

Pain Management

1. MCG Criteria Used

Clinical Criteria: MCG Care Guidelines, 30th Edition

- Facet Joint Injection (MCG ORG: A-0695 AC, 30th Edition)
- Epidural Corticosteroid Injection (MCG ORG: A-0225 AC, 30th Edition)

Applicable CPT / HCPCS Codes:

CPT / HCPCS Code	Description
64490-64495	Paravertebral facet joint or facet joint nerve injection, cervical/thoracic and lumbar/sacral, with image guidance, single and additional levels
0213T-0218T	Paravertebral facet joint injection with ultrasound guidance (emerging technology codes)
62320-62327	Injection of diagnostic or therapeutic substance into the epidural space, cervical/thoracic and lumbar/sacral, with or without imaging guidance
64479-64484	Transforaminal epidural injection of anesthetic and/or steroid, cervical/thoracic and lumbar/sacral, including each additional level
77003	Fluoroscopic guidance and localization for spinal injection procedures
72240-72270	Myelography or imaging of the spine when performed to characterize pathology before injection

2. Statement of Rationale

Akido Labs uses the criteria in MCG Care Guidelines (30th Edition) to supplement the general Medicare criteria regarding interventional pain management procedures, specifically facet joint injection and epidural corticosteroid injection for spinal pain, where Medicare coverage criteria are not fully established or require additional clinical specificity. MCG criteria are used to ensure consistency in reviewing the conditions to be met for coverage of pain management procedures and to determine when such services are medically necessary. Interventional spinal pain procedures in the Medicare Advantage population are common and carry both procedural risk and the risk of overuse. Repeated injections without an evidence-based indication expose older patients to corticosteroid effects, bleeding in the setting of anticoagulation, infection, and the deferral of more appropriate treatment, while inappropriate denial can prolong disabling pain and delay confirmation of a pain generator before definitive treatment. Absent consistent, evidence-based criteria, there is material risk of both inappropriate denial of medically necessary procedures and inappropriate approval of procedures that are not indicated.

Potential Clinical Harms:

Facet joint injection: Inappropriate denial of a diagnostic facet joint or medial branch block in a patient with chronic spinal pain who is a candidate for facet neurotomy could prevent confirmation of the facet joint as the pain generator, delaying definitive treatment. Conversely, inappropriate approval of facet injection in a patient who does not meet criteria, or repeated injection without a diagnostic rationale, exposes the patient to procedural risk and corticosteroid exposure without benefit and may defer more appropriate care.

Epidural corticosteroid injection: Inappropriate denial of epidural corticosteroid injection for cervical or lumbar radicular pain that has failed noninvasive treatment could prolong radicular pain and neurologic symptoms. Inappropriate approval of epidural injection in a patient with coagulopathy, local infection, or without failure of noninvasive treatment, or repeated beyond an effective course, exposes the patient to bleeding, infection, and corticosteroid-related risk.

Clinical Benefits:

Facet joint injection: MCG criteria require a diagnostic block to confirm the facet joint as the source of spinal pain in patients who are candidates for facet neurotomy, with chronic spinal pain of at least a defined duration and the use of dual diagnostic blocks to establish the diagnosis. By requiring an objective diagnostic rationale, these criteria directly mitigate the harm of unconfirmed pain generators and unnecessary repeated injection identified above.

Epidural corticosteroid injection: MCG criteria reserve epidural corticosteroid injection for cervical or lumbar radicular pain after failure of noninvasive treatment, in the absence of coagulopathy, local infection, and other contraindications. This evidence-based selection directly counters both the harm of prolonged radicular pain in appropriate candidates and the harm of bleeding, infection, and corticosteroid exposure in patients who do not meet criteria. The clinical benefits of using MCG Care Guidelines are highly likely to outweigh any clinical harms, including delayed or decreased access to services, because the criteria incorporate diagnostic and treatment-failure thresholds drawn from current specialty society guidelines and are unlikely to lead to inappropriate denials.

