Executive Summary: 2016 Interventional Pain and Large Joint Services Guideline Updates

On December 4, 2014, CareCore National and MedSolutions announced a merger that brought together two of the leading medical benefits management (MBM) companies into eviCore healthcare. This combination allowed for two complementary businesses to jointly develop a broader portfolio of innovative and efficient solutions that improve quality of care and reduce medical costs. As a result, eviCore healthcare is better positioned to enhance our health plan partners’ ability to control cost growth and improve health outcomes by ensuring their members receive appropriate, evidence-based care.

At the outset of the merger, CareCore and MedSolutions each had legacy sets of proprietary and nationally recognized Interventional Pain and Large Joint Services guidelines. eviCore has taken advantage of this overlap by merging their respective strengths into one set of harmonized guidelines. The results of that extensive harmonization process resulted in the forthcoming condition based patient/member centric guidelines. The publication of one set of guidelines improves the ability to maintain the highest quality, evidence-based clinical guidelines.

The eviCore guidelines undergo a formal review annually and are based upon major national and international association and society guidelines and criteria, peer-reviewed literature, major treatises and, input from health plans, practicing academic and community-based physicians.

This executive summary represents the results of the most recent annual revision process. Presented in this executive summary are the material changes made to the eviCore Interventional Pain Management and Large Joint Services guidelines. "Material changes" are defined as changes that could greatly impact the approval or denial rate of specific, common requests. (Note: In the following summary, all new language for 2016 is presented in blue font. Language that has been removed for 2016 is crossed through).

- CMM 200: Epidural Steroid Injections
- CMM 201: Facet Joint Injections
- CMM 207: Epidural Adhesiolysis
- CMM 208: Radiofrequency Ablation
- CMM 210: Implantable Intrathecal Drug Delivery Systems
- CMM 311: Knee Arthroplasty

The effective date of these changes is targeted for August 19, 2016.
Radiculopathy definition for 2015:
**Radiculopathy** must be documented by physical examination and should be corroborated with imaging studies and/or electrodiagnostic testing if performed. In cases with clearly evident radicular symptoms and correlating neurological findings on examination, imaging studies and/or electrodiagnostic testing is not necessary to clinically document a radiculopathy. The presence of leg pain or arm pain and possible findings on an advanced diagnostic imaging study in and of itself does not substantiate the diagnosis of radiculopathy. There must also be clinical evidence as described above.

Radiculopathy definition for 2016:
**Radiculopathy**, for the purpose of this policy, is defined as the presence of severe, disabling pain, dysaesthesia(s) or paraesthesia(s) reported by the individual in a specified dermatomal distribution of an involved named spinal root(s) and ONE or MORE of the following:

- Loss of strength of specific named muscle(s) or myotomal distribution(s) demonstrated on detailed neurologic examination (within the prior 3 months) concordant with nerve root compression of the involved named spinal nerve root(s)
- Altered sensation to light touch, pressure, pin prick or temperature demonstrated on a detailed neurologic examination (within the prior 3 months) in the sensory distribution concordant with nerve root compression of the involved named spinal nerve root(s)
- Diminished, absent or asymmetric reflex(es) within the prior 3 months concordant with nerve root compression of the involved named spinal nerve root(s)
- Either of the following:
  - A concordant radiologist’s interpretation of an advanced diagnostic imaging study (MRI or CT) of the spine demonstrating compression of the involved named spinal nerve root(s) (Performed within the prior 12 months)
  - Electrodiagnostic studies (EMG/NCV’s) diagnostic of nerve root compression of the involved named spinal nerve root(s). (Performed within the prior 12 months).
CMM 201: Facet Joint Injections

The guidelines were updated to allow for a second diagnostic facet joint injection/medial branch block, as follows:

One diagnostic facet joint injection/medial branch block is considered medically necessary to determine whether chronic neck or back pain is of facet joint origin when ALL of the following criteria are met:

- Pain is exacerbated by extension and rotation, or is associated with lumbar rigidity
- Pain has persisted despite appropriate conservative treatment (e.g., nonsteroidal anti-inflammatory drugs (NSAIDs, exercise)
- Clinical findings and imaging studies suggest no other obvious cause of the pain (e.g., spinal stenosis, disc degeneration or herniation, infection, tumor, fracture).

