

## Aetna Injection Policy For Back Pain

**Number: 0016**

### **Policy**

Aetna considers *any* of the following injections or procedures medically necessary for the treatment of back pain; provided, however, that *only 1* invasive modality or procedure will be considered medically necessary at a time.

1. Facet joint injections (intraarticular and medial branch blocks) are considered medically necessary in the diagnosis of facet pain in persons with chronic back or neck pain (pain lasting more than 3 months despite appropriate conservative treatment).

Facet joint injections (intraarticular and medial branch blocks) are considered experimental and investigational as therapy for back and neck pain and for all other indications because their effectiveness for these indications has not been established.

A set of facet joint injections (intraarticular or medial branch blocks) means up to 6 such injections per sitting, and this can be repeated once to establish the diagnosis. Additional sets of facet injections or medial branch blocks are considered experimental and investigational because they have no proven value.

2. Trigger point injections of corticosteroids and/or local anesthetics, are considered medically necessary for treating members with chronic neck or back pain or myofascial pain syndrome, when *all* of the following selection criteria are met:
  1. Conservative therapies such as bed rest, exercises, heating or cooling modalities, massage, and pharmacotherapies such as non-steroidal anti-inflammatory drugs, muscle relaxants, non-narcotic analgesics, should have been tried and failed, *and*
  2. Symptoms have persisted for more than 3 months, *and*
  3. Trigger points have been identified by palpation; *and*
  4. Trigger point injections are not administered in isolation, but are provided as part of a comprehensive pain management program, including physical therapy, patient education, psychosocial support, and oral medication where appropriate.

Trigger point injections are considered experimental and investigational for all other indications because their effectiveness for indications other than the ones

listed above has not been established.

A trigger point is defined as a specific point or area where, if stimulated by touch or pressure, a painful response will be induced. A set of trigger point injections means injections in several trigger points in one sitting. It is not considered medically necessary to repeat injections more frequently than every 7 days. Up to 4 sets of injections are considered medically necessary to diagnose the origin of a patient's pain and achieve a therapeutic effect; additional sets of trigger point injections are not considered medically necessary if no clinical response is achieved. Once a diagnosis is established and a therapeutic effect is achieved, it is rarely considered medically necessary to repeat trigger point injections more frequently than once every 2 months. Repeated injections extending beyond 12 months may be reviewed for continued medical necessity.

3. Sacroiliac joint injections are considered medically necessary to relieve pain associated with lower lumbosacral disturbances in members who meet *both* of the following criteria:
  1. Member has back pain for more than 3 months; *and*
  2. The injections are not used in isolation, but are provided as part of a comprehensive pain management program, including physical therapy, patient education, psychosocial support, and oral medication where appropriate.

Sacroiliac joint injections are considered experimental and investigational for all other indications because their effectiveness for indications other than the ones listed above has not been established.

Up to 2 sacroiliac injections are considered medically necessary to diagnose the patient's pain and achieve a therapeutic effect. It is not considered medically necessary to repeat these injections more frequently than once every 7 days. If the member experiences no symptom relief or functional improvement after 2 sacroiliac joint injections, additional sacroiliac joint injections are not considered medically necessary. Once the diagnosis is established, it is rarely medically necessary to repeat sacroiliac injections more frequently than once every 2 months. Repeat injections extending beyond 12 months may be reviewed for continued medical necessity.

4. Epidural injections of corticosteroid preparations (e.g., Depo-Medrol), with or without added anesthetic agents, are considered medically necessary in the outpatient setting for management of persons with radiculopathy or sciatica when *all* of the following are met:
  1. Intraspinal tumor or other space-occupying lesion, or non-spinal origin for pain, has been ruled out as the cause of pain; *and*
  2. Member has failed to improve after 2 or more weeks of conservative measures (e.g., rest, systemic analgesics and/or physical therapy); *and*

3. Epidural injections beyond the first set of 3 injections are provided as part of a comprehensive pain management program, which includes physical therapy, patient education, psychosocial support, and oral medications, where appropriate.

