519.21 PAIN MANAGEMENT SERVICES

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BACKGROUND

West Virginia Medicaid covers various medically necessary pain management procedures for chronic conditions. Other aspects of pain management such as monitoring for substance abuse, and drug screenings are addressed in *Chapter 529 Laboratory Services, Policy 529.2 Drug Screenings*; *Chapter 502, Behavioral Health Clinic*; *Chapter 503, Behavioral Health Rehabilitation*; *Chapter 521, Psychological Services*; *Chapter 536, Psychiatric Services*; and *Chapter 537, Licensed Independent Clinical Social Worker (LICSW) of* the BMS Provider Manual.

POLICY

519.21.1 COVERED SERVICES

West Virginia Medicaid utilizes the Centers for Medicare and Medicaid Services (CMS) pain management medical necessity criteria for these services, however**,** not all pain management services covered by Medicare are covered by West Virginia Medicaid. Refer to CMS' Local Coverage Determination (LCD) for Pain Management for West Virginia. At the time this rule was promulgated this LCD could be found here.

All covered services must be prior authorized before services are rendered. Covered services may be provided in the office, outpatient hospital, ambulatory surgical center, or pain management clinic settings by enrolled anesthesiologists, neurologists, and physicians with board certification in pain management.

The appropriate diagnosis and CPT procedure code(s) must be requested when submitting documentation to the Utilization Management Contractor (UMC) for prior authorization review. The same diagnosis and procedure codes must be documented on the CMS 1500 claim form or electronic claim form when submitting a claim to the BMS Fiscal Agent for payment consideration.

Fluoroscopic Guidance is also covered when medically necessary and failure of trigger point injections is documented. The need for fluoroscopic guidance, to assure correct needle placement and avoid nerve or other injury, must be documented for joint/nerve blocks or joint/nerve denervation. In addition, fluoroscopic guidance with appropriate CPT procedural codes for pain management modality and appropriate diagnosis codes must be submitted to the UMC when requesting authorization for covered pain management services. The same information must be documented on the CMS 1500 claim form submitted to the BMS Fiscal Agent for payment consideration. When this information is not provided to the UMC or is not included on the claim form, the fluoroscopy request or claim will be denied.

The member's medical record must contain documentation that fully supports the medical necessity of injections provided. This documentation includes, but is not limited to, relevant medical history, physical examination and results of pertinent diagnostic or therapeutic injections to substantiate the suspected diagnosis and fluoroscopic results.

519.21.1.1 Paravertebral Facet Joint/Nerve Blocks

Paravertebral joint/nerve injection is utilized as a diagnostic tool to determine whether a specific facet joint is responsible for chronic spinal pain. This service must be prior authorized before services are rendered. Diagnostic or therapeutic injections and/or nerve blocks may be required for the management of chronic

pain. Fluoroscopic guidance must be used for both diagnostic and therapeutic injections to assure the injection is properly placed.

Evidence-based practice guidelines indicate the frequency of diagnostic paravertebral facet blocks is a maximum of two procedures spaced up to two weeks apart. For therapeutic paravertebral facet blocks, a frequency of one every two months or greater is indicated, providing there is a 50% pain relief for six weeks. Therapeutic maximum limitation is four injections/spinal levels per year.

Repeat injections would be considered medically necessary only upon subsequent return of pain and deterioration in functional status. If pain returns after a satisfactory response it may be necessary to give a second injection on a different date of service to determine the etiology of the pain and effectiveness of the injection.

The bilateral modifier (-50) is required when submitting a claim for injections administered bilaterally at the same spinal level. Add-on codes must be used to identify additional spinal levels beyond the primary CPT code.

519.21.1.2 Paravertebral Facet Joint Denervation

Paravertebral facet joint denervation is the destruction of a paravertebral facet joint nerve by neurolytic agent (e.g., chemical, thermal, electrical, radiofrequency). This service must be prior authorized before services are rendered. Facet joint denervation may be considered if double-comparative paravertebral facet joint/nerve blocks do provide significant pain relief, but the pain relief is not long-lasting.