When there is greater than 80% pain relief from a single diagnostic facet joint injection/medial branch block, there is sufficient evidence of facet pathology and a second confirmatory block is unnecessary.

A second diagnostic facet joint injection/medial branch block is medically necessary when the first diagnostic facet joint injection/medial branch block is positive.

A second diagnostic facet joint injection/medial branch block is medically necessary no sooner than one week following the initial diagnostic facet joint injection/medial branch block.

Positive diagnostic medial branch block or facet joint injection using either a local anesthetic or a local anesthetic combined with corticosteroid as evidenced by either of the following:

- A beneficial clinical response to an intra-articular facet injection or medial branch block performed with a local anesthetic with greater than 80% pain relief reported for 50% of the duration of the effect of the local anesthetic used
- A beneficial clinical response to an intra-articular facet joint injection or medial branch block performed with a local anesthetic and a corticosteroid with at least a 50% reduction in pain for at least two (2) weeks.

If the first diagnostic facet joint injection/medial branch block is not positive, then a second diagnostic facet joint injection/medial branch block is considered not medically necessary.
CMM 201: References Added


CMM 207: Epidural Adhesiolysis

CMM 207: Epidural Adhesiolysis Indications

Previously, Epidural Adhesiolysis was approvable for limited clinical scenarios. eviCore now considers this procedure as experimental, investigational or unproven as a treatment for back pain:

- There is insufficient scientific evidence to support the use of epidural adhesiolysis, performed by catheter or endoscopically, as a treatment for back pain. It is considered experimental, investigational or unproven.

CMM 207: Epidural Adhesiolysis References Added

CMM 208: Radiofrequency Ablation

CMM 208: Conservative Care
The duration of conservative care was updated from “4 weeks of conservative care” to “3 months.”

- Failure of at least 4 weeks of conservative care (e.g., exercise, physical methods including physical therapy, chiropractic care, NSAID’s and/or analgesics)

To align with the changes made to CMM 201: Facet Joint Injections, CMM 208: Radiofrequency Joint Ablation/Denervation was updated to state that radiofrequency ablation (RFA) of facet mediated pain is considered medically necessary if two sequential diagnostic facet joint injections/medial branch blocks are positive; if the two injections-blocks are not positive, then RFA is considered not medically necessary.

- Radiofrequency ablation of facet mediated pain is considered medically necessary if two sequential diagnostic facet joint injections/medial branch blocks are positive

- If the two sequential diagnostic facet joint injections/medial branch blocks are not positive, radiofrequency ablation of facet mediated pain is **considered not medically necessary**

- When an injection or block is considered positive, a second (confirmatory) block is not medically necessary to perform a radiofrequency joint denervation/ablation.

CMM 208: References Added

CMM 210: Implantable Intrathecal Drug Delivery Systems

CMM 210: Life Expectancy Criterion
Previously, the criteria for trial with percutaneous intrathecal or epidural drug delivery system included the requirement that the patient have a “life expectancy of greater than three (3) months. This criterion was removed from the 2016 guidelines for Implantable Intrathecal Drug Delivery Systems.

CMM 210: Additional Indications
Two additional indications were added to the guidelines for 2016, as follows:

- A trial with a percutaneous intrathecal drug delivery system for severe, refractory spasticity or chronic intractable dystonia is considered medically necessary when there is failure, contraindication or intolerance to at least a six-week trial of oral antispasmodic drugs and physical therapy.

- A trial with a percutaneous intrathecal or epidural drug delivery system for cancer-related pain is considered medically necessary when there is failure, intolerance, or contraindication to noninvasive methods of pain control, including systemic opioids.
CMM 311: Knee Arthroplasty

CMM 311: CPT® Codes
The following CPT® codes were added to the Knee Arthroplasty guidelines:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>27488</td>
<td>Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee</td>
</tr>
<tr>
<td>27580</td>
<td>Arthrodesis, knee, any technique</td>
</tr>
</tbody>
</table>

CMM 311: Age and BMI
Previously, patients had to be at least 50 years of age and have a Body Mass Index (BMI) of less than 40 to be considered for a partial knee arthroplasty. Age and BMI requirements were removed from these guidelines for 2016.

