

The American Society of Anesthesiologists recommended LCD on Facet Therapy for Noridian 08232009

DRAFT LCD for Lumbar Paravertebral Facet Joint Nerve (Medial Branch) Block and Radiofrequency Denervation Procedures

Contractor Information

Contractor Name	
Contractor Number	
Contractor Type	
Other Contractor Numbers to which this policy applies	

LCD Information

LCD Database ID Number	
LCD Version Number	
LCD Title	Paravertebral Facet Joint Nerve (Medial branch) Block/Denervation
Contractor's Determination Number	
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CMS National Coverage Policy	<p>Title XVIII of the Social Security Act, Section 1862(a) (1) (A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.</p> <p>Title XVIII of the Social Security Act, Section 1862(a) (7). This section excludes routine physical examinations.</p> <p>Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.</p>
Primary Geographic Jurisdiction	
Oversight Region	
Projected Determination Effective Date	
Original Determination Ending Date	
Revision Effective Date	
Revision Ending Date	
Indications and Limitations of Coverage and/or	Lumbar Paravertebral Facet Joint and Facet Joint Nerve (Medial branch) Therapy

Medical Necessity

Introduction

Lumbar paravertebral facet joint nerve blocks are used to both diagnose and treat pain associated with the lumbar paravertebral facet joints. Facet joint pain is diagnosed by facet nerve (medial branch) anesthetic blocks and treated with corticosteroid injection or denervation (radiofrequency thermal ablation) of the lumbar paravertebral facet joint (medial branch) nerves.

Establishing the diagnosis of lumbar facet joint pain syndrome or lumbar medial branch nerve-generated pain is often challenging. No specific history, physical examination, or radiological imaging findings point exclusively to the diagnosis. This diagnosis is considered in patients who describe nonspecific, low back pain that lacks a strong radicular component and has no associated neurologic deficit. These patients often complain of focal tenderness over the facet joint, with increased intensity of pain associated with passive or active rotation or extension of the spine.

A physical examination of the spine shall be performed on all patients prior to judging their candidacy for diagnostic and therapeutic facet interventions. Detailed assessment of the patient's response to provocative passive and active motion shall be made and recorded. Facet joint pain is a diagnosis of exclusion and appropriate radiological imaging and other diagnostic testing shall be reviewed if available or performed as clinically indicated to exclude other diagnoses.

The decision to treat chronic pain by invasive procedures must be based on a systematic assessment of the location, intensity, and pathophysiology of the pain. The pain must have been present for greater than 6 weeks

and be unresponsive to conservative measures. A detailed pain history is essential and must provide detail about prior treatments and responses. Interventional treatments shall be performed only in the context of a multimodal approach to the treatment of the chronic pain and in all cases the physician performing the intervention must be aware of the patient's physical diagnoses, comorbidities, medication use and must maintain sufficient contact with the patient's other treating physicians so as to assess the patient's overall physical and mental status prior and subsequent to all interventions. Lumbar paravertebral facet nerve (medial branch) injections ("blocks") have both diagnostic and therapeutic functions. Additionally, facet joint denervation (e.g. medial branch radio-frequency neurotomy) has been demonstrated to be an effective therapeutic intervention in treating facet pain.

Diagnostic procedures:

- A. Injection of the facet joint may be used as either a diagnostic or therapeutic procedure. The description of this as a therapeutic intervention is located in the 'therapeutic block' section, below. For diagnostic purposes, the injection of medication into the joint must be performed with either fluoroscopic or CT guidance and the volume of injectate should not exceed 0.5 cc, in order to avoid spillage outside the joint. If performing an intra-articular injection as a diagnostic procedure, steroid should not be included in the injectate. Two image views are necessary to portray intra-articular needle point placement and retention of those images is required, as outlined below
- B. Diagnostic lumbar paravertebral facet (medial branch) nerve blocks are used to assess and to localize the nerve(s) involved in pain or neuromuscular dysfunction generated by specific

facet joints. Immediately before the block, the pain in response to extension and rotation as described above must be present in moderate to severe intensity (i.e., 5/10 or more on NRS; absent or less intense pain shall result in the cancellation of the procedure for that day). Evaluation of the presence of pain in response to those same maneuvers must be an inherent aspect of the assessment of the patient immediately following (i.e., within one hour) the block. Any changes in range of motion or function shall be recorded, also.

