

DISCLAIMER

This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Facet joint syndrome is a condition leading to chronic spinal pain due to unclear etiology. Classic findings include pain in the cervical or low back radiating to the buttock and posterior thigh, pain due to hyperextension, pain on palpation of joint, and absence of both radiculopathy below the knee and neurologic deficits. Facet blocks can be performed in cervical or lumbar segments of the spine and may be performed as a diagnostic or therapeutic procedure. Facet blocks using short- or long-acting local anesthetics can be used to diagnose facet (zygapophyseal) joint syndrome as the cause of chronic back pain. Diagnostic injections involve the injection of a local anesthetic into the facet joints (intra-articular) or around the nerve supply to the joints (medial branches of the dorsal rami aka medial branch block [MBB]). Injections should be fluoroscopically guided. Pain relieved following the injection for the appropriate amount of time given the type of medication used, without definitive clinical or imaging findings, would suggest that the pain originated in the facet joint. A positive diagnostic block is the prerequisite for undergoing other treatments to alleviate facet joint pain such as radiofrequency denervation of the facet joints. (^{1,2} Hayes, 2021).

COVERAGE POLICY

Please refer to *Radiofrequency Ablation* (MCP-085) for related criteria.

1. Diagnostic facet joint injections / MBBs **may be considered medically necessary** for facet joint pain in adults who are age 18 years or older as part of a comprehensive pain management treatment program when **ALL** of the following criteria are met:
 - a. Presence of chronic severe back pain (cervical, or lumbar) that is predominantly axial not associated with radiculopathy or neurogenic claudication present for a minimum of 3 months that is:
 - Resulting from disease, injury or surgery; **AND**
 - Confirmed by provocative testing resulting in reproducible pain (e.g., hyperextension, rotation).
 - AND**
 - b. Pain is affecting activity of daily living functional ability: > 4 on the NRS Pain Rating Scale*; **AND**
 - c. Physical evaluation has ruled out that no non-facet pathology that could explain the source of the patient's pain, such as discogenic, sacroiliac joint pain, disc herniation, fracture, tumor, infection; **AND**
 - d. Has tried and failed a minimum of 3 months of conservative therapy (e.g., for the current episode of pain that includes:
 - Physical therapy (PT) for a minimum of 4 weeks (3-4x per week for a total of 12 sessions); **OR**
 - There must be documentation submitted that explains why physical therapy is contraindicated – note that PT may be contraindicated if any of the following are present:
 - i. Pain worsened with PT;

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- ii. PT tried but was not able to be tolerated.

AND

- Activity or exercise modification; **AND**
- Drug therapy (e.g., NSAIDS, muscle relaxants, corticosteroids, antidepressants, anticonvulsants, or opiates).

* The Numeric Rating Scale (NRS-11): Rating Pain Level

- 0: No Pain
- 1 – 3: Mild Pain (nagging, annoying, interfering little with ADLs)
- 4 – 6: Moderate Pain (interferes significantly with ADLs)
- 7 – 10: Severe Pain (disabling; unable to perform ADLs)

2. Diagnostic Facet Joint Injection / Medial Branch Block (MBB) Criteria

The primary efficacy of diagnostic facet injections / MBBs is to determine the appropriateness for a radiofrequency neurotomy of painful segmental levels in order to achieve long-term pain management. A positive response is defined as at least 70% relief of the primary (index) pain, with the onset and duration of relief being consistent with the local anesthetic employed and measured by a decrease in pain medication and increase in functional ability **ALL** of the following criteria apply:

- a. For each covered spinal region (cervical or lumbar), diagnostic facet joint injections/MBBs should be performed at no more than four (4) joints per session (e.g., two [2] bilateral levels or four [4] unilateral levels).
- b. A second diagnostic facet joint injection/medial branch block (e.g., dual), performed to confirm the validity of the clinical response to the initial facet joint injection performed in the same location(s) on two separate occasions at least one week apart, are considered medically necessary to confirm the diagnosis due to the unacceptably high false positive rate of single MBB injections when **ALL** of the following criteria are met:
 - Administered at the same level as the initial block; **AND**
 - The initial diagnostic facet joint injection produced a positive response (e.g., at least 70% relief of facet mediated pain for at least the expected minimum duration of the effect of the local anesthetic); **AND**
 - A radiofrequency joint denervation/ablation procedure is being considered.
- c. A maximum of six (6) facet joint procedural sessions per region (cervical or lumbar) may be performed in a 12-month period.
- d. More than two facet injections/medial branch blocks at the same level are considered to be therapeutic rather than diagnostic. Therapeutic facet injections/medial branch blocks are considered NOT medically necessary.

