Clinical Policy: Facet Joint Interventions
Reference Number: WNC.CP.267
Last Review Date: 09/21

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description
Chronic low back pain is frequently attributed to disorders of the facet joint. Neck pain related to whiplash injury is also thought to be related to the cervical zygapophyseal facet joint. However, the diagnosis of facet joint pain is difficult and often is based on pain relief following a diagnostic pain block of the medial branch of the posterior rami of the spinal nerve supplying the facet joint.

Policy/Criteria
I. It is the policy of WellCare of North Carolina® that invasive pain management procedures performed by a physician are medically necessary when the relevant criteria are met and the patient receives only one procedure per visit, with or without radiographic guidance.
   A. Facet Joint Injections, performed under fluoroscopy or computed tomographic (CT) guidance, are considered medically necessary for the following indications:
      1. Up to two* controlled medial branch blocks/facet joint injections in the lumbar and cervical regions when all the following criteria are met:
         a. Intermittent or continuous back or neck pain that interferes with ADLs has lasted for ≥ 3 months;
         b. The member has failed to respond to conservative therapy including all of the following:
            i. ≥ 6 weeks chiropractic, physical therapy or prescribed home exercise program;
            ii. NSAID ≥ 3 weeks or NSAID contraindicated or not tolerated;
            iii. ≥ 6 weeks activity modification;
         c. Clinical findings suggest facet joint syndrome and imaging studies suggest no other obvious cause of the pain (e.g., disc herniation, radiculitis, discogenic or sacroiliac pain). Physical findings of spinal facet joint syndrome can include low back pain exacerbated on extension and rotation; positive response to facet joint loading maneuvers or pain worse at night;
         d. No more than three spinal levels (unilateral or bilateral) are to be treated at the same session;
         e. If a second injection is required, it is performed at the same level(s) to confirm the validity of a positive clinical response (i.e. >75 % pain relief) to the initial injection, and the injections should be given at least 2 weeks apart;
         f. A radiofrequency joint denervation/ablation procedure is being considered.

*Note: If the first controlled medial branch block/facet joint injection has < 75% pain relief, a second block is not medically necessary.
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B. Facet joint medial branch conventional radiofrequency neurotomy, performed under fluoroscopy or computed tomographic (CT) guidance is considered medically necessary for the following indications:

1. Initial facet joint medial branch conventional radiofrequency neurotomy in the lumbar or cervical region is medically necessary when all of the following criteria are met:
   a. Chronic neck or back pain is present;
   b. There was a positive response to two diagnostic controlled facet joint injections/medial branch blocks (at each region to be treated), as indicated by ≥ 75% pain relief with the ability to perform prior painful movements without significant pain;
   c. No more than three spinal levels (unilateral or bilateral) are to be treated at the same session.

2. Repeat facet joint medial branch conventional radiofrequency neurotomy, performed under fluoroscopy or computed tomographic (CT) guidance, in the lumbar or cervical regions when all the following criteria are met:
   a. At least 6 months have elapsed since the previous treatment;
   b. ≥ 50% relief was obtained for at least 4 months, with associated functional improvement, following the previous treatment;
   c. No more than three spinal levels (unilateral or bilateral) are to be treated at the same session.

C. Facet joint injections of the thoracic region are considered not medically necessary because effectiveness has not been established.

D. Conventional radiofrequency neurotomy of the facet joints of the thoracic region is considered not medically necessary because effectiveness has not been established. There is a need for further well-designed, randomized controlled trials to evaluate effectiveness.

E. Pulsed radiofrequency neurotomy of the facet joints is considered not medically necessary. The available evidence on the effectiveness of pulsed radiofrequency in the treatment of patients with various chronic pain syndromes is largely based on retrospective, case series studies. Its clinical value needs to be examined in well-designed, randomized controlled trials with large sample size and long-term follow-up. Studies on pulsed radiofrequency ablation continue to be done.

Background

Facet Joint Injection

Patients referred for facet injections most often have degenerative disease of the facet joints. However, even if the facet joint appears radiologically normal, facet injections still may be of use as radiologically occult synovitis can cause facet pain, particularly in younger patients. Post laminectomy syndrome, or nonradicular pain occurring after laminectomy, is also an acceptable reason to perform facet injections.

The body of evidence for facet joint injection equivocally supports to use of corticosteroids or local anesthetic for low back pain of facet joint origin, but questions remain regarding long-term safety, patient selection criteria, and comparative effectiveness versus standard therapies. It is unclear whether improvements from facet joint injections last beyond three to six months.
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Evidence is insufficient to support the use of facet joint injections for thoracic pain of facet joint origin, as only one randomized controlled trial has been conducted.\(^1\)

It is recommended that facet joint interventions be performed under fluoroscopy or computed tomographic (CT) guidance.\(^2\) The evidence evaluating ultrasound guidance for facet joint interventions is limited and inconclusive at this time.

