
  - ◆ When performed for neck pain or low back pain in the presence of an untreated radiculopathy
  - ◆ When performed at a posteriorly fused spinal motion segment (with the exception of patients with clinically suspected pseudarthrosis)
  - ◆ When performed on more than three (3) contiguous spinal joint levels during the same session/procedure
  - ◆ When performed to treat pain arising from above C2-3 and below L5-S1 spinal levels
- Performance of radiofrequency joint denervation/ablations for **ANY** of the following indications is considered **experimental, investigational, or unproven**:
  - ◆ Pulsed radiofrequency ablation for chronic pain syndromes
  - ◆ Endoscopic radiofrequency denervation/endoscopic dorsal ramus rhizotomy
  - ◆ Cryoablation/cryoneurolysis/cryodenervation
  - ◆ Chemical ablation (e.g., alcohol, phenol, glycerol)
  - ◆ Laser ablation
  - ◆ Ablation by any method for sacroiliac (SI) joint pain
  - ◆ Cooled radiofrequency ablation

## CMM-208.5: Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
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)

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.

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<b>CMM-209: Regional Sympathetic Blocks</b>	
<b>CMM-209.1: Definitions</b>	<b>52</b>
<b>CMM-209.2: General Guidelines</b>	<b>53</b>
<b>CMM-209.3: Indications</b>	<b>53</b>
<b>CMM-209.4: Non-Indications</b>	<b>54</b>
<b>CMM-209.5: Procedure (CPT®) Codes</b>	<b>54</b>
<b>CMM-209.6: References</b>	<b>55</b>

## **CMM-209.1: Definitions**

- **Regional sympathetic blocks** (i.e., Stellate Ganglion Blocks and Lumbar Sympathetic Blocks) refer to the injection of local anesthetic along the sympathetic ganglia of the under fluoroscopy to reduce sympathetic nervous system activity. A diagnostic regional sympathetic block is considered positive when there is significant reduction in pain and improvement in function for the duration of the local anesthetic used.
- **Complex Regional Pain Syndrome (CRPS)** is defined by the International Association for the Study of Pain (IASP) as a variety of painful conditions following injury which appear regionally having a distal predominance of abnormal findings, exceeding in both magnitude and duration the expected clinical course of the inciting event and often resulting in significant impairment of motor function, and showing variable progression over time. In addition to injury, CRPS can also occur as a result of various medical disorders or illnesses. The diagnostic criteria for CRPS are as follows:
  - ◆ Continuing pain that is disproportionate to any inciting event
  - ◆ Must report at least one (1) of the symptoms in the following categories:
    - Sensory: reports of hyperesthesia
    - Vasomotor: reports of temperature asymmetry, skin color changes, and/or skin color asymmetry
    - Sudomotor/edema: reports of edema, sweating changes, and/or sweating asymmetry
    - Motor/trophic: reports of decreased range of motion, motor dysfunction (weakness, tremor, dystonia), and/or trophic changes (hair, nail, skin).
  - ◆ Must display at least one (1) of the signs on physical examination in **TWO or MORE** the following categories:
    - Sensory: evidence of hyperalgesia (to pinprick) and/or allodynia (to light touch)
    - Vasomotor: evidence of temperature asymmetry, skin color changes, and/or asymmetry
    - Sudomotor/edema: evidence of edema, sweating changes, and/or sweating asymmetry
    - Motor/trophic: evidence of decreased range of motion, motor dysfunction (weakness, tremor, dystonia). and/or trophic changes (hair, nail, skin).

## **CMM-209.2: General Guidelines**

- The determination of medical necessity for the performance of regional sympathetic blocks is always made on a case-by-case basis.
- **Please note:** this guideline does not apply to injections/blocks of other autonomic nerves (e.g. sphenopalatine ganglion, carotid sinus, superior hypogastric plexus, celiac plexus, Gasserian ganglion [trigeminal nerve], splanchnic nerve, Ganglion of Impar, rami communicans).
- Regional sympathetic blocks should be performed using fluoroscopy.
- Due to insufficient evidence that regional sympathetic blocks (Stellate Ganglion Blocks and Lumbar Sympathetic Chain Blocks) performed as an isolated treatment alter the long term outcome of CRPS, all regional sympathetic blocks in recalcitrant cases of CRPS should be performed with the intent of facilitating involvement and advancement in an active rehabilitation/functional restoration program.