Facet joint nerve injections MUST be performed under fluoroscopic or CT guidance to assure accurate placement of the needles on the medial branch nerves that innervate the targeted facet joint. A permanent image with both AP and either oblique or lateral views of the needle placement shall be created, including the patient's name and the date of the procedure imbedded in the image. The image (the quality of which must be sufficient to allow identification of pertinent anatomic structures and location of the needle at its intended target) must be saved and recorded in the patient's medical record.

To perform this block, a needle is placed adjacent to the medial branch nerves above and at the level of the joint to be blocked. The total dose of anesthetic used for each medial branch block must be limited to a maximum of 0.5 cc.

In addition to the examination of the patient in the hour post blockade, the patient is required to keep a pain diary for 24 hours (a copy of which will be kept in the record) and return that diary to the physician. The patient is asked to participate in the activities that usually incur or aggravate his/her pain and record pain and functional response (e.g., VAS scale assessments and changes in

range of motion) while awake.).

Diagnostic blocks of the medial branch nerves or intra-articular joint injections performed for diagnostic purposes are administered at up to two sessions, at least one to two weeks apart from one another. If a second block is indicated, it often is performed with an anesthetic (e.g. bupivacaine) that possesses a different duration of action than that used for the first block (e.g. lidocaine). Care must be taken to limit the volume of the injection to 0.5 ml to avoid spread to structures other than the intended medial branch nerve. If maximal relief of pain is rated at greater than 50% by the patient as documented in the pain diary during at least a portion of the following 24 hours after each block, and the described duration of relief of pain and functional improvement following each injection appropriately correlates with the typical duration of the local anesthetic used, then the diagnosis of paravertebral facet pain can reasonably be made.

Steroid shall not be included in the diagnostic block of the facet nerve or joint, as it may ablate the variation in the duration of the response to the two local anesthetics.

Exemption from limitation on diagnostic blocks of two per year per level:

Note that if a patient has undergone diagnostic blockade with or without either steroid or RF therapeutic intervention at a given level, and then is referred to another physician, the second physician may contemplate application of the alternative therapeutic intervention at the same level. The second physician may in this case determine that diagnostic injections are appropriate prior to proceeding with therapeutic intervention and therefore would not be limited by the fact that the first physician performed one or two diagnostic injections. This allowance would not apply to any physicians who are

partners or employees of the same entity.

If a block needs to be discontinued and was not completed (e.g. patient complication, vaso-vagal reaction, vascular injection, etc.), the provider should, depending on the circumstances involved apply the appropriate "-52 (reduced services)" or "-53 (discontinued procedure)" modifier to the facet (CPT) injection code. Such a procedure would not be counted against the limit of total number of procedures allowed each year.

Therapeutic interventions:

Therapeutic interventions are performed only after the diagnosis of lumbar paravertebral facet joint related pain is established via the technique of diagnostic blocks as noted above and are intended to provide long-term relief via denervation of the joint and/or the medial branch nerve. Therapeutic blocks consist of the injection of anesthetic and corticosteroid substances, alcohol, phenol, cryoablation, or radiofrequency thermal denervation for the long-term denervation of the joint(s) and/or nerve(s) and control (palliation) of pain. In some cases, repetitive therapeutic blocks are a reasonable approach to palliate pain in patients who are not candidates for other means of denervation or when such therapy is unavailable or not desired by the patient. Such therapeutic blocks shall not be performed more frequently than twice per year for any one medial branch nerve or joint, and shall not be performed if significant relief from previous therapeutic procedure at that site did not last at least 3 months, as determined by evidence in the medical record of improved function and decreased requirement for analgesics, as well as patient-perceived relief in pain intensity of greater than 50%. Therapeutic blocks must be performed with either CT or fluoroscopic guidance. Permanent fluoroscopic or CT images (a minimum of two views, the

quality of which shall be sufficient to allow identification of pertinent anatomic structures and location of the needle at its intended target) shall be made and retained to portray the needle location prior to injection or thermal radiofrequency ablation. The image shall be kept in the patient's medical record.

