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To: Medicare Policy Comments <medicarepolicycomments@wpsic.com>
Cc: Amol Soin2 <drsoin@gmail.com>
Subject: LCD Reconsideration Request - Facet Joint Interventions for Pain Management (L38841)

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American Society of Interventional Pain Physicians®

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March 24, 2023

Wisconsin Physician Services Insurance Corporation
Policycomments@wpsic.com

Re: LCD Reconsideration Request - Facet Joint Interventions for Pain Management (L38841)

Dear Medicare Director:

Thank you for considering our request to include facet joint nerve blocks as therapeutic modality; and we appreciate your promptness. Hopefully this will be presented to the committee as soon as you can. We are hoping that you will expedite the process since it appears that it is an error in following comments.

In addition, we missed providing you with references describing intraarticular injections, the difficulties, and false-negative results, which we are providing below. We will submit further literature as it is available.

As described in our letter, technically facet joint nerve blocks or medial branch blocks are easier to perform and less painful than intraarticular injections. In addition, intraarticular injections have been documented technical failure rate ranging between 29% and 38% for joint, and from 46% to 64% for procedure (1,2). Other issues include false-negative results which may be arising from excessive procedure related pain and discomfort which has been shown to be a cause of false-negative blocks, whereas a less painful procedure is associated with a lower false negative rate, even though this has not been systematically studied (3). One may question that false-negative blocks are only for diagnostic blocks; however, it also indicates lack of appropriate procedure with medicine not reaching the joint space. The technical failure rate for intraarticular injections is higher at L5-S1, which is the most common clinically affected facet joint, along with L4-5 which is the most frequently radiologically degenerated joint and involvement of both joints goes together (4-7). In contrast, lumbar medial branch blocks rarely (less than 2%) miss the targeted nerve (8), even though intravascular uptake, which occurs in between 4% and 19% of injections, may lead to false-negative results. Kaplan et al (9) evaluating the ability of medial branch blocks in a small study to anesthetize facet joints, showed that among the 6 patients in whom intravascular uptake was appreciated, they were still able to perceive pain during capsular distention despite repositioning the needle to avoid intravascular contrast uptake. This may be essentially overcome with appropriate injection practices and also indicates that false negatives may occur from intravascular uptake even with real-time contrast injection; however, these are substantially less than intraarticular injections where the failure rate tends to be 46% to 64% per procedure.

In addition, complications are much more severe in cervical spine followed by thoracic spine, apart from extensive difficulty of entering the facet joint in thoracic spine, the complications of the needle passing through the joint and damaging the spinal cord are very real in the cervical spine, leading to multiple medical liability suits.

Consequently, once again we request that appropriate action be taken soon.

Thank you again for all of your assistance.

Laxmaiah Manchikanti, MD

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