## **CMM-209.3: Indications**

- The performance of an initial diagnostic regional sympathetic block is considered **medically necessary** to establish the presence or absence of sympathetically mediated complex regional pain syndrome. A positive response is defined as at least 50% reduction in pain and improvement in function for the duration of the local anesthetic used.
- Following a successful initial diagnostic block, three (3) additional regional sympathetic blocks, performed within the first two (2) weeks of the initial block, may be considered **medically necessary** to diagnose the individual's pain and obtain a therapeutic response.
- Additional therapeutic regional sympathetic blocks are considered **medically necessary** when provided as part of a comprehensive pain management program and **ALL** of the following criteria are met:
  - ◆ Decreased use of pain medication
  - ◆ Increased functional ability (e.g., increased range of motion, strength, and use of the extremity in activities of daily living)
  - ◆ Increased tolerance to touch (e.g., decreased allodynia)
  - ◆ Ongoing participation in an active rehabilitation program
  - ◆ Performed at a frequency of no more than one time per week
  - ◆ No more than six (6) total blocks

### **CMM 209.4: Non-Indications**

Regional sympathetic blocks are considered **not medically necessary** for each of the following:

- When the individual is not capable of participating or is not involved in an ongoing active rehabilitation program
- Without the use of fluoroscopic guidance
- No significant reduction in pain and no improvement in function for the duration of the local anesthetic following the diagnostic block
- A repeat therapeutic block when there is no decrease in use of pain medication, increase in functional ability, and increase of tolerance to touch

### **CMM-209.5: Procedure (CPT®) Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required.

CPT®	Code Description/Definition
<b>64510</b>	Injection, anesthetic agent; stellate ganglion(cervical sympathetic)
<b>64520</b>	Injection, anesthetic agent; lumbar or thoracic(paravertebral sympathetic)

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.



## **CMM-209.6: References**

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<b>CMM-210: Implantable Intrathecal Drug Delivery Systems</b>	
<b>CMM-210.1: Definitions</b>	<b>58</b>
<b>CMM-210.2: General Guidelines</b>	<b>58</b>
<b>CMM-210.3: Indications</b>	<b>58</b>
<b>CMM-210.4: Non-indications</b>	<b>60</b>
<b>CMM-210.5: Replacement</b>	<b>60</b>
<b>CMM-210.6: Procedure (CPT®) Codes</b>	<b>60</b>
<b>CMM-210.7: References</b>	<b>62</b>

### **CMM-210.1: Definitions**

- **An implantable intrathecal drug delivery system** (Pain pump or Baclofen pump) is a device used for the continuous infusion of a drug directly into the cerebrospinal fluid via a catheter placed in the intrathecal or epidural space. A pump is placed in the subcutaneous tissue of the abdomen and connected to the catheter. The pump reservoir holds the medication(s), and the pump is programmed to give a set dose of medication over time. For most individuals, it should be used as part of a program to facilitate restoration of function and return to activity, and not just for pain reduction. An intrathecal drug delivery trial can be accomplished by either a single intrathecal bolus injection or an intrathecal catheter infusion.

### **CMM-210.2: General Guidelines**

- **Please note:** this guideline does not apply to epidural injections administered for obstetrical or surgical epidural anesthesia.
- The determination of medical necessity for the performance of an implantable intrathecal or epidural drug delivery system is always made on a case-by-case basis.

### **CMM-210.3: Indications**

- The use of an implantable intrathecal or epidural drug delivery system is considered **medically necessary** for **ANY** of the following indications when the associated criteria are met:
  - ◆ Nonmalignant, chronic intractable pain (e.g., failed back surgery syndrome with low back pain and/or radicular pain, complex regional pain syndrome [i.e., reflex sympathetic dystrophy], post-herpetic neuralgia)
  - ◆ Severe, refractory spasticity or chronic intractable dystonia in individuals who are unresponsive to or cannot tolerate oral anti-spasticity agents (i.e., Baclofen [Lioresal®]) (i.e., intrathecal injection of Baclofen)
  - ◆ Cancer-related pain