Epidural injections of corticosteroid preparations, with or without added anesthetic agents, are considered experimental and investigational for all other indications (e.g., non-specific low back pain [LBP] and failed back syndrome) because their effectiveness for indications other than the ones listed above has not been established.

Repeat epidural injections beyond the first set of 3 injections are considered medically necessary when provided as part of a comprehensive pain management program, which includes physical therapy, patient education, psychosocial support, and oral medications, where appropriate. Repeat epidural injections more frequently than every 7 days are not considered medically necessary. Up to 3 epidural injections are considered medically necessary to diagnose a member's pain and achieve a therapeutic effect; if the member experiences no pain relief after three epidural injections, additional epidural injections are not considered medically necessary. Once a therapeutic effect is achieved, it is rarely medically necessary to repeat epidural injections more frequently than once every 2 months. In selected cases where more definitive therapies (e.g., surgery) can not be tolerated or provided, additional epidural injections may be considered medically necessary. Repeat injections extending beyond 12 months may be reviewed for continued medical necessity.

See also [CPB 0722 - Selective Nerve Root Blocks](#)

5. Chymopapain chemonucleolysis is considered medically necessary for the treatment of sciatica due to a herniated disc when *all* of the following are met:
  1. Member has leg pain worse than low back pain; *and*
  2. Member has radicular symptoms reproduced by sciatic stretch tests; *and*
  3. Member has only a single level herniated disc with nerve root impingement at clinically suspected level demonstrated by MRI, CT, or myelography; *and*
  4. Member has objective neurologic deficit (e.g., diminished deep tendon reflex, motor weakness, or hypalgesia in dermatomal distribution); *and*
  5. Pain not relieved by at least 6 weeks of conservative therapy.

Chymopapain chemonucleolysis is considered experimental and investigational for all other indications, including the following because its effectiveness for these indications has not been established:

6. Acute LBP alone
7. Cauda equina syndrome
8. For herniated thoracic or cervical discs

9. Multiple back operations (failed back surgery syndrome)
  10. Neurologic disease (e.g., multiple sclerosis)
  11. Pregnancy
  12. Profound or rapidly progressive neurologic deficit
  13. Sequestered disc fragment
  14. Severe spinal stenosis
  15. Severe spondylolisthesis
  16. Spinal cord tumor
  17. Spinal instability
  18. When performed with chondroitinase ABC or agents other than chymopapain
6. Percutaneous lumbar discectomy, manual or automated, is considered medically necessary for treatment of herniated lumbar discs when *all* of the following are met:
1. Member is otherwise a candidate for open laminectomy; *and*
  2. Member has failed 6 months of conservative management; *and*
  3. Diagnostic studies show that the nuclear bulge of the disc is contained within the annulus (i.e., the herniated disc is contained); *and*
  4. Member has no previous surgery or chemonucleolysis of the disc to be treated; *and*
  5. Member must have typical clinical symptoms of radicular pain corresponding to the level of disc involvement.

Percutaneous lumbar discectomy is considered experimental and investigational for all other indications because its effectiveness for indications other than the one listed above has not been established.

Note: Clinical studies have not established any clinically significant benefit of use of a laser over use of a scalpel for percutaneous lumbar discectomy.

7. Non-pulsed radiofrequency facet denervation (also known as facet neurotomy, facet rhizotomy, or articular rhizolysis) is considered medically necessary for treatment of members with intractable cervical or back pain with or without sciatica in the outpatient setting when *all* of the following are met:
1. Member has experienced severe pain limiting activities of daily living for at least 6 months; *and*
  2. Member has had no prior spinal fusion surgery; *and*
  3. Neuroradiologic studies are negative or fail to confirm disc herniation; *and*
  4. Member has no significant narrowing of the vertebral canal or spinal instability requiring surgery; *and*
  5. Member has tried and failed conservative treatments such as bed rest, back supports, physiotherapy, correction of postural abnormality, as well as pharmacotherapies (e.g., anti-inflammatory agents, analgesics and muscle relaxants); *and*

6. Trial of facet joint injections has been successful in relieving the pain.

Non-pulsed radiofrequency facet denervation is considered experimental and investigational for all other indications because its effectiveness for indications other than the ones listed above has not been established.

