Cigna Musculoskeletal Program
Interventional Pain Management
Frequently Asked Questions

Note: Prior authorization requests should *only* include those codes for the current Interventional Pain treatment plan and *not* codes for every contingency Interventional Pain treatment plan. Should additions, deletions and/or other changes be required for a current authorization, please contact eviCore to provide supporting documentation for review of the medical necessity of requested additions, deletions and/or other changes.

What criteria are needed for a repeat epidural steroid injection (ESI)?

The criteria needed for a repeat epidural steroid injection is **any** of the following for the duration of two weeks or more:

1. At least 50 percent pain relief,
2. Increase in the level of function (i.e., return to work), or
3. Reduction in the use of pain medication or additional medical services such as physical therapy or chiropractic care.

Does radiculopathy allow facet joint injection/medial branch nerve block?

Facet joint injections/medial branch blocks should only be performed for neck pain or low back pain in the absence of an untreated radiculopathy.

Can I perform more than two facet joint injections/medial branch blocks at the same level?

More than two facet injections/medial branch blocks at the same level are considered to be therapeutic rather than diagnostic. There is no scientific evidence to support the use of a therapeutic facet joint injection/medial branch block and it is considered experimental, investigational or unproven.

Can I perform injections/blocks at more than three facet levels?

The performance of injections/blocks on more than three levels is considered not medically necessary.

Can I perform an ESI on patients if they are not complaining of disabling or burning pain, pins and needles, or altered sensation?

The definition of radiculopathy, for the purpose of this policy, is defined as the presence of pain, dysaethesia(s), or paraesthesia(s) reported by the individual in a specified dermatomal distribution of an involved named spinal root(s) causing significant functional limitations resulting in diminished quality of life and impaired, age-appropriate activities of daily living, and **one** or **more** of the following:

1. Documented loss of strength of specific named muscle(s) or myotomal distribution(s), or demonstrated on detailed neurologic examination (within the prior three months), concordant with nerve root compression of the involved named spinal nerve root(s),

2. Documented altered sensation to light touch, pressure, pin prick, or temperature demonstrated on a detailed neurologic examination (within the prior three months) in the sensory distribution concordant with nerve root compression of the involved named spinal nerve root(s), or
3. Documented diminished, absent, or asymmetric reflex(es) (within the prior three months) concordant with nerve root compression of the involved named spinal nerve root(s) and documentation of either of the following:

- A concordant radiologist's interpretation of an advanced diagnostic imaging study (MRI or CT scan) of the spine demonstrating compression of the involved named spinal nerve root(s) or foraminal stenosis at the concordant level(s) (performed within the prior 12 months), or
- An electromyogram (EMG) or nerve conduction (NCV) diagnostic study of nerve root compression of the involved named spinal nerve root(s) (performed within the prior 12 months).

Is there a period of conservative care that is required prior to requesting a therapeutic ESI?

An ESI is considered medically necessary for presumed radiculopathy resulting from disease, injury, or surgery that has not responded sufficiently to a reasonable course (four week minimum) of conservative treatment (exercise, physical methods including physical therapy, chiropractic care, NSAIDs, or muscle relaxants).

How do I justify the need for radiofrequency ablation of the medial branch nerve innervating the facet joint?

A radiofrequency joint denervation/ablation is considered medically necessary for facet mediated pain resulting from disease, injury, or surgery and confirmed by provocative testing when **both** of the following criteria are met:

1. Failure of at least three months of conservative therapy (e.g., exercise, physical methods including physical therapy, chiropractic care, NSAIDs or analgesics), and
2. Two positive diagnostic facet joint injections/medial branch blocks using either a local anesthetic or a local anesthetic combined with corticosteroid as evidenced by **either** of the following:

- A beneficial clinical response to dual (two) sequential intra-articular facet injections or medial branch blocks performed with a local anesthetic with greater than 80 percent pain relief for the duration of the effect of the local anesthetic used, or
- A beneficial clinical response to dual (two) sequential intra-articular facet joint injections or medial branch blocks performed with a local anesthetic and a corticosteroid with at least a 50 percent reduction in pain for at least two weeks.

What needs to be documented for a patient to be approved for facet injection/medial branch nerve block?

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:

1. Pain is exacerbated by extension and rotation,
2. Pain has persisted despite appropriate conservative treatment (e.g., NSAIDs or exercise), and
3. Clinical findings and imaging studies suggest no other obvious cause of the pain (e.g., spinal stenosis, disc degeneration or herniation, infection, tumor, or fracture).

What physical examination signs should be documented to justify a facet based procedure?

Facet joint injections/medial branch blocks are considered medically necessary for facet mediated pain resulting from disease, injury, or surgery and confirmed by provocative testing resulting in reproducible pain (i.e., hyperextension, rotation).

Is there a limit to the amount of epidural sessions?

No more than three ESIs should be performed per episode of pain and no more than four injections per region per year.

Can I perform an epidural as an isolated treatment?

Based on the limited long- term benefit of performing an ESI as an isolated intervention with regard to pain and improved function, all they should be performed in conjunction with active rehabilitative care or therapeutic exercise.

Can multiple epidurals be approved on a single request for services?

There is insufficient scientific evidence to support the scheduling of a “series-of-three” injections 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.

What needs to be documented for a patient to be approved for an ESI?

An ESI may be considered medically necessary when a detailed neurologic exam within the last three months demonstrated any of the following consistent with spinal nerve root compression:

1. Loss of strength of a specific named muscle(s) or myotomal distribution(s),
2. Altered sensation to light touch, pressure, pin prick or temperature, or

Diminished, absent or asymmetric reflex(es). ESI may also be considered medically necessary when a CT, MRI, or EMG/NCV performed within the last 12 months demonstrated compression of the involved named spinal nerve root(s).

What type of guidance is acceptable for facet injection/medial branch nerve block?

Facet joint injection/medial branch nerve block under fluoroscopy or CT scan is acceptable. The performance of a facet joint injection/medial branch block injection under ultrasound guidance is considered experimental, investigational, or unproven for any indication.

How much conservative care is needed for radiofrequency ablation of the medial branch nerves?

The criteria needed for radiofrequency ablation of the medial branch nerves includes failure of at least three months of conservative therapy (e.g., exercise, physical methods including physical therapy, chiropractic care, NSAID’s or analgesics).

How frequently can repeat radiofrequency ablation of the medial branch nerve be performed?

A repeat radiofrequency joint denervation/ablation is considered medically necessary when there is documented pain relief of at least 50 percent that has lasted for a minimum of 12 weeks. While repeat radiofrequency joint denervations/ablations may be required, they should not occur at an interval of less than six months from the first procedure. No more than two procedures at the same level(s) should be performed in a 12-month period.

Can radiofrequency ablation of the medial branch nerve take place at a previously fused level?

A radiofrequency joint denervation/ablation is considered medically necessary when performed on an individual with previous spinal fusion only when performed at levels above or below the fusion.

Where can I find additional tools and resources related to my musculoskeletal requests for prior authorization?

You can access important **Cigna MSK program resources** on the implementation website at **http://www.medsolutions.com/implementation/cigna/msk/index.html.**

To access **eviCore healthcare's clinical guidelines** on the web, visit www.evicore.com.

- Click on "**Resources**" from the main menu, and select "**Providers."** Once you have clicked "Providers," you will see the Clinical Guidelines section.
- The "Clinical Guidelines" section provides a dropdown box that allows you to **Select Solution** (Musculoskeletal). Click on the solution you need, and all clinical guidelines for that solution will populate.