Facet Joint Radiofrequency Neurotomy

Based on the outcome of a facet joint nerve block, if the patient gets sufficient relief of pain but the pain recurs, one of the options is to denervate the facet joint. Radiofrequency neurotomy, also known as radiofrequency ablation, has been shown to temporarily reduce cervical and lumbar pain. Radiofrequency neurotomy involves delivering radio waves to targeted nerves via needles inserted through the skin. The heat created by the radio waves interferes with the nerves’ ability to transmit pain signals.

Evidence from several randomized controlled trials suggests that conventional radiofrequency neurotomy is either equivalent or superior to sham and other active treatments for low back pain of facet joint origin.\(^2\)

Few randomized controlled trials have evaluated pulsed radiofrequency neurotomy versus sham therapy, and have reached differing conclusions.\(^2\) Further research should be conducted to determine safety and efficacy of pulsed radiofrequency neurotomy for low back pain.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT\(^\circ\)). CPT\(^\circ\) is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<table>
<thead>
<tr>
<th>CPT(^\circ) Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>64491</td>
<td>Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>64492</td>
<td>Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)</td>
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<tr>
<td>64494</td>
<td>Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)</td>
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<tr>
<td>64495</td>
<td>Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)</td>
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<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tr>
<td>64634</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)</td>
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<tr>
<td>64636</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)</td>
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<tr>
<th>HCPCS codes</th>
<th>Description</th>
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<tr>
<td></td>
<td>No applicable codes.</td>
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#### ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

<table>
<thead>
<tr>
<th>ICD-10-CM Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>M43.11</td>
<td>Spondylolisthesis, occipito-atlanto-axial region</td>
</tr>
<tr>
<td>M43.12</td>
<td>Spondylolisthesis, cervical region</td>
</tr>
<tr>
<td>M43.16</td>
<td>Spondylolisthesis, lumbar region</td>
</tr>
<tr>
<td>M46.92</td>
<td>Unspecified inflammatory spondylopathy, cervical region</td>
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<tr>
<td>M46.96</td>
<td>Unspecified inflammatory spondylopathy, lumbar region</td>
</tr>
<tr>
<td>M47.11</td>
<td>Other spondylosis with myelopathy, occipito-atlanto-axial region</td>
</tr>
<tr>
<td>M47.12</td>
<td>Other spondylosis with myelopathy, cervical region</td>
</tr>
<tr>
<td>M47.16</td>
<td>Other spondylosis with myelopathy, lumbar region</td>
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<tr>
<td>M47.811</td>
<td>Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region</td>
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<tr>
<td>M47.812</td>
<td>Spondylosis without myelopathy or radiculopathy, cervical region</td>
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<td>M47.816</td>
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<td>M47.892</td>
<td>Other spondylosis, cervical region</td>
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<tr>
<td>M47.896</td>
<td>Other spondylosis, lumbar region</td>
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<tr>
<td>M51.36</td>
<td>Other intervertebral disc degeneration, lumbar region</td>
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<tr>
<td>M53.0</td>
<td>Cervicocranial syndrome</td>
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<tr>
<td>M53.1</td>
<td>Cervicobrachial syndrome</td>
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<tr>
<td>M53.81</td>
<td>Other specified dorsopathies, occipito-atlanto-axial region</td>
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<tr>
<td>M53.82</td>
<td>Other specified dorsopathies, cervical region</td>
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<td>M53.86</td>
<td>Other specified dorsopathies, lumbar region</td>
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<tr>
<td>M54.2</td>
<td>Cervicalgia</td>
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<td>M54.30-M54.32</td>
<td>Sciatica</td>
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<td>M54.40-M54.42</td>
<td>Lumbago with sciatica</td>
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<td>M54.5</td>
<td>Low back pain</td>
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<tr>
<td>M54.89</td>
<td>Other dorsalgia</td>
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<tr>
<td>M54.9</td>
<td>Dorsalgia, unspecified</td>
</tr>
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References
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**North Carolina Guidance**

**Eligibility Requirements**

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise); or
   2. the NC Health Choice (NCHC is NC Health Choice program, unless context clearly indicates otherwise) Program on the date of service and shall meet the criteria in this policy.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

**EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age**
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a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the NCTracks Provider Claims and Billing Assistance Guide, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

EPSDT does not apply to NCHC beneficiaries.

Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s)
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shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid’s clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the, NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
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HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

d. Modifiers - Providers shall follow applicable modifier guidelines.

e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

f. Co-payments -

For Medicaid refer to Medicaid State Plan: https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan: https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise
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professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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