### **Nonmalignant, Chronic Intractable Pain**

- A trial with a percutaneous intrathecal or epidural drug delivery system for nonmalignant chronic intractable pain is considered **medically necessary** when **ALL** of the following criteria have been met:
  - ◆ There is a documented pathology (i.e., an objective basis for the pain complaint)
  - ◆ Failure of a sufficient trial of at least six (6) months of provider-directed noninvasive pain management, including active rehabilitative exercise and fixed schedule dosing of opioids or other analgesics unless contraindicated and the reason(s) for the contraindication(s) is/are documented in the medical record
  - ◆ Further surgical intervention or other treatment is not indicated or likely to be effective
  - ◆ Statement from a primary care physician, neurologist, physiatrist, psychiatrist, psychologist, or other licensed behavioral and/or medical health care provider attesting to the absence of untreated, underlying mental health conditions/issues (e.g., depression, drug, alcohol abuse) as a major contributor to chronic pain.

- ◆ Individual agrees to a 50% reduction in systemic opiates prior to undergoing an intrathecal opiate trial.
- A permanent implantable intrathecal or epidural drug delivery system for the above listed pain conditions is considered **medically necessary** if the individual has met the above criteria for a preliminary trial and has experienced > 50% reduction in pain for 8 hours and concomitant increase in function during an appropriate trial.

### **Severe, Refractory Spasticity/Chronic Intractable Dystonia**

- A trial with a percutaneous intrathecal drug delivery system for severe, refractory spasticity or chronic intractable dystonia is considered **medically necessary** for **EITHER** of the following indications:
  - ◆ There is failure, contraindication or intolerance to at least a six-week trial of oral antispasmodic drugs and physical therapy.
  - ◆ Individual has a baseline average Ashworth score of at least 3 (or a Modified Ashworth score of 2) and a Spasm Frequency score of at least 2.
    - An Ashworth score of 3 represents a considerable increase in muscle tone when testing resistance to passive movement about a joint with varying degrees of velocity.
    - A Modified Ashworth score of 2 represents a slight increase in muscle tone followed by minimal resistance of the range of motion.
    - A Spasm Frequency score of 2 represents a patient's self-report of between 1 to 5 spasms per day.
- A permanent implantable infusion for the treatment of chronic intractable spasticity or chronic intractable dystonia is considered **medically necessary** when a preliminary trial of intrathecal antispasmodic drug administration, that meets the above medical necessity criteria, demonstrates a beneficial clinical response (e.g., demonstrates at least a 2-point reduction in the Ashworth or Spasm Frequency score for 4 hours following an intrathecal trial bolus of Baclofen)

### **Cancer-Related Pain**

- A trial with a percutaneous intrathecal or epidural drug delivery system for cancer-related pain is considered **medically necessary** when there is failure, intolerance, or contraindication to noninvasive methods of pain control, including systemic opioids.
- A permanent implantable intrathecal or epidural drug delivery system for the above listed pain conditions is considered **medically necessary** if the individual has met the above criteria for a preliminary trial and has experienced at least a 50% reduction in pain during an appropriate trial.
- **Please Note:** A trial with a percutaneous intrathecal or epidural drug delivery system for cancer-related pain is not required in the presence of advanced disease, when survival time is limited, and when the individual is considered at high risk for procedures.

### **CMM-210.4: Non-indications**

- An intrathecal or epidural drug delivery system is considered **experimental, investigational or unproven** for **ANY** other indication, including the following:
  - ◆ Cancer-related pain, spastic/dystonic, or other pain conditions that do not meet the above criteria
  - ◆ Administration of insulin for diabetes
  - ◆ Administration of antibiotics for osteomyelitis
  - ◆ Administration of heparin for thromboembolic disease

### **CMM-210.5: Replacement**

- Replacement of an implanted intrathecal or epidural drug infusion system is considered **medically necessary** when **BOTH** of the following criteria have been met:
  - ◆ The existing device is documented to be nearing end of battery life, will no longer be beneficial and cannot be repaired, or a built-in component provides notification of impending failure
  - ◆ There is no evidence to suggest the device has been abused or neglected
- Replacement of an implantable intrathecal infusion pump is considered **not medically necessary** when the existing infusion pump and/or components remain functional.