Denervation involves placing a needle or radiofrequency cannula adjacent to each of the two or more, medial branch nerves innervating the target joint(s).

The effects of denervation should last at least six months. In some instances, however, the effects may be permanent. Repeat denervation procedures at the same joint/nerve level will only be considered medically necessary when the member had significant improvement of pain after the initial facet joint nerve destruction that lasted an appropriate period of time (>/= to six months).

Medical documentation must demonstrate that the member's pain has been refractory to repeated attempts at medical management prior to paravertebral facet joint/nerve injections. In addition, the medical records must document a positive response to the injection for the joint being denervated. A positive response is defined as initial significant pain relief >/= 80%-90% with the ability to perform previously painful maneuvers.

519.21.1.3 Trigger Point Injections

Trigger point injection is one modality utilized in the management of chronic pain. This service must be prior authorized before services are rendered. Myofascial trigger points are self-sustaining hyperirritative foci that may occur in any skeletal muscle in response to strain produced by acute and chronic overload. These trigger points produce a referred pain pattern characteristic for that individual muscle. Injection is achieved with needle insertion and the administration of agents such as local anesthetics. Only one trigger point injection will be reimbursed on the same day, no matter how many sites or regions are injected.

For the treatment of established trigger point(s), the medical record must clearly document:

- The evaluation leading to the diagnosis of the trigger point in an individual muscle;
- Identification of the affected muscle(s); and,
- Reason for selecting the trigger point injection as a therapeutic option and whether it is being used as an initial or subsequent treatment for myofascial pain.

519.21.1.4 Injection of Tendon Sheaths, Ligaments, Ganglion Cysts, Carpal and Tarsal Tunnels

Injections into tendon sheaths, ligaments, ganglion cysts, carpal and tarsal tunnels is covered to provide relief of pain, reduce inflammation and relieve the resulting functional disability when more conservative measures have failed, are contraindicated or not appropriate. This service must be prior authorized before services are rendered.

Proper use of this modality should be part of an overall management plan including diagnostic evaluation in order to clearly identify and properly treat the primary cause. There should be a reasonable likelihood that injection will significantly improve the patient's pain and/or functional disability.

Injection of a carpal tunnel may be indicated for the patient with mild to moderate symptoms when pharmaceutical and other conservative measures have failed or are not otherwise indicated. Injection of the tarsal tunnel may be indicated for conservative management of tarsal tunnel syndrome.

When a given specific tendon, ligament, tunnel, or cyst is injected, it will be considered one injection service regardless of the number of injections administered at that specific anatomical location on a single date of service.

519.21.1.5 Epidural and Intrathecal Injections: Interlaminar and Caudal and Treatment of Spasticity

Epidural and intrathecal (epidural and subarachnoid) injections are utilized for acute and chronic pain, cancer pain management, and treatment of spasticity. Epidural and intrathecal injections are utilized both for diagnostic and therapeutic purposes. This service must be prior authorized before services are rendered.

The medical record should describe the presence of radicular pain or discogenic pain and the neuropathic diagnosis for the pain being treated. In addition, the medical record should indicate one or more of the following:

- Conservative management has failed unless the patient has acute disabling and debilitating pain;
- The patient is a candidate for surgery, but surgery is unacceptable to the patient or the patient is a poor surgical risk; and/or
- The epidural injection is being performed as a therapeutic adjunct to a conservative therapy program, to provide temporary relief and to facilitate a more aggressive rehabilitative program.

519.21.1.6 Epidural Injections - Transforaminal

Transforaminal epidural injection is a selective block of the cervical/thoracic, lumbar, or sacral nerve roots with proximal spread of contrast/local anesthetic through the neural foramen to the epidural space. This service must be prior authorized before services are rendered.

Transforaminal epidural injections are appropriate for the following **diagnostic** purposes:

- To differentiate the level of radicular nerve root pain;
- To differentiate radicular from non-radicular pain;
- To evaluate a discrepancy between imaging studies and clinical findings;
- To identify the source of pain in the presence of multi-level nerve root compression; and/or
- To identify the level of pathology at a previous operative site.