Limitations and Exclusions

- Therapeutic or subsequent facet injections/medial branch blocks at the same level are considered experimental, investigational or unproven as there is insufficient data to support the effectiveness of these interventions.
- Facet joint injections in the thoracic region are considered experimental, investigational and unproven.
- The performance of facet joint injections/medial branch blocks in the presence of an untreated radiculopathy is considered not medically necessary.
- The performance of injections/blocks no more than four (4) joints per session (e.g., two [2] bilateral levels or four [4] unilateral levels) on the same day is considered not medically necessary.
- The following are considered contraindications to the procedure and require physician documentation of medical necessity in the presence of any the following:
 - Previous history of spinal fusion in the area treated
 - Unstable medical conditions or psychiatric illness
 - Current anticoagulation treatment
 - Current systemic infection or infection over the injection site

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DOCUMENTATION REQUIREMENTS. Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

Perolat et al. (2018) analyzed low back pain (LBP) and lumbar facet joints (FJ) which is a common source of pain (15–45%) – facet arthrosis is the most common form of facet pathology. The authors explore specific interventional facet joint management. Diagnostic positive facet joint block can specify facet joints as the source of a patient's pain and may benefit from facet joint neurolysis (especially radiofrequency or cryoablation). Diagnostic blocks are important for diagnosing facet syndrome. If diagnostic blocks supplying specific facet joints can relieve pain, denervation procedure lesioning of the same nerves can be performed for long term outcomes. Radiologists are particularly important in the management of patients with LBP with respect to pain management from diagnosis to interventional management.

Manchukonda et al. (2007) performed a retrospective review with the objective of evaluating the occurrence of facet joint pain in chronic spinal pain of cervical, thoracic, and lumbar origin by using controlled, comparative local anesthetic blocks and evaluation of false-positive rates of single blocks in the diagnosis of chronic spinal pain of facet joint origin. Facet joints are clinically important sources of chronic cervical, thoracic, and lumbar spine pain. Previous studies show the value and validity of controlled, comparative local anesthetic blocks in the diagnosis of FJ pain (prevalence of 15–67% in lumbar, thoracic, and cervical regions). False-positive rates of single diagnostic blocks ranged from 17% to 63%. A total of 500 consecutive patients were analyzed; all had received controlled, comparative local anesthetic blocks of medial branches for the diagnosis of facet or zygapophysial joint pain. Diagnostic blocks used 0.5 mL of 1% lidocaine per nerve; patients with lidocaine-positive results were further studied using 0.5 mL of 0.25% bupivacaine per nerve on a separate occasion. Positive responses included patients with at least 80% pain relief from a block of at least 2 hours in duration when lidocaine was used, and at least 3 hours than the duration of relief with lidocaine when bupivacaine was used. Patients were also evaluated in terms of their ability to perform movements that were previously painful. In conclusion, 438 patients were included. Facet joint prevalence was 39% in the cervical spine; 34% in the thoracic pain; and 27% in the lumbar spine. The false-positive rate with a single block in the cervical region was 45%, 42% in the thoracic region, and 45% in the lumbar region.

Studies primarily address the diagnosis and/or treatment of patients with chronic low (lumbar) back pain and involved patients with cervical or thoracolumbar pain. Outcome measures varied among studies but generally included assessment of pain, assessment of ability to perform functions of daily living and to return to previous work, use of pain medication, and patient satisfaction. The randomized controlled trials reported a relatively large placebo effect, with improvement in all groups, but no difference in clinical response between local anesthetic block and placebo (saline injection). One study reported some improvement in lumbar mobility but no greater improvement in pain or disability when facet injections were added to an exercise program compared with exercise alone. The uncontrolled studies reported conflicting results regarding the accuracy of facet blocks for identifying facet joint syndrome as a cause of chronic back pain, but all reported relief of pain in some patients following facet block. The Cochrane systematic review analyzed 21 randomized trials and found that there was no convincing evidence for the therapeutic efficacy of facet joint blocks in patients with lower back pain. The primary outcome measure was pain relief, and all of the studies that involved patients with low back pain persisting longer than one month were reviewed. The overall body of evidence regarding facet injections as a treatment for chronic neck and back pain shows that while facet blocks are associated with some pain relief; most studies suggest that the effects are attributable to the anesthetic or placebo effect. (Staal et al., 2008; Nelemans et al., 2000).