### **CMM-210.6: Procedure (CPT®) Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior	
CPT®	Code Description/Definition
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.



<b>62325</b>	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)
<b>62326</b>	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.
<b>62350</b>	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy
<b>62351</b>	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy
<b>62355</b>	Removal of previously implanted intrathecal or epidural catheter
<b>62360</b>	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
<b>62361</b>	Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump
<b>62362</b>	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump with or without programming
<b>62365</b>	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion
<b>62367</b>	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming
<b>62368</b>	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming
<b>95990</b>	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed
<b>95991</b>	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump when performed; requiring skill of a physician or other qualified health care professional
This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual's policy or benefit entitlement structure as well as claims processing rules.	

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## **CMM-211: Spinal Cord Stimulators**

### **Prior Authorization Requirements:**

For Spinal Cord Stimulators, please refer to **Asuris Northwest SUR Policy No. 45 Spinal Cord and Dorsal Root Ganglion Stimulation.**

**CMM-308: Thermal Intradiscal Procedures**

<b>CMM-308.1: Definitions</b>	<b>66</b>
<b>CMM-308.2: Non-indications</b>	<b>66</b>
<b>CMM-308.3: Procedure (CPT®) Codes</b>	<b>67</b>
<b>CMM-308.4: References</b>	<b>68</b>

### **CMM-308.1: Definitions**

- **Thermal intradiscal procedures** are minimally invasive surgical procedures which involve the percutaneous placement of an intradiscal probe into the suspected painful disc(s) and through the use of radiofrequency energy or electrothermal energy, produce heat to either coagulate and/or disrupt (shrink) type I collagen within the disc for decompression of the disc material. The goal of thermal intradiscal procedures is to treat symptomatic patients with annular disruption of contained herniated disc, to seal annular tears or fissures, or destroy nociceptors for the purpose of relieving pain. These techniques include those that use single or multiple probes/catheters, which utilize a resistance coil or other delivery system technology, are flexible or rigid, and are placed within the nucleus, the nuclear-annular junction or the annulus.
- **Thermal intradiscal procedures** include, but are not limited to:
  - ◆ Annulo-nucleoplasty (The Disc-FX procedure)
  - ◆ Cervical intradiscal radiofrequency lesioning
  - ◆ Coblation percutaneous disc decompression
  - ◆ Intradiscal biacuplasty (IDB)/intervertebral disc biacuplasty/cooled radiofrequency
  - ◆ Intradiscal electrothermal annuloplasty (IEA)
  - ◆ Intradiscal electrothermal therapy (IDET)
  - ◆ Intradiscal thermal annuloplasty (IDTA)
  - ◆ Nucleoplasty (also known as percutaneous radiofrequency thermomodulation or percutaneous plasma discectomy)
  - ◆ Percutaneous (or plasma) disc decompression (PDD)
  - ◆ Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT)/intradiscal radiofrequency thermomodulation/percutaneous radiofrequency thermomodulation
  - ◆ Radiofrequency annuloplasty (RA)
  - ◆ Targeted disc decompression (TDD)

### **CMM-308.2: Non-indications**

- Based on the lack of conclusive scientific evidence demonstrating the clinical efficacy of thermal intradiscal procedures and the potential to expose patients to serious adverse side effects or complications, the use of thermal intradiscal procedures are considered **experimental, investigational, or unproven**.



**CMM-308.3: Procedure (CPT®) Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required. Pre- authorization requirements vary by individual payor.

CPT®	Code Description/Definition
<b>22526</b>	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
<b>22527</b>	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (list separately in addition to code for primary procedure)
<b>62287</b>	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
<b>62292</b>	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar
<b>0274T</b>	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopy, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic
<b>0275T</b>	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopy, CT), single or multiple levels, unilateral or bilateral; lumbar
<p>This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the individual payor (health insurance company, etc.) and is based on the member/patient/client/beneficiary's policy or benefit entitlement structure as well as any third party payor guidelines and/or claims processing rules. Providers are strongly urged to contact each payor for individual requirements if they have not already done so.</p>	

## CMM-308.4: References

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**CMM-310: Manipulation of the Spine Under Anesthesia**

<b>CMM-310.1: Indications</b>	<b>71</b>
<b>CMM-310.2: Non-Indications</b>	<b>71</b>
<b>CMM-310.3: Procedure (CPT®) Codes</b>	<b>71</b>
<b>CMM-310.4 References</b>	<b>72</b>

### **CMM-310.1: Indications**

- The use of manipulation of the spine when the patient is either sedated or under general anesthesia may be considered **medically necessary** as a closed treatment of traumatically induced vertebral fracture or dislocation in an emergent situation to mitigate the potential for neurological compromise when the decision for an open reduction has been considered by a qualified physician.
- Manipulation under anesthesia should be performed in conjunction with an active rehabilitation/therapeutic exercise program.