Therapeutic intra-articular joint injections may include steroid, alcohol or phenol. The injectate should not be of greater volume than 0.5cc in order to avoid overfilling the joint space, except in the event that the target of the injection is an intra-articular cyst. If this is so, then images on CT or MRI scanning must document that finding. If an intra-articular cyst is present and apparently generating pain, then a larger volume of medication may be used in an effort to rupture the cyst.

Radiofrequency (RF) denervation of facet joint nerves should be a consideration for patients who obtain greater than 50% pain relief and functional (e.g., range of motion) benefit from diagnostic blocks. In the case of RF denervation, appropriate electrical testing must be performed to assure safety in performing subsequent thermal denervation in the same tested needle position. After the radiographic position of the RF cannulae is verified to be optimal, but prior to generating the RF lesion, electrical stimulation in frequencies to affect both sensory and motor nerves will be performed to exclude a cannula position that would likely damage the adjacent spinal nerve. Conventional (e.g., 80°C) or other thermal (e.g., 67°C) radiofrequency ablation of the medial branch nerves to the facet joint should be performed only when previous diagnostic or therapeutic injections of the joint or corresponding medial branch nerves have provided temporary relief in excess of 50% of the patient's baseline pain or that elicited by the maneuvers noted above.

RF neurotomy must be performed using a parallel

trajectory to the nerve with an adequate lesion volume generated to incorporate the target nerve in its known anatomic location. In rare cases, a thermal radiofrequency block may not work despite apparently correct needle placement and the block may need to be repeated. It is possible that a patient who did not respond to RF would respond to corticosteroid injection at the medial branch nerves, and vice-versa.

Limitations

The maximum number of interventions possible would be:

A. DIAGNOSTIC: 1 or 2 intra-articular non-steroid injections, **OR** 1 or 2 non-steroid diagnostic MBB of each nerve (the two nerves injected for each joint would be considered one billable event);

B. THERAPEUTIC: 1 therapeutic joint injection (with steroid, phenol or alcohol) **OR** 1 therapeutic MBB (same substances); **AND** up to 2 RF lesionings per each nerve at each level per annum. If a therapy is successful, further use of that therapy would be limited to two interventions per annum, and no other therapy would be attempted, without prior authorization by the Carrier

Once a diagnostic paravertebral facet joint (medial branch) nerve block is negative at a specific level, or if therapeutic interventions do not effect greater than 50% relief in the patient's pain, then no repeat interventions may be directed at that level unless there is a new clinical presentation with symptoms, signs, and diagnostic studies that implicate that level. A diagnostic block is 'negative' if does not obtain greater than 50% relief of pain and improved function after the block, in accordance with the temporal expectation of the local anesthetic

used.¹

Injections into the paravertebral musculature shall NOT be billed as facet joint nerve blocks. These constitute trigger point injections, and might be billed as such, if appropriate.

Intra-articular injections (IAs) are not diagnostic for facet nerve (MB) dysfunction and response to IAs cannot be used to justify RF of the nerve.

Injections performed in any location without fluoroscopic or CT guidance shall NOT be billed using the facet injection CPT codes or facet joint neurolysis codes (64622-64627). Fluoroscopic or CT guidance is necessary to ascertain proper placement of the needle tip for facet joint nerve injections. Maintenance of detailed records (including retention of images as detailed above) documenting the use of fluoroscopic or CT guidance with each patient is mandatory and such records must be made available to CMS upon request. Failure to use and document fluoroscopic or CT guidance will subject claims to denial upon post-payment review.

Therapeutic lumbar paravertebral facet joint (medial branch) nerve blocks exceeding three levels on one side (six levels maximum, if both sides are done) will receive no additional payment above that for three levels of therapy.

Note: Each facet joint is supplied by two medial branch nerves (or the L5 dorsal ramus nerve for the L5-S1 facet joint). One nerve originates from above and one from below (or "at") each facet joint (level). Therefore, blocking one facet joint (level) requires two injections.