CMM 311: Not Medically Necessary Criteria
Three indications were added to the “not medically necessary” criteria for Partial (unicompartmental) knee arthroplasty, as follows:

Partial (unicompartmental) knee arthroplasty is considered not medically necessary when any of the following criteria is present:

- Severe Grade III or IV patellofemoral joint arthritis (when unicompartamental arthroplasty to be performed is medial or lateral)
- Prior high tibial osteotomy
- Tibial or femoral shaft deformity
- Radiographic evidence of medial or lateral subluxation
- Flexion contracture greater than 15º
- Varus deformity greater than 15º or a valgus deformity greater than 20º
- Inflammatory arthropathy
- Active local or systemic infection
- Severe loss of musculature, neuromuscular compromise or vascular deficiency in the affected limb, rendering the procedure unjustifiable
- Osteoporosis or other osseous abnormalities which would make the likelihood of a poor outcome more probable
- Severe lack of collateral ligament integrity leading to joint instability.

CMM 311: Simultaneous Bilateral Total Knee Replacement
The following language was removed from the knee arthroplasty guidelines:

- Based on the increased risk of serious complications (cardiac complications, pulmonary complications and mortality) simultaneous bilateral total knee replacement may be considered not medically necessary.
CMM 311: References Added/Updated


CMM 312: Knee Surgery (Arthroscopic and Open)

CPT® Codes

The following CPT® Codes were added to CMM 312:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>29881</td>
<td>Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when</td>
</tr>
<tr>
<td>29882</td>
<td>Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral).</td>
</tr>
<tr>
<td>29883</td>
<td>Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral).</td>
</tr>
<tr>
<td>29885</td>
<td>Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of</td>
</tr>
<tr>
<td>29886</td>
<td>Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion</td>
</tr>
<tr>
<td>29887</td>
<td>Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation</td>
</tr>
<tr>
<td>29888</td>
<td>Arthroscopically aided anterior cruciate ligament repair/augmentation or</td>
</tr>
<tr>
<td>29889</td>
<td>Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction.</td>
</tr>
</tbody>
</table>

CMM 312: Anterior Cruciate Ligament Reconstruction

Guidelines were added for Anterior Cruciate Ligament Reconstruction:

Allograft Knee Ligament Reconstruction - Knee ligament reconstruction (i.e., anterior cruciate) using allograft tissue is considered medically necessary for the treatment of ligament injury (e.g., rupture, laxity) when ANY of the following conditions is met:

- Previous reconstruction has failed and requires revision
- Surgical reconstruction requires the use of multiple ligament transfers
- Individual has a medical condition (e.g., anatomic anomaly, prior knee injury or prior knee surgery) that precludes the use of autograft tissue.

Knee ligament reconstruction (i.e., anterior cruciate) using allograft tissue for ANY other indication not listed above is considered not medically necessary.

Anterior cruciate ligament reconstruction with allograft (see above for allograft specific criteria) or autograft is considered medically necessary when ALL the following criteria have been met:

- Severe, disabling pain and a documented loss of knee function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment
- Knee instability which is noted as “giving way weakness”, or “buckling”
• MRI, Arthroscopy, or Arthrogram demonstrates a tear/disruption or significant laxity of the anterior cruciate ligament
• Positive Lachman’s Test
• ANY of the following abnormal physical examination findings:
  o Positive Anterior Drawer Test
  o Positive Pivot Shift Test
  o Positive KT arthrometer (>3.5 mm = +1, >5-7 mm = +2, >7 mm = +3)
• Failure of non-surgical management for at least three (3) months in duration.

Anterior cruciate ligament reconstruction with allograft (see above for allograft specific criteria) or autograft is considered medically necessary in an acute injury setting where hemarthrosis, effusion, and joint instability have been documented. This may include ANY of the following:
• A confirmed ACL tear and a repairable meniscus tear
• Need to return to high demand activities that require cutting, pivoting, and/or agility activities in which ACL insufficiency may predispose to further instability episodes, that may result in new articular or meniscal cartilage injuries
• Concomitant ligament injuries (i.e., multiligamentous knee injury) that require reconstruction to provide stability.