The 2015 AHRQ comparative effectiveness study on injection therapies for low back pain concluded that the studies found no clear differences between various facet joint corticosteroid injections (intraarticular, extra-articular [peri-capsular], or medial branch) and placebo interventions (Chou et al., 2015).

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National and Specialty Organizations

The **American College of Radiology (ACR)** (2021) published *Appropriateness Criteria: Low Back Pain* which provides evidence-based guidelines that are reviewed annually by a multidisciplinary expert panel. The ACR recommends imaging for patients with up to six weeks of medical management and physical therapy but had minimal or no improvement in their back pain. Imaging is also recommended for patients that present with symptomology for a serious underlying condition (e.g., cauda equina syndrome, malignancy, fracture, or infection).

An updated 2020 practice guideline published by the **American Society of Interventional Pain Physicians (ASIPP)** states the following (Manchikanti et al., 2020; ¹⁻²Manchikanti et al, 2013; Manchikanti et al., 2008):

- **Lumbar Spine Diagnosis:** The level of evidence is I to II with moderate to strong strength of recommendation for lumbar diagnostic facet joint nerve blocks; ten relevant diagnostic accuracy studies with 4 of 10 studies utilizing controlled comparative local anesthetics with concordant pain relief criterion standard of $\geq 80\%$ were included; the prevalence rates ranged from 27% to 40% with false-positive rates of 27% to 47%, with $\geq 80\%$ pain relief.
- **Cervical Spine:** The level of evidence is II with moderate strength of recommendation; ten relevant diagnostic accuracy studies, 9 of the 10 studies with either controlled comparative local anesthetic blocks or placebo controls with concordant pain relief with a criterion standard of $\geq 80\%$ were included. the prevalence and false-positive rates ranged from 29% to 60% and of 27% to 63%, with high variability.
- **Thoracic Spine:** The level of evidence is II with moderate strength of recommendation; three relevant diagnostic accuracy studies, with controlled comparative local anesthetic blocks, with concordant pain relief, with a criterion standard of $\geq 80\%$ were included; the prevalence varied from 34% to 48%, whereas false-positive rates varied from 42% to 58%.

*Note: Level I evidence is strong evidence obtained from multiple relevant high quality randomized controlled trials or evidence obtained from multiple high quality diagnostic accuracy studies Level II is moderate evidence obtained from at least one relevant high quality randomized controlled trial or multiple relevant moderate or low quality randomized controlled trials or evidence obtained from at least one high quality diagnostic accuracy study or multiple moderate or low quality diagnostic accuracy studies.

Guidelines also indicate that diagnostic cervical facet joint nerve blocks are recommended in patients with somatic or non-radicular neck pain or headache and upper extremity pain, with duration of pain of at least three months, without preponderance of evidence of discogenic pain, disc herniation, or evidence of radiculitis. Diagnostic lumbar facet joint nerve blocks are recommended in patients with suspected facet joint pain. (¹⁻² Manchikanti et al, 2013).

Qaseem et al. (2017) published a clinical practice guideline from the **American College of Physicians (ACP)** on *Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain*. Using data from a systematic review of randomized, controlled trials and systematic reviews, the ACP developed recommendations regarding noninvasive pharmacologic and nonpharmacologic treatments for low back pain. Outcomes analyzed include: reduction or elimination of low back pain, improvement in back-specific and overall function, improvement in health-related quality of life, reduction in work disability and return to work, global improvement, number of back pain episodes or time between episodes, patient satisfaction, and adverse effects. The following recommendations were made by the ACP:

1. Nonpharmacologic treatment should include superficial heat (moderate-quality evidence), massage, acupuncture, or spinal manipulation (low-quality evidence). If pharmacologic treatment is needed, the Provider and should discuss options with their patients including nonsteroidal anti-inflammatory drugs or skeletal muscle relaxants (moderate-quality evidence).
2. Initial nonpharmacologic treatment should include exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction (moderate-quality evidence), tai chi, yoga, motor control exercise, progressive relaxation, electromyography biofeedback, low-level laser therapy, operant therapy, cognitive behavioral therapy, or spinal manipulation (low-quality evidence).
3. For patients who had an inadequate response to nonpharmacologic therapy, Providers should consider pharmacologic treatment with nonsteroidal anti-inflammatory drugs as a first-line therapy, or tramadol or duloxetine as second-line therapy. Opioids should only be considered in patients who have failed the previously mentioned treatments and only if the potential benefits outweigh the risks for individual patients and after a discussion of known risks and realistic benefits with patients.

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The **Department of Veterans Affairs and Department of Defense** (2022) published the *VA/DoD Clinical Practice Guideline: Diagnosis and Treatment of Low Back Pain*. The guidelines offer an evidence-based approach for patients with acute, subacute, or chronic LBP (with or without neurological symptoms) in order to improve clinical outcomes. This includes how providers can assess a patient's condition while collaborating with the patient and their caregiver(s) to determine the best approach to care; how to highlight the use of patient-centered care and shared decision making; minimizing preventable complications and morbidity; and optimizing the patient's health outcomes and quality of life. Recommendations are also made regarding:

- Evaluation and Diagnostic Approach
- Patient Education and Self-Care
- Non-Pharmacologic and Non-Invasive Therapy
- Pharmacotherapy
- Dietary Supplements
- Non-surgical Invasive Therapy

The **National Institute for Health and Clinical Excellence (NICE)** (2020) published a guideline for *Low Back Pain and Sciatica* which addresses patients over age 16. The guideline covers physical, psychological, pharmacological and surgical treatments to manage low back pain and sciatica by promoting the most effective forms of care for low back pain and sciatica. Recommendations are also included for pharmacological management of sciatica as well as serve as supplemental information for existing recommendations on the assessment as well as invasive and non-invasive treatments of low back pain and sciatica. Guidance is also being developed by NICE for the use of opioids for non-cancer pain. Guidance includes patient education about safe opioid prescribing and withdrawal management.

The **North American Spine Society (NASS)** (2020) published the *Clinical Guideline for the Diagnosis and Treatment of Low Back Pain* to provide evidence-based recommendations for the diagnosis and treatment of adults with nonspecific low back pain. Goals of the guideline recommendations focus on the delivery of optimum, efficacious treatment and functional recovery from nonspecific low back pain. Recommendations are provided for:

- Diagnosis
- Imaging
- Medical and Psychological Treatment
- Physical Medicine and Rehabilitation
- Interventional Treatment
- Surgical Treatment
- Cost-Utility

The **Institute for Clinical Systems Improvement (ICSI)** (2018) published a guideline on *Low Back Pain, Adult Acute and Subacute* for adults over age 18 who present with symptoms of low back pain or radiculopathy. This pain may be acute (pain for up to 4 weeks) and subacute (pain for between 4 and 12 weeks); the guideline does not address chronic pain (after 12 weeks).

The ICSI (2017) also published a guideline on *Pain: Assessment, Non-Opioid Treatment Approaches and Opioid Management* which is a combination ICSI's *Acute Pain Assessment/Opioid Prescribing Protocol* and the *Assessment and Management of Chronic Pain* guidelines. The guideline also addresses the entire continuum for acute, sub-acute, and chronic non-cancer pain in adults. A major aim of the guideline is to assist primary care clinicians on how to provide effective assessment, treatment and ongoing management of patients with pain.

SUPPLEMENTAL INFORMATION

Definitions

- A zygapophyseal (facet) joint level is defined as the zygapophyseal joint or the two medial branch (MB) nerves that innervate that zygapophyseal joint.
- A session is defined as all injections / blocks procedures performed on one day and includes medial branch blocks (MBB), and facet intraarticular injections (IA).

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- A region is defined as all injections performed in cervical/thoracic or all injections performed in lumbar (not sacral) spinal areas.