3. Explanation of Supplementation

Basis for Use: Original Medicare clinical criteria are not fully established and require supplementation to ensure consistent medical necessity determinations for interventional pain management procedures, specifically facet joint injection and epidural corticosteroid injection. While Medicare statutes establish the general 'reasonable and necessary' standard, they do not fully specify the clinical indications and thresholds (e.g., the diagnostic-block requirement and chronicity criteria for facet injection, and the radicular pain and treatment-failure criteria for epidural injection) required to distinguish indicated from nonindicated procedures.

Applicable Medicare References: Social Security Act Section 1862(a)(1): 'Reasonable and necessary' standard Code of Federal Regulations: 42 CFR 410.32 (diagnostic tests); 42 CFR 419.22; 42 CFR 422.101 Medicare Benefit Policy Manual, Chapter 15: Covered Medical and Other Health Services (CMS IOM Publication 100-02) Medicare Program Integrity Manual, Chapter 6, Section 6.5 (CMS IOM Publication 100-08) Medicare Coverage Database: <https://www.cms.gov/medicare-coverage-database/search.aspx> For facet joint injection and epidural corticosteroid injection, no specific NCD or LCD fully establishes clinical procedural thresholds; Original Medicare criteria are not fully established for these services, requiring supplementation. Within the above statutes and regulations, MCG criteria assist in determining the appropriateness of diagnostic facet joint injection in candidates for facet neurotomy, and of epidural corticosteroid injection for radicular pain after failed noninvasive treatment; the appropriate number and interval of injections; and the presence of contraindications. Use of these

criteria helps ensure pain management procedures are not incorrectly denied when medically appropriate, nor incorrectly approved when not reasonable and necessary, and may decrease inappropriate denials by creating a consistent set of evidence-based review criteria.

4. Summary of Clinical Evidence

Note: The following evidence summary is derived directly from MCG Care Guidelines, 30th Edition (guidelines A-0695 and A-0225). The reference lists below are drawn from those respective MCG guidelines.

Background

Facet Joint Injection (MCG ORG: A-0695 AC) Facet joint injection, including medial branch nerve block and intra-articular injection, is an ambulatory procedure used primarily as a diagnostic block to confirm the facet joint as the source of spinal pain in patients who are candidates for facet neurotomy. Dual diagnostic blocks are necessary to diagnose facet pain. Indications require chronic spinal pain of at least a defined duration that has not responded to conservative care.

Epidural Corticosteroid Injection (MCG ORG: A-0225 AC) Epidural corticosteroid injection is an ambulatory procedure indicated for cervical or lumbar radicular pain after failure of noninvasive treatment, in the absence of coagulopathy, local infection at the injection site, and other contraindications. It is delivered by interlaminar or transforaminal approach, typically with imaging guidance.

Evidence Summary

Facet Joint Injection (MCG ORG: A-0695 AC) The evidence for the clinical indications in this guideline (30th Edition) includes published peer-reviewed articles and specialty society guidance. Key evidence establishes that the primary role of facet joint injection is to diagnose facet joint pain and determine whether a patient is a candidate for facet neurotomy, and that controlled diagnostic block evidence supports the requirement for dual diagnostic blocks to reduce false-positive diagnoses.

Epidural Corticosteroid Injection (MCG ORG: A-0225 AC) The evidence for the clinical indications in this guideline (30th Edition) includes published peer-reviewed articles and specialty society guidance. Key evidence supports the use of epidural corticosteroid injection for radicular pain after failure of noninvasive treatment, the importance of screening for coagulopathy and infection before the procedure, and the limitation of injections to an effective course.

Rationale (from MCG) Use of these MCG care guidelines helps the clinician identify patient-specific clinical factors that establish the medical necessity of interventional pain management procedures. The evidence-based clinical criteria ensure patients receive the most appropriate care for their specific condition, reduce unnecessary risks including procedural and corticosteroid-related harm, and provide a standard that can reduce disparities in care. These guidelines supplement but do not replace, modify, or supersede existing Medicare regulations or applicable NCDs or LCDs.

Related CMS Coverage Guidance (as cited in MCG 30th Edition): Code of Federal Regulations (CFR): 42 CFR 419.22; 42 CFR 422.101; CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 15; CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6, Section 6.5; Medicare Coverage Database: <https://www.cms.gov/medicare-coverage-database/search.aspx>

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5. Public Accessibility

Transparency Tool URL: <https://akido.access.mcg.com/index>

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