¹ Cohen SP et al. Lumbar zygapophysial (facet) joint radiofrequency denervation success as a function of pain relief during diagnostic medial branch blocks: a multicenter analysis. *The Spine J.* 2008; 8:498-504.

Despite the fact that 2 anesthetic injections are required to block one joint level, only one facet joint injection code shall be billed. However, for the facet neurolysis CPT codes (64622-64627) each nerve treated (each neurolysis) should be billed.

Multiple paravertebral facet nerve blocks administered over a period of several weeks or months not in accordance with the requirements for diagnostic and therapeutic blockade outlined above is not an effective method of chronic pain management and will be denied as not medically necessary.

Repeat therapeutic paravertebral nerve blocks at the same level, in the absence of a prior response demonstrating greater than 50% relief of pain by patient self-assessment, decreased analgesic use **and** improved function lasting at least 90 days, will be denied as not medically necessary.

A lumbar epidural (62311), lumbar transforaminal epidural (64483, 64484), sacroiliac joint injection (27206), trigger point injection of the lumbar musculature (20552, 20553), or lumbar sympathetic block (64520) shall not be performed on the same day as lumbar facet joint or facet joint nerve therapies or diagnostic injections. Concomitantly applied therapy not supported by evidence in the medical record of a pain problem separate, distant from and in addition to the facet-generated pain will be denied as not medically necessary. Furthermore, only one type of a block or injection (i.e., diagnostic-short acting local anesthetic, diagnostic-long acting anesthetic, therapeutic-steroid or therapeutic-RF) shall be performed at any facet level in a single day ("session") so that the effectiveness of its treatment can be assessed before attempting another type of spinal block or injection. Steroid or RF injections at any given level shall not be followed by any therapy at that level

within 30 days, to allow the effectiveness of the therapy to be evaluated.

All injections and RF must be followed by evaluation of the patient's functional status, in addition to the monitoring of self-evaluations of pain level (e.g., Visual Analog Scores). Patients undergoing therapeutic facet interventions shall be at minimum evaluated socially with one or more of the following: direct physician examination of the patient performed during passive and active physical maneuvers that elicited pain rated higher than 5/10 scale prior to the intervention, standardized and validated psychological testing, Oswestry Disability Index or equivalent tool, measurement of alternative care consumption (health care office visits, analgesic consumption, Emergency Department visits, hospital admissions), or physical and occupational therapist evaluations. Note that the patient need not return to the physician's office in order to meet this obligation. Rather, a phone interview with the physician or her/his designee in which the patient rates his/her pain with provocative maneuvers would be sufficient to meet this requirement, as long as it were done 30 days or more post intervention.

These evaluations must reveal a pattern of steady and sustained improvement, or that treatment course shall not be continued. Such evaluations shall be made at least 30 days after the intervention's performance and recorded in such a way as the provider is able to evaluate and record the experience of each patient through time and also the practitioner's collective patient experience with various therapies.

Noridian highly recommends that the practitioner maintain a record of patient outcomes in a relational database, either on site or, if available, as part of a regional or national, multi-practice outcomes registry

(database). The practitioner's data from such a registry shall be made available to the Carrier for auditing of therapeutic efficacy upon request. Patients that do not cooperate with follow-up or are non-compliant with treatment shall not receive further facet interventions and such interventions will be denied as not medically necessary, unless there is clear documentation in the medical record to justify or explain the lack of compliance (e.g. hospitalizations, family illnesses, socio-economic issues, etc.).

Currently, the medical literature does not support the efficacy or safety of ultrasound (US) guidance or magnetic resonance imaging (MRI) guidance in the performance of diagnostic or therapeutic facet procedures (joint injections, facet nerve blocks, RF neurotomies, etc.) and therefore facet intervention utilizing these imaging modalities will not be covered or paid separately.

Any injections performed without appropriate radiographic guidance shall be billed as, and will be paid as, trigger point injections (CPT codes 20552, 20553), assuming the appropriate documentation justifies the coding and reimbursement of the procedure performed.

They shall not be billed with a -52 modifier as "reduced services."

Any procedure performed that does not meet the "Indications and Limitations of Coverage and/or Medical Necessity" section outlined in this policy shall not be covered.