CODING & BILLING INFORMATION

CPT Codes

CPT	Description
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
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)

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

4/13/2022	Policy reviewed, no changes to coverage criteria, updated Summary of Medical Evidence section and References.
4/5/2021	Policy reviewed, no changes to criteria. One new guideline found reference #43 American Society of Interventional Pain Physicians (ASIPP).
4/23/2020	Policy reviewed, criteria updated based on current standard of care medical guidelines that include ODG and InterQual; eviCore and other guidelines. The entire criteria was changed under initial recommendation #2: changed improvement scale from 50% to 70%, levels restricted to no more than four (4) joints per session (e.g., two [2] bilateral levels or four [4] unilateral levels), sessions

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restricted to a maximum of six (6) facet joint procedural sessions per region (cervical or lumbar) may be performed in a 12-month period and more than two facet injections/medial branch blocks at the same level are considered to be therapeutic rather than diagnostic. Therapeutic facet injections/medial branch blocks are considered NOT medically necessary. Added additional criteria for a second diagnostic facet joint injection/medial branch block (i.e dual), performed to confirm the validity of the clinical response to the initial facet joint injection performed in the same location(s). Revised conservative therapy to tried and failed a minimum of 3 months that includes PT for a minimum of 4 weeks. These changes are consistent with ODG, eviCore and other current guidelines and vetted by AMR reviewer.

6/19/2019

Policy reviewed, no changes to criteria.

3/8/2018

Policy reviewed, no changes to criteria.

7/2017

Reduced PT requirement from 20 sessions to 10-12 sessions over 8 weeks, changed improvement scales from significant functional improvement of 80% to significant functional pain relief of 50% measured by a decrease in pain medication and increase in functional ability, changed diagnostic injection criteria from 3 levels to 2 levels, removed significant narrowing of the vertebral canal or spinal instability as a contraindication, added that thoracic region injections are considered experimental, investigational and unproven and removed the requirement for a comprehensive psychosocial assessment. Changes are based on 2017 ODG Guidelines per AMR review.

REFERENCES

Government Agency

1. Centers for Medicare and Medicaid Services (CMS). Medicare coverage database. Available from [CMS](https://www.cms.gov). Accessed March 16, 2022.

Other Evidence Based Reviews and Publications

1. ¹ Hayes. Intra-articular facet joint injections for the treatment of chronic nonmalignant spinal pain of facet joint origin. <https://evidence.hayesinc.com>. Published April 19, 2018. Updated June 8, 2021. Accessed March 16, 2022. Registration and login required.
2. ² Hayes. Medial branch nerve block injections for the treatment of chronic nonmalignant spinal pain of facet joint origin. <https://evidence.hayesinc.com>. Published January 2019. Updated April 23, 2021. Accessed March 16, 2022. Registration and login required.
3. Chou R. Subacute and chronic low back pain: Nonsurgical interventional treatment. <http://www.uptodate.com>. Updated November 11, 2021. Accessed March 16, 2022. Registration and login required.
4. Isaac, Z. Management of non-radicular neck pain in adults. <http://www.uptodate.com>. Updated November 16, 2021. Accessed March 16, 2022. Registration and login required.
5. MCG. Facet joint injection (ACG: A-0695 AC), 25th ed. <https://www.mcg.com/>. Updated June 7, 2021. Accessed March 16, 2022. Registration and login required.
6. Advanced Medical Reviews (AMR) Peer Review. Policy reviewed on January 13, 2020 by an AMR practicing, board-certified physician in the areas of Pain Management and Physical Medicine and Rehabilitation.