CMM 312: Posterior Cruciate Ligament Reconstruction

Guidelines were added for Posterior Cruciate Ligament Reconstruction:

Allograft Knee Ligament Reconstruction - Knee ligament reconstruction (i.e., posterior cruciate) using allograft tissue is considered medically necessary for the treatment of ligament injury (e.g., rupture, laxity) when ANY of the following conditions is met:
• Previous reconstruction has failed and requires revision
• Surgical reconstruction requires the use of multiple ligament transfers
• Individual has a medical condition (e.g., anatomic anomaly, prior knee injury or prior knee surgery) that precludes the use of autograft tissue.

Knee ligament reconstruction (i.e., posterior cruciate) using allograft tissue for ANY other indication not listed above is considered not medically necessary.

Posterior cruciate ligament reconstruction with allograft (see above for allograft specific criteria) or autograft is considered medically necessary when ALL the following criteria have been met:
• Severe, disabling pain and a documented loss of knee function to an extent which interferes with the ability to carry out the age appropriate activities of daily living and/or demands of employment
• Individual has undergone an MRI or Arthroscopy or Arthrogram which demonstrates a tear/disruption or significant laxity of the posterior cruciate ligament;
• Individual demonstrates Positive Posterior Drawer Sign and/or positive Tibial Drop Back Test and/or Quadriceps Active Test either of the following abnormal physical examination findings:
  o Eight (8) millimeters or more of increased posterior translation on stress radiographs
  o Positive KT-1000 arthrometer (>7.6 mm of increased posterior translation)
• Failure of non-surgical care for at least three (3) months in duration
• Posterior cruciate ligament reconstruction with allograft (see above for allograft specific criteria) or autograft is considered medically necessary in an acute injury setting where hemarthrosis, effusion and joint instability have been documented. This may include instances where there are concomitant ligament injuries (i.e., multiligamentous knee) that require reconstruction.

CMM 312: Medial Collateral/Lateral Collateral Ligament Repair/Reconstruction

Guidelines were added for Medial Collateral/Lateral Collateral Ligament Repair/Reconstruction:

Allograft Knee Ligament Reconstruction - Knee ligament reconstruction (i.e., medial collateral, lateral collateral) using allograft tissue is considered medically necessary for the treatment of ligament injury (e.g., rupture, laxity) when ANY of the following conditions is met:
  • Previous reconstruction has failed and requires revision
  • Surgical reconstruction requires the use of multiple ligament transfers
  • Individual has a medical condition (e.g., anatomic anomaly, prior knee injury or prior knee surgery) that precludes the use of autograft tissue.

Knee ligament reconstruction (i.e., medial collateral, lateral collateral) using allograft tissue for ANY other indication not listed above is considered not medically necessary.

Medial collateral/lateral collateral ligament repair with allograft (see above for allograft specific criteria) or autograft is considered medically necessary when ALL of the following criteria have been met:

• Severe, disabling pain
• Loss of knee function which interferes with the ability to carry out age appropriate activities of daily living and/or demands of employment
• Individual reports knee instability which is noted as “giving way weakness” or “buckling”
• MRI or other diagnostic study demonstrates a tear/disruption of the medial or lateral collateral ligament
• Positive Valgus Stress Test (Medial), or Varus Stress Test (Lateral)
• Failure of non-surgical management for at least six (6) weeks duration.

Medial collateral or lateral collateral ligament repair/reconstruction with allograft or
autograft is considered medically necessary in an acute injury setting where total disruption of the ligament (i.e., multi-ligamentous knee injury) is documented on MRI examination and effusion and joint instability have been documented on physical examination.

CMM 312: References Added

CMM 313: Hip Arthroplasty

CMM 313: Age and BMI
Previously, patients had to be at least 50 years of age and have a Body Mass Index (BMI) of less than 40 to be considered for partial and total hip arthroplasty. Age and BMI requirements were removed from these guidelines for 2016.