Any procedure performed on a beneficiary that lacks a diagnosis listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy shall not be covered.

Coverage Topic	<p>Doctor Office Visits Hospital Care (Inpatient) Outpatient Hospital Services</p>
Bill Type Codes	<p>999x Not Applicable</p>
Revenue Codes	
CPT/HCPCS Codes	<p>Italicized and/or quoted material is excerpted from the American Medical Association <i>Current Procedural Terminology (CPT)</i> codes.</p> <p>CPT/HCPCS Codes for Paravertebral Facet Joint Nerve Injections</p> <p>64475 INJECTION, ANESTHETIC AGENT AND/OR STEROID, PARAVERTEBRAL FACET JOINT OR FACET JOINT NERVE; LUMBAR OR SACRAL, SINGLE LEVEL</p> <p>64476 INJECTION, ANESTHETIC AGENT AND/OR STEROID, PARAVERTEBRAL FACET JOINT OR FACET JOINT NERVE; LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</p> <p>64622 DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; LUMBAR OR SACRAL, SINGLE LEVEL</p>

	<p>64623 DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)</p>
<p>Does the CPT 30% Coding Rule Apply?</p>	<p>No</p>
<p>ICD-9 Codes that Support Medical Necessity</p>	<p>It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.</p> <p>These ICD-9-CM codes apply to the CPT/HCPCS Codes 64470, 64472, 64475, 64476, 64622, 64623, 64626, and 64627.</p>

720.0 ANKYLOSING SPONDYLITIS

721.3 LUMBOSACRAL SPONDYLOSIS WITHOUT
MYELOPATHY

721.42 SPONDYLOSIS WITH MYELOPATHY
LUMBAR REGION

724.2 LUMBAGO

724.5 Lumbar pain of vertebral origin

738.4 ACQUIRED SPONDYLOLISTHESIS

847.2 LUMBAR SPRAIN

Diagnoses that Support Medical Necessity	N/A
ICD-9 Codes that DO NOT Support Medical Necessity	All those not listed under the "ICD-9 Codes that Support Medical Necessity" section of this policy.
Non-Medical Necessity ICD-9 Codes Asterisk Explanation	
Diagnoses that DO NOT Support Medical Necessity	Conditions that are not listed in the "ICD-9-CM Codes that Support Medical Necessity" section of this policy.

Documentation Requirements

1. All documentation, including permanent radiographic images with the patient's identification information and date imbedded in the image, must be maintained in the patient's medical record and available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.
3. The submitted medical record must support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. The drugs injected, the doses used, the site of the injection and the response must all be documented in the patient's medical record.

Specific Documentation Requirements for Lumbar Paravertebral Facet Joint Injections:

1. The patient's medical record must indicate the medical necessity of services for each date of service billed. This must include the patient's history (complete pain history and inclusion of failed conservative measures), physical examination and adequate follow-up documentation specific to patient response to the nerve blocks. Assessment of patient's response must include detailed information about use of analgesics, other therapeutic interventions (including visiting other physician offices and emergency room visits

	<p>seeking pain relief), and appropriate functional changes (such as return to work, improved ambulation, improved physical stamina, etc.).</p> <ol style="list-style-type: none"> 2. The pre-procedure evaluation leading to suspicion of the presence of the facet joint pathology must be explicitly documented in the patient's medical record along with the post procedure conclusions. All documentation must be available to Medicare upon request. 3. For subsequent treatments of facet joint nerves (therapeutic injections or RF treatments), the documentation in the medical record must show the benefits received from the prior set(s) of diagnostic or therapeutic injections, as detailed above. 4. Indication that noninvasive treatments (i.e. rest, physical therapy, NSAIDs, etc.) have been tried and were unsuccessful or contraindicated.
<p>Appendices</p>	<p>N/A</p>
<p>Utilization Guidelines</p>	<p>In accordance with CMS Ruling 95-1 (V), utilization of these services must be consistent with locally acceptable standards of practice.</p> <p>Evidence-based practice guidelines indicate the following descriptions of the frequency of paravertebral facet joint nerve blocks:</p>

Paravertebral Facet Joint Nerve Blocks

Diagnostic No more than 3 levels per session, no more than 2 sessions per spinal level per year and with sessions at least 1-2 weeks apart.