### **CMM-310.2: Non-Indications**

- In the absence of traumatically induced vertebral fracture or dislocation, based on the lack of evidence of long term efficacy and safety, the use of manipulation of the spine under sedation or general anesthesia is considered **not medically necessary**.
- Manipulations performed in isolation without the patient participating in an active rehabilitation program in conjunction with a home exercise program is considered **not medically necessary**.

### **CMM-310.3: Procedure (CPT®) Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required. Pre- authorization requirements vary by individual payor.

CPT®	Code Description/Definition
<b>22505</b>	Manipulation of spine requiring anesthesia, any region.

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the individual payor (health insurance company, etc.) and is based on the member/patient/client/beneficiary's policy or benefit entitlement structure as well as any third party payor guidelines and/or claims processing rules. Providers are strongly urged to contact each payor for individual requirements if they have not already done so.

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## **CMM-400: Anesthesia Services for Interventional Pain Procedures**

<b>CMM-400.1: Definitions</b>	<b>74</b>
<b>CMM-400.2: General Guidelines</b>	<b>74</b>
<b>CMM-400.3: Indications</b>	<b>75</b>
<b>CMM-400.4: Non-Indications</b>	<b>76</b>
<b>CMM-400.5: Procedure (CPT®) Codes</b>	<b>77</b>
<b>CMM-400.6: References</b>	<b>77</b>

## **CMM-400.1: Definitions**

- **Conscious sedation** includes:
  - ◆ **Minimal sedation (anxiolysis)** indicates a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilation and cardiovascular functions are unaffected<sup>3</sup>.
  - ◆ **Moderate sedation/analgesia (conscious sedation)** indicates a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained<sup>3</sup>.
  - ◆ **Deep sedation/analgesia** is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated or painful stimulation<sup>3</sup>.
- **Monitored anesthesia care (MAC)** includes the administration of sedatives and/or analgesics often used for mild to moderate sedation. An essential component of MAC is the preprocedural anesthesia assessment and understanding of the patient's coexisting medical conditions and management of a patient's actual or anticipated physiological derangements or medical problems that may occur during a diagnostic or therapeutic procedure. The provider of MAC must be prepared and qualified to convert to general anesthesia when necessary. MAC is administered by a certified registered nurse anesthetist (CRNA) or anesthesiologist. Additionally, a provider's ability to intervene to rescue a patient's airway from any sedation-induced compromise is a mandatory professional qualification to provide MAC<sup>7</sup>.
- **General anesthesia** is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired<sup>3</sup>.

## **CMM-400.2: General Guidelines**

- The determination of medical necessity for the performance of monitored anesthesia care (MAC) is always made on a case-by-case basis.
- The medical necessity of monitored anesthesia care (MAC) is:
  - ◆ Evaluated prior to each procedure and the determination is made independent of any prior medical necessity determinations for monitored anesthesia care (MAC); **and**
  - ◆ Only considered once an interventional pain procedure is approved or if the interventional pain procedure does not require prior authorization.
    - Benefits, coverage policies, and eligibility issues pertaining to each health plan may take precedence over eviCore's guidelines. Providers are urged to obtain written instructions and requirements directly from each payor.

