# Jurisdiction 15 Open Draft LCD Meeting

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| **Meeting Date & Time:** | February 13, 2024 |
| **Facilitator:** | Dr. Meredith Loveless |
| **Location:** | Teleconference |

**Dr. Loveless** briefly introduced the collaborative Proposed Polices:

## DL39741/DA59608 Cervical Fusion

- Previous Contractor Advisory Meeting on August 16, 2024
- Comments period through March 2, 2024

A. Cervical fusion surgery is considered medically reasonable and necessary for the decompression of symptomatic cervical nerve root impingement when all of the following requirements are met:

1. Persistent or recurrent moderate or severe arm pain measured by a visual analog scale or alternative pain scale, that must be present for a minimum of 12 weeks and it must have documented failure to respond to multimodal conservative management, and the policy does define the various conservative management AND
2. Nerve compression negatively impacts activities of daily living AND
3. All other potential sources of pain have been excluded AND
4. Imaging (MRI or CT) evidence of central, lateral recess or foraminal stenosis at the level corresponding with clinical myotome signs or symptoms and including at least one of the following:

    a. Persistent or recurrent moderate or severe arm pain (4 or more on the visual analog scale or equivalent) present for a minimum of 12 weeks within the current episode of neck pain with documented failure to respond to multimodal conservative management (as tolerated) in the absence of exceptional circumstances (below) AND
    b. Nerve compression negatively impacts activities of daily living AND
    c. All other potential sources of pain/neurological deficit have been excluded AND
    d. Imaging (MRI or CT) evidence of central, lateral recess or foraminal stenosis at the level corresponding with clinical myotome signs or symptoms.

## Limitations

The following is considered not reasonable and necessary for the decompression of symptomatic cervical nerve root impingement:

- Isolated chronic axial cervical pain.

**Symptomatic Cervical Canal Stenosis requirements are similar.**

B. It would be considered reasonable and necessary with:

1. The persistent pain for a duration of 12 weeks or more
2. Failure of conservative therapy impacting activities of daily living.
3. Spastic gait, loss of manual dexterity, problems with sphincter control
4. Requires other sources have been excluded
5. Imaging finding consistent with central stenosis with a variety in potential imaging findings listed within the policy.

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## Limitations Include

Not indicated for isolated chronic axial cervical pain or asymptotic myelopathy

Exceptions to the conservative management requirement include:

- Myelopathy Class 3 or above, with progression of neurological deficits during the trial of conservative treatment
- Radiculopathy with progressive motor weakness interfering with activities of daily living and pain greater than 7/10 on a vast scale or equivalent scale with confirmatory imaging findings or in the presence of cauda equina syndrome

C. Decompression or stabilization of the cervical spine

1. Traumatic injuries including fracture dislocation, traumatic ligament destruction and with instability present and surgical management necessary at that time
2. This would also be indicated for spinal tumors if they are causing instability or neurological deficit, in which the removal of the tumor will likely require stabilization of the spine
3. As for chemo or radiation where additional stabilization of the spine is anticipated
4. Deformities of the cervical spine
5. At this time, there is no FDA approved biologics to be injected into the joint at the time of surgery and therefore those are non covered.

## DL38773 Facet Joint Intervention for Pain Management (Revision to Existing LCD)

Updated sections of the LCD are open for comment and changes include:

- Providing clarifying language and supporting evidence on the anesthesia limitations, with facet injections and clarification on the use for RFA
- The number of levels covered under the policy is clarified and reviewed in rationale for decision making
- Response to a reconsideration requesting expansion of therapeutic joint injection as a first line option has been added to the summary of evidence section with rationale for decision explained

## Open Comment Period

- Confirmed that the comment period is open until March 2, 2024
- The preferred method of comment submission is CMD.INQUIRY@cgsadmin.com
  - » Comments can be fax or mailed
  - » PDF form to submit comments is available on CGS's website
    - https://www.cgsmedicare.com/pdf/j15/j15_draft_lcd_comment_submission_form.pdf
  - » Comments must include peer reviewed and published support literature

Reminder: Informal meetings are preliminary discussions related to guidance on the process of LCD request or reconsideration.