It might be necessary to perform injections at two different nerve root levels on the same date of service, whether injected unilaterally or bilaterally, if multi-level nerve root compression or stenosis is present on imaging studies and documented in the medical record, and suspected to be responsible for the patient's symptoms and findings.

Transforaminal epidural injections are appropriate for the following therapeutic purposes:

- Radicular pain resistant to other therapeutic means or when surgery is contraindicated;
- Post-decompressive radiculitis or post-surgical scarring;
- Monoradicular pain, confirmed by diagnostic blockade, in which a surgically correctable lesion cannot be identified; and/or
- Treatment of acute herpes zoster or post-herpetic neuralgia.

519.21.1.7 Sacroiliac (SI) Joint Injections

Sacroiliac joint injections are considered medically reasonable and necessary for the diagnosis and/or treatment of chronic low back pain that is considered to be secondary to suspected sacroiliac joint dysfunction.

Diagnostic blocks of a sacroiliac joint can be performed to determine whether it is the source of low back pain.

Therapeutic sacroiliac joint injections of an anesthetic and/or steroid to block the joint for immediate, and potentially long lasting, pain relief are considered medically reasonable and necessary if it is determined that the SI joint is the source of pain in the lower back. This service must be prior authorized before services are rendered.

If previous diagnostic or therapeutic SI injections of an anesthetic and/or steroid to block the joint for immediate, and potentially long lasting, pain relief have not effectively relieved the pain, further injections would **not** be considered medically necessary.

519.21.1.8 Acute Post-Operative Pain Management

Management of acute pain (obstetric, post-operative, or secondary to major trauma not requiring an operative procedure) in the hospital may be provided by several means: oral and parenteral administration of analgesics, intravenous patient controlled analgesia (PCA), and by the administration of epidural opiates or anesthetics. This service must be prior authorized before services are rendered.

Reimbursement will be allowed for the initial insertion of the catheter by an anesthesiologist or CRNA on the date of surgery if it is performed for postoperative pain relief rather than to provide the regional block for surgical procedures.

Except in special circumstances, payment for physician services related to patient controlled analgesia is included in the global fee paid to the surgeon. Routine management of PCA is not reimbursable to another physician or provider, and may not be billed as an anesthesia or evaluation and management (E&M) service. Prescription is part of the surgeon's post-operative management and included in the global surgery.

Catheters placed in an operative site for infusion of a local anesthetic are included in the global surgical package.

Anesthesia services provided by the performing surgeon are included in the global reimbursement for surgery, and neither the catheter placement nor the daily management of the administration of drugs is separately payable to the surgeon.

Daily management of epidural or subarachnoid drug administration is defined as a daily service and may only be billed by one provider other than the surgeon per day.

519.21.2 NON-COVERED SERVICES

West Virginia Medicaid does not cover hypnosis, acupuncture, prolotherapy, any treatment not approved by the FDA or therapy not accepted as effective by the medical community for chronic pain management.

Pulse radiofrequency for denervation is considered investigational and not medically necessary. This service is not covered.

The local anesthetics administered in conjunction with trigger point injections are included in the procedure and are not reimbursed separately. Only injections of local anesthetics and corticosteroids are covered. Injections consisting of only saline and/or botanical-supported substances are not considered medically necessary, and are therefore, non-covered.

Trigger point injections used on a routine basis (e.g., on a regular and continuous basis for members with chronic non-malignant pain syndromes) are not considered medically necessary, and are therefore, non-covered.

Non-covered services are not eligible for a DHHR Fair Hearing or a Desk/Document review.

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REFERENCES

CMS' Local Coverage Determination (LCD) for Pain Management for West Virginia - At the time this rule was promulgated this LCD could be found here.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter.

CHANGE LOG

REPLACE	TITLE	CHANGE DATE	EFFECTIVE DATE
Entire Chapter	Pain Management Services		January 15, 2016