Only 1 treatment procedure per level per side is considered medically necessary in a 6-month period.

See also [CPB 0735 - Pulsed Radiofrequency](#).

8. Implantable infusion pumps are considered medically necessary when used to administer drugs (e.g., morphine and ziconotide) intrathecally or epidurally for treatment of severe chronic intractable pain of malignant or non-malignant origin in members with life expectancies of more than 3 months who have proven unresponsive to less invasive medical therapy as determined by the following criteria:
  1. Member's history must indicate that he/she would not respond adequately to non-invasive methods of pain control, such as systemic opioids (including attempts to eliminate physical and behavioral abnormalities which may cause an exaggerated reaction to pain); *and*
  2. A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary intrathecal/epidural catheter to substantiate adequately acceptable pain relief, the degree of side effects (including effects on the activities of daily living), and member's acceptance.

Implantable infusion pumps for intrathecal or epidural infusion of opioids and ziconotide are considered experimental and investigational for all other indications because their effectiveness for indications other than the one listed above has not been established. (Note: Currently, morphine and ziconotide are the only FDA-approved analgesics for long-term intrathecal infusion [Turk et al, 2011]).

9. Pedicle screws for spinal fixation are considered medically necessary for the following indications:
  1. Fusion adjacent to prior lumbar fusion
  2. Fusion after decompression
  3. Pseudoarthrosis repair
  4. Revision lumbar disc surgery requiring instrumentation because of instability at the previous level of surgery
  5. Scoliosis and kyphosis requiring spinal instrumentation
  6. Segmental defects or loss of posterior elements following tumor resection
  7. Spinal trauma of all types including fractures and dislocations
  8. Spondylolisthesis -- grades I to IV

## 9. Thoracic fractures

Pedicle screw fixation is considered experimental and investigational for all other indications, including the following because its effectiveness for indications other than the ones listed above has not been established:

10. Decompressive laminectomy for spinal stenosis without evidence of instability
  11. Degenerative disc disease
  12. Failed lumbar surgery without documentation of instability pattern or pseudarthrosis
  13. First time intervertebral disc herniation
  14. Isolated low back pain without spinal instability or neurologic deficits
  15. Single level discectomy
10. Intervertebral body fusion devices (spine cages) (e.g., BAK Interbody Fusion System, carbon fiber cage, Ray Threaded Fusion Cage, STALIF stand-alone anterior lumbar fusion cage) are considered medically necessary for use with autogenous bone graft in members who meet criteria for spinal fusion as outlined in [CPB 0743 Spinal Surgery: Laminectomy and Fusion](#). Spine cages are considered experimental and investigational for all other indications because their effectiveness for indications other than the one listed above has not been established.
11. Percutaneous polymethylmethacrylate vertebroplasty (PPV) or kyphoplasty is considered medically necessary for members with persistent, debilitating pain in the cervical, thoracic or lumbar vertebral bodies resulting from *any* of the following:
1. Multiple myeloma; *or*
  2. Painful and/or aggressive hemangiomas; *or*
  3. Painful vertebral eosinophilic granuloma; *or*
  4. Painful, debilitating osteoporotic collapse/compression fractures (e.g., Kummell's disease); *or*
  5. Primary malignant neoplasm of bone or bone marrow; *or*
  6. Secondary osteolytic metastasis, excluding sacrum and coccyx; *or*
  7. Steroid-induced fractures

AND all of the following criteria have been met:

8. Other causes of pain such as herniated intervertebral disk have been ruled out by computed tomography or magnetic resonance imaging; *and*
9. Severe debilitating pain or loss of mobility that cannot be relieved by optimal medical therapy (e.g., acetaminophen, non-steroidal anti-inflammatory drugs [NSAIDS], narcotic analgesics, braces, physical therapy, etc.); *and*
10. The affected vertebra has not been extensively destroyed and is at least one-third of its original height.

12. Lateral (including extreme [XLIF], extra and direct lateral [DLIF]) interbody fusion is considered an acceptable method of performing a medically necessary anterior interbody fusion. See [CPB 0743 Spinal Surgery: Laminectomy and Fusion](#).

