

MEDICAL POLICY STATEMENT

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Medical Policy Statement prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

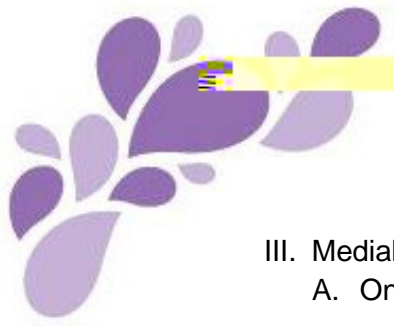
Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

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III. Medial Branch Nerve Block Injections

A. Once a positive diagnostic medial branch nerve block injection has been

performed, the following procedure codes are payable for up to two (2) injections per

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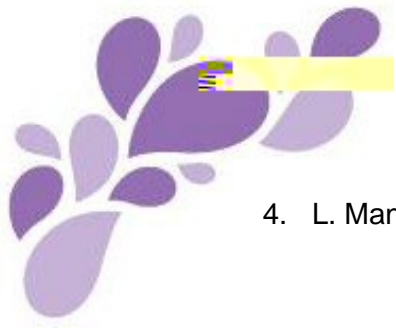
medical record lasting for six (6) weeks or more within the past six (6) months including ONE (1) of the following:

1. Rest;
2. Ice;
3. Heat;
4. Medical devices;
5. Acupuncture;
6. TENS unit use as defined in this policy; or
7. Pain medications (RX or OTC) such as: non-steroidal anti-inflammatory drugs (NSAIDS), acetaminophen. Opioid narcotics are not required for consideration.

V. Radiofrequency Facet Ablations (RFA)

- A. A maximum of two (2) radiofrequency facet ablations per rolling twelve (12) months for each spinal region (cervical/thoracic or lumbar) involving no more than four (4) joints per session (e.g., two (2) bilateral levels or four (4) unilateral levels).
- B. Radiofrequency Facet Ablations are considered medically necessary when ALL of the following have been met in the last thirty-six (36) months:
 1. The clinical criteria above (IV: A-F) have been met and ONE (1) of the following:
 - a. Two (2) diagnostic medial branch nerve block injections have been performed at the same spinal region and vertebral location achieving 50% or more pain relief; OR
 - b. One (1) successful single or multilevel facet radiofrequency ablation, in the same spinal region and vertebral location (cervical, thoracic or and

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