**Dr. Manchikanti**

**Specific Issue**

Proposed Rule:

- Therapeutic facet joint procedures (IA or MBB)

Final Rule:

- Therapeutic facet joint procedures (IA) only

Request to add medial branch blocks

ASIPP Guidelines show supporting evidence for joint nerve blocks in all areas.

- Cervical Spine: the evidence is equivalent radiofrequency neurotomy and better than intraarticular injections for cervical facet joint nerve blocks
- Lumbar Spine: The lumbar radiofrequency ablation and facet joint nerve blocks both have level 2 evidence, whereas intraarticular injections were level 4

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- Thoracic Spine: Radiofrequency ablation was Level 3, but facet joint nerve blocks were level 2, and thoracic facet joint intraarticular injections were Level 3.
- Overall, there was better evidence for facet joint nerve blocks.
  - It was changed because of 1 commentator stated that there was no evidence for facet joint nerve blocks, so it was removed and nobody even realized that for several months or a year or so after the final rule was published

**Dr. Soin**

**Emerging Evidence Beyond Guidelines**

An intraarticular joint injection carries significant risks that nerve blocks do not. It is a traumatic procedure compared to a nerve block, and that is why you'll see a lot of practitioners and physicians now sort of moving towards facet joint nerve intervention.

**Dr. Manchikanti**

- *Baroncini et al Surgon 2021. Management of Facet Joints Osteoarthritis Associated with Chronic Low Back Pain: A Systematic Review*
  - Reviewed facet joint arthritis associated with chronic low back pain, and confirmed 8 publications with 487 patients and the effect was positive.
- *Mazmudar el al, Clin Spine Surg 2020. Therapeutic Facet Joint Interventions in the Lumbar Spine: An Economic Value Perspective*
  - This was published in 2020 after the LCD was published
  - Economic value and perspective were reviewed
  - They showed moderate evidence for nerve blocks and radiofrequency neurotomy, but limited evidence for intraarticular injections

## Methodolody

- PRISMA was used for reporting
- There were 24 reports which met the criteria and this is this included 21 studies
- Randomized trails and observational studies with month follow up
- Methodological quality assessment of high, moderate, low
  - Cochrane
  - IPM-QRB
  - IPM-QRBNR
- Grade assessment of high, moderate, low
  - Methodological limitations
  - Consistency
  - Indirectness
  - Imprecision
  - Publication bias
- Real world applicability
- Meta-analysis: qualitative, quantitative, dual arm and single ARM analysis

Per the Prisma analysis, 24 reports met the criteria and this is this included 21 studies.

## Studies

- 9 RCT's and there was one RCT which came out after review.
  - Cervical–5, Lumbar–2 (plus 1 not included), Thoracic–2
- 12 Observational studies
  - Cervical–6, Lumbar–3, and Thoracic–3
- Controlled diagnostic–9 and single diagnostic–1
- Methodological quality
- Randomized (12) 11 high and 1 moderate
- Non-randomized (12) 8 high and 4 moderate

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## Conclusion

- Based on this present systematic review and meta-analysis with nine RCT's and 12 nonrandomized studies, the evidence is level 2 with moderate to strong recommendation for therapeutic facet joint nerve blocks in managing spinal facet joint pain.
- 60 patients: 30 patients with lumbar facet joint intraarticular, 30 patients with lumbar facet joint nerve block, in conclusion that both techniques are safe and effective and improvement in both groups was six points improvement at six months.
- Cost is very similar to facet joint radio frequency neurotomy for lumbar facet joint nerve blocks.

**Dr. Soin**

**Final Solution**

The best interest of patients is to revise as in proposed with inclusion of medial branch blocks.

- There are several robust studies and publications that support the coverage of the medial branch blocks since it has more evidence and data behind facet joint injections, which is already covered.

**Dr. Loveless**

- Gave thanks to the presenters
- Requested for written comments
- Comment period is from January 18 through March 2
- Comments can be submitted, ideally through the CMD.INQUIRY@cgsadmin.com
- Gave thanks to attendees and closed the meeting

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