### Experimental and Investigational Interventions

Aetna considers *any* of the following injections or procedures experimental and investigational:

- Coccygeal ganglion (ganglion impar) block for coccydynia, pelvic pain, and all other indications;
- Dynamic stabilization (e.g., Dynesys Spinal System, Graf ligamentoplasty/Graf artificial ligament, and the Stabilimax NZ Dynamic Spine Stabilization System);
- Endoscopic laser foraminoplasty, endoscopic foraminotomy, laminotomy, and rhizotomy (endoscopic radiofrequency ablation);
- Epidural fat grafting during lumbar decompression laminectomy/discectomy;
- Epidural injections of lytic agents (e.g., hyaluronidase, hypertonic saline) or mechanical lysis in the treatment of adhesive arachnoiditis, epidural fibrosis, , failed back syndrome, or other indications;
- Epiduroscopy (also known as epidural myeloscopy, epidural spinal endoscopy, myeloscopy, and spinal endoscopy) for the diagnosis and treatment of intractable LBP or other indications;
- Facet chemodenervation/chemical facet neurolysis;
- Facet joint implantation;
- Far lateral microendoscopic discectomy (FLMED) for extra-foraminal lumbar disc herniations or other indications;
- Interlaminar lumbar instrumented fusion (ILIF);
- Inter-spinous and interlaminar distraction (e.g., the Aspen spinous process fixation system, the Coflex interlaminar stabilization spinal implant, the Coflex-F implant for minimally invasive lumbar fusion, Eclipse inter-spinous distraction device, ExtenSure bone allograft inter-spinous spacer, X-Stop device, and the TOPS System) for spinal stenosis or other indications;
- Khan kinetic treatment (KKT);
- Laser facet denervation;
- Microendoscopic discectomy (MED) procedure for decompression of lumbar spine stenosis, lumbar disc herniation, or other indications;
- Microsurgical anterior foraminotomy for cervical spondylotic myelopathy or other indications;
- Minimally invasive/endoscopic cervical laminoforaminotomy for cervical radiculopathy/lateral and foraminal cervical disc herniations or other indications;
- Minimally invasive lumbar decompression (MILD) procedure for lumbar canal stenosis or other indications;
- Minimally invasive transforaminal lumbar interbody fusion (MITLIF) for

- lumbar disc degeneration and instability or other indications;
- NuFix facet fusion;
- OptiMesh grafting system;
- Percutaneous endoscopic discectomy with or without laser (PELD) (also known as arthroscopic microdiscectomy or Yeung Endoscopic Spinal Surgery System [Y.E.S.S.]);
- Piriformis muscle resection;
- Racz procedure (epidural adhesiolysis with the Racz catheter) for the treatment of members with adhesive arachnoiditis, epidural adhesions, failed back syndrome from multiple previous surgeries for herniated lumbar disk, or other indications;
- Radiofrequency denervation for sacroiliac joint pain;
- Radiofrequency lesioning of dorsal root ganglia for back pain;
- Radiofrequency lesioning of terminal (peripheral) nerve endings for back pain;
- Radiofrequency/pulsed radiofrequency ablation of trigger point pain;
- Sacroiliac fusion or pinning for the treatment of LBP due to sacroiliac joint syndrome; Note: Sacroiliac fusion may be medically necessary for sacroiliac pain due to severe traumatic injury, where a trial of an external fixator is successful in providing pain relief;
- Sacroplasty for osteoporotic sacral insufficiency fractures and other indications;
- TruFuse facet fusion;
- Vesselplasty (e.g., Vessel-X);
- Xclose Tissue Repair System.

See also [CPB 0602 - Thermal Intradiscal Procedure](#).

Reimbursement Notes:

- *Laser*: Clinical studies have not established a clinically significant benefit of use of a laser over a scalpel in spinal surgery. No additional benefit will be provided for the use of a laser in spinal surgery.
- *Microscope and endoscope*: Use of a microscope or endoscope is considered an integral part of the spinal surgery and not separately reimbursable.

Regards,

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National Pain Institute CEO

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