Therapeutic: No more than 2 RF procedures per nerve per 12 months, with repetition only allowed if there is a 50% pain relief for the greater portion of 2 weeks, as well as recorded evidence of improved function and decreased consumption of analgesics and other treatments, following the preceding procedure.

Therapeutic: Two steroid injections per side per maximum number spinal level per year. If a patient at first responds to steroid blockade and then repeat injections fail, two RF lesioning sessions per level may still be applied in the same year, but no further steroid injections may be applied at that level.

Paravertebral facet joint nerve therapeutic blocks in excess of more than (2) injections/side/per spinal level/per year will be reviewed on an individual consideration basis.

	<p>This contractor may request records when it is apparent that patients are requiring a significant number of injections to manage their pain.</p>
<p>Sources of Information and Basis for Decision</p>	<ol style="list-style-type: none"> 1. American Medical Association; CPT 2000 code and guideline changes: A comprehensive review. CPT Assistant. Nov.1999; 9 (11). 2. Bogduk N, Macintosh J, Marsland J. Technical limitations to the efficacy of radiofrequency neurotomy for spinal pain. Neurosurgery 20:529-535, 1987 3. Datta S,, Lee M, MD, Frank Falco F, Bryce DA, Hayek SM, Systematic Assessment of Diagnostic Accuracy and Therapeutic Utility of Lumbar Facet Joint Interventions 12;437-460,2009 4. Lau P, Mercer S, Govind J, Bogduk N. The surgical anatomy of lumbar medial branch neurotomy (facet denervation). Pain Med 2004; 5:289-298 5. International Spine Intervention Society. Lumbar medial neurotomy. In: Bogduk N (ed). Practice Guidelines for Spinal Diagnostic and Treatment Procedures. International Spinal Intervention Society, San Francisco, 2004 pp 186-218. 6. International Spine Intervention Society. Lumbar medial branch blocks. In: Bogduk N (ed). Practice Guidelines for Spinal Diagnostic and Treatment Procedures. International Spinal Intervention Society, San Francisco, 2004 pp 47-65. 7. Schwarzer AC, Aprill CN, Derby R, Fortin J, Kine G, Bogduk N. The false-positive rate of uncontrolled diagnostic blocks of the lumbar zygapophysial joints. Pain 1994; 58:195-200. 8. Kaplan M, Dreyfuss P, Halbrook B, Bogduk N. The ability of lumbar medial branch blocks to anesthetize the zygapophysial joint. Spine 1998; 23:1847-1852. 9. Dreyfuss P, Schwarzer AC, Lau P, Bogduk N. Specificity of lumbar medial branch and L5 dorsal ramus blocks: a computed tomographic study. Spine 1997; 22:895-902. 10. Schofferman J, Kine G. Effectiveness of repeated radiofrequency neurotomy for lumbar facet pain. Spine 2004; 29:2471-2473.

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18. Boswell MV A systematic review of therapeutic facet joint interventions in chronic spinal pain. *Pain Physician* - 01-JAN-2007; 10(1): 229-5.
19. Wasan AD. Psychopathology predicts the outcome of medial branch blocks with corticosteroid for chronic axial low back or cervical pain: a prospective cohort study. *BMC Musculoskelet Disord* 2009; 10: 22.

Advisory Committee Meeting Notes	<p>This policy does not reflect the sole opinion of the contractor or Contractor Medical Directors. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from the appropriate specialties.</p> <p>CAC Distribution:</p>
Start Date of Comment Period	
End Date of Comment Period	
Start Date of Notice Period	
Revision History Number	
Revision History Explanation	
Reason for Change	<p>Coverage Change (actual change in medical parameters)</p> <p>Narrative Change</p>
Last Reviewed on Date	

Notes	
Does this LCD contain a "Least Costly Alternative" provision?	No
Related Documents	This LCD has no Related Documents.
LCD Attachments	Please see flow chart that follows.
Draft Contact	
Draft Approved for Display to Public on Front End	No
Saved By	
Saved On	
Other Versions	

ASA Proposed LCD