CMM 313: Tonnis Grade 3
For Partial Hip Arthroplasty, Tonnis Grade 3 was added as a criterion:

Partial hip arthroplasty is considered medically necessary when all of the following criteria have been met:

- Tonnis Grade 3 osteoarthritis
- History of chronic severe, disabling pain for at least six (6) months in duration
- Loss of hip function secondary to osteoarthritis which interferes with the ability to carry out age-appropriate activities of daily living and/or their demands of employment
- Failure of non-surgical management (e.g., ice, relative rest/activity modification, weight loss, bracing, medications [e.g., anti-inflammatories], injections [steroid] and/or physical therapy) for at least three months.

CMM 313: References Added

CMM 314: Hip Arthroscopy

CMM 314: Additional Criteria

This policy was reorganized into two sections: 1) indications for non-arthroscopic hip surgery and 2) indications for arthroscopic hip surgery. Additional criteria were added as follows:

Non-arthroscopic hip surgery, Hip surgery either arthroscopic or open surgery is considered medically necessary for ANY of the following clinical situations:
- Individual has experienced an acute fracture of the hip (femoral or acetabular)
- Individual has a mal-union of a previous fracture
- Individual has experienced an acute or post traumatic injury in which there is a correlation between examination and diagnostic imaging findings confirming a condition which is reasonably suspected of producing the individual’s severe pain and limitation in function
- Individual with persistent hip pain or dysfunction of a non-traumatic etiology for at least three (3) months in duration (e.g., avascular necrosis, loose bodies, dysplasia)
- Tumor or infection
- Femoroacetabular Impingement (FAI) Syndrome, including labral tear or synovial biopsy when an individual has ALL of the following criteria:
  - Positive impingement sign (i.e., sudden pain on 90 degree hip flexion with adduction and internal rotation or extension and external rotation)
  - Moderate to severe hip pain that is worsened by flexion activities (e.g. squatting or prolonged sitting) that significantly limits activities
  - Unresponsive to at least 3 months of physician-directed non-surgical care
  - Radiographic confirmation of FAI (e.g., pistol-grip deformity, alpha angle greater than 50 degrees, coxa profunda, and/or acetabular retroversion)
  - Documented closure of the proximal femoral physis
  - Documented absence of ALL of the following:
    - Tönnis grade 2 osteoarthritis (i.e., small cysts in femoral head or acetabulum, increasing narrowing of joint space, moderate loss of sphericity of femoral head)
    - Tönnis grade 3 osteoarthritis (i.e., large cysts, severe narrowing or obliteration of joint space, severe deformity of femoral head, avascular necrosis
    - Joint space is less than 2 mm wide anywhere along the sourcil

Arthroscopic hip surgery is considered medical necessary for ANY of the following clinical situations:
- Femoroacetabular Impingement (FAI) Syndrome when an individual has ALL of the following criteria:
  - Positive impingement sign (i.e., sudden pain on 90 degree hip flexion with adduction and internal rotation or extension and external rotation)
  - Moderate to severe hip pain that is worsened by flexion activities (e.g. squatting or prolonged sitting) that significantly limits activities
• Unresponsive to at least 3 months of physician-directed non-surgical care
• Radiographic confirmation of FAI (e.g., pistol-grip deformity, alpha angle greater than 50 degrees, coxa profunda, and/or acetabular retroversion)
• Documented closure of the proximal femoral physis
• Documented absence of ALL of the following:
  ▪ Tönnis grade 2 osteoarthritis (i.e., small cysts in femoral head or acetabulum, increasing narrowing of joint space, moderate loss of sphericity of femoral head)
  ▪ Tönnis grade 3 osteoarthritis (i.e., large cysts, severe narrowing or obliteration of joint space, severe deformity of femoral head, avascular necrosis)
  ▪ Joint space is less than 2 mm wide anywhere along the sourcil
  ○ In conjunction with a periacetabular osteotomy
  ○ Labral pathology when an individual has ALL of the following criteria:
    • Mechanical symptoms of the hip catching, locking or giving way
    • An advanced diagnostic imaging study confirming labral pathology amenable to surgical management
  ○ Synovial biopsy
  ○ Irrigation and debridement of an intra-articular joint space infection
  ○ Removal of an ossific or osteochondral loose body confirmed radiographically
  ○ Arthroscopic hip surgery is considered experimental and investigational for all other indications.

CMM 314: References Added