### **CMM-400.3: Indications**

Monitored anesthesia care (MAC) is considered **medically necessary** when **EITHER** of the following are met:

- Monitored anesthesia care (MAC) will be used during **ANY** of the following interventional pain procedures<sup>8</sup>:
  - ◆ Regional sympathetic blocks
  - ◆ Radiofrequency ablation of the medial branch nerves
  - ◆ Discography
  - ◆ Spinal cord stimulator trial and permanent implantation
  - ◆ Vertebral augmentation
  - ◆ Implantation of intrathecal drug delivery systems
- There is a presence of **ANY** of the following:
  - ◆ Attestation that a behavioral health professional has determined that severe anxiety, psychiatric condition(s), or cognitive impairment(s) would decrease patient safety during the procedure<sup>13</sup>
  - ◆ Hyperkinetic movement disorders including **ANY** of the following<sup>12</sup>:
    - Acquired/traumatic/hypoxic brain injury/stroke
    - Athetoid cerebral palsy
    - Basal ganglia disease
    - Dystonia
    - Familial paroxysmal choreoathetosis
    - Hemiballismus
    - Huntington's Chorea
    - Multiple sclerosis
    - Paroxysmal kinesigenic choreathetosis
    - Spasticity related involuntary movements
    - Spinal cord injury
  - ◆ Patients at risk for airway obstruction due to an anatomic variation including **ANY** of the following<sup>11,14</sup>:
    - Dysmorphic facial features
    - History of stridor
    - Jaw abnormalities (e.g., micrognathia)
    - Mallampati score of 4
    - Neck abnormalities (e.g., mass)
    - Oral abnormalities (e.g., macroglossia)
    - Pierre-Robin syndrome
    - Trisomy 21
  - ◆ Significant medical condition that increases the risk for complications including **ANY** of the following<sup>10</sup>:
    - Active hepatitis
    - Cardiac disease including **ANY** of the following:
      - Poorly controlled hypertension
      - Implanted pacemaker/defibrillator
      - Moderate to severe reduction in ejection fraction requiring medical treatment

- End stage renal disease requiring dialysis
- Morbid obesity (BMI  $\geq$  40 kg/m<sup>2</sup>)
- Pulmonary disease including poorly controlled COPD requiring oxygen
- Sleep apnea requiring **BOTH** of the following during sleep:
  - BiPAP support
  - Supplemental oxygen

When the criteria for the performance of monitored anesthetic care (MAC) are met, **ALL** of the following criteria must also be met<sup>6</sup>:

- A preoperative evaluation has been performed by a member of the anesthesia delivery team which includes airway examination and medical assessment.
- Informed consent has been obtained with a discussion of alternative sedation options.
- **BOTH** of the following are present during the delivery of monitored anesthesia care (MAC):
  - ◆ Continual monitoring of ventilatory function with capnography to supplement standard monitoring by observation and pulse oximetry
  - ◆ A qualified medical professional to recognize and treat airway complications.
- Recovery from monitored anesthesia care (MAC) will be managed by skilled nursing personnel with direct supervision by a certified registered nurse anesthetist or anesthesiologist.

#### **CMM-400.4: Non-Indications**

- Monitored anesthesia care (MAC) for manipulation of the spine or for closed procedures on the cervical, thoracic, or lumbar spine is considered **experimental, investigational, or unproven.**

## **CMM-400.5: Procedure (CPT®) Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required. Pre- authorization requirements vary by individual payor.

<b>CPT®</b>	<b>Code Description/Definition</b>
<b>01991</b>	Anesthesia for Diagnostic or Therapeutic Nerve Blocks and Injections (When Block or Injection is Performed by a Different Physician or Other Qualified Health Care Professional); Other Than the Prone Position
<b>01992</b>	Anesthesia for Diagnostic or Therapeutic Nerve Blocks and Injections (When Block or Injection is Performed by a Different Physician or Other Qualified Health Care Professional); Prone Position
<b>01935</b>	Anesthesia for Percutaneous Image Guided Procedures on the Spine and Spinal Cord; Diagnostic
<b>01936</b>	Anesthesia for Percutaneous Image Guided Procedures on the Spine and Spinal Cord; Therapeutic
<b>CPT®</b>	<b>Code Considered Experimental, Investigational, or Unproven</b>
<b>00640</b>	Anesthesia for Manipulation of the Spine or for Closed Procedures on the Cervical, Thoracic or Lumbar Spine

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the individual payor (health insurance company, etc.) and is based on the member/patient/client/beneficiary's policy or benefit entitlement structure as well as any third party payor guidelines and/or claims processing rules. Providers are strongly urged to contact each payor for individual requirements if they have not already done so.

## **CMM-400.6: References**

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