Peer Reviewed Publications

1. Chou R, Hashimoto R, Friedly J, Fu R, Dana T, Sullivan S, et al. Pain management injection therapies for low back pain. Technology assessment report ESIB0813. Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. HHS290-2012-00014-I. Rockville, MD: Agency for Healthcare Research and Quality. <https://pubmed.ncbi.nlm.nih.gov/25879124/>. Published March 2015. Accessed April 6, 2022.
2. Manchukonda R, Manchikanti KN, Cash KA, Pampati V, Manchikanti L. Facet joint pain in chronic spinal pain: an evaluation of prevalence and false-positive rate of diagnostic blocks. *J Spinal Disord Tech*. 2007 Oct;20(7):539-45. doi: 10.1097/BSD.0b013e3180577812. Accessed April 6, 2022.
3. Nelemans PJ, de Bie RA, de Vet HC, Sturmans F. Injection therapy for subacute and chronic benign low back pain. *Cochrane Database Syst Rev*. 2000;(2):CD001824. doi: 10.1002/14651858.CD001824. Accessed April 6, 2022.
4. Perolat R, Kastler A, Nicot B, Pellat JM, Tahon F, Attye A, Heck O, et al. Facet joint syndrome: from diagnosis to interventional management. *2018 Oct;9(5):773-789*. doi: 10.1007/s13244-018-0638-x. Accessed April 6, 2022.
5. Staal JB, Bie R, de Vet H, et al. Injection therapy for subacute and chronic low-back pain. *Cochrane Database Syst Rev*. 2008 Jul 16;2008(3):CD001824. doi: 10.1002/14651858.CD001824.pub3. Accessed April 6, 2022.

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1. American College of Radiology. Appropriateness criteria: Low back pain. Available from [ACR](https://www.acr.org). Updated 2021. Accessed April 6, 2022.
2. Department of Veterans Affairs, Department of Defense. VA/DoD clinical practice guideline: Diagnosis and treatment of low back pain. Available from [VA/DoD](https://www.va.gov). Updated 2022. Accessed April 6, 2022.
3. Institute for Clinical Systems Improvement (ICSI). Low back pain, adult acute and subacute (16th ed.). Available from [ICSI](https://www.icsi.org). Published March 2018. Accessed April 6, 2022.
4. Institute for Clinical Systems Improvement (ICSI). Pain: Assessment, non-opioid treatment approaches and opioid management (8th ed., ver. 2). Available from [ICSI](https://www.icsi.org). Updated August 2017. Accessed April 6, 2022.
5. Manchikanti L, Kaye AD, Sooin A, Albers SL, Beall D, Latchaw RE, et al. Comprehensive evidence-based guidelines for facet joint interventions in the management of chronic spinal pain: American Society of Interventional Pain Physicians (ASIPP) guidelines. *Pain Physician* 2020; 23:S1-S127. Available from [ASIPP](https://www.asipp.org). Accessed April 6, 2022.
6. ¹ Manchikanti L, Falco FJ, Singh V, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part I: introduction and general considerations. *Pain Physician*. 2013b;16(2 Suppl):S1-S48. <https://pubmed.ncbi.nlm.nih.gov/23615882/>. Accessed April 6, 2022.
7. ² Manchikanti L, Abdi S, Atluri S, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: Guidance and recommendations. *Pain Physician*. 2013a;16(2 Suppl):S49-S283. <http://www.painphysicianjournal.com/2013/april/2013;16:S49-S283.pdf>. Accessed April 6, 2022.

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8. Manchikanti L, Boswell MV, Singh V. et al. Comprehensive evidence-based guidelines for interventional techniques in the management of chronic spinal pain. *Pain Physician* 2009; 12:699-802. <https://pubmed.ncbi.nlm.nih.gov/19644537/>. Accessed April 6, 2022.
9. National Institute for Health and Clinical Excellence (NICE). Low back pain and sciatica in over 16s: Assessment and management [NG59]. <https://www.nice.org.uk/guidance/NG59>. Published November 30, 2016. Updated December 11, 2020. Accessed April 6, 2022.
10. North American Spine Society (NASS). Evidence-based clinical guidelines for multidisciplinary spine care: Diagnosis and treatment of low back pain. Available from Spine.org. Published 2020. Accessed April 6, 2022.
11. Qaseem A, Wilt TJ, McLean RM, Forcica MA, Clinical Guidelines Committee of the American College of Physicians. Noninvasive treatments for acute, subacute, and chronic low back pain: A clinical practice guideline from the American College of Physicians. *Ann Intern Med*. 2017 Apr 4;166(7):514-530. doi: 10.7326/M16-2367. Accessed April 6, 2022.

APPENDIX

Reserved for State specific information. Information includes, but is not limited to, State contract language, Medicaid criteria and other mandated criteria.