Clinical Policy: Facet Joint Interventions

Reference Number: CP.MP.171
Date of Last Revision: 05/25

Coding Implications
Revision Log

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

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 is often 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 health plans affiliated with Centene Corporation® 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. *Diagnostic 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 activities of daily living (ADLs) has lasted for ≥ three months;
   b. The member/enrollee has failed to respond to conservative therapy within the past year, including all of the following:
      i. ≥ four weeks physical therapy or prescribed home exercise program, or documentation of member/enrollee inability to tolerate;
      Note: Physical therapy or prescribed home exercise program is not necessary in the presence of a facet joint synovial cyst causing nerve root compression with moderate to severe radicular pain and associated functional limitations.
      iii. Nonsteroidal anti-inflammatory drugs (NSAIDs) ≥ three weeks, or NSAIDs contraindicated or not tolerated;
   c. Clinical findings suggest facet joint syndrome, and imaging studies suggest no other obvious cause of the pain (e.g., fracture, tumor, infection, extraspinal lesion), and pain is not associated with radiculopathy (except for radiculopathy caused by a facet joint synovial cyst) or myelopathy. Physical findings of spinal facet joint syndrome can include low back pain exacerbated on extension and rotation or positive response to facet loading maneuvers;
   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., ≥ 80% pain relief) to the initial injection, and the injections should be given at least two weeks apart;

f. A radiofrequency joint denervation/ablation procedure is being considered.

Note: If the first controlled medial branch block/facet joint injection has < 80% pain relief, a second block at the same level is **not medically necessary.**

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. Neck or back pain present for ≥ three months;
      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 ≥ 80% pain relief;
      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 is medically necessary when all the following criteria are met:
      a. At least six months have elapsed since the previous treatment;
      b. ≥ 50% pain relief was obtained for at least six 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. *Therapeutic facet joint injections*, performed under fluoroscopy or computed tomographic (CT) guidance, is considered **medically necessary** when meeting all of the following:
   1. There was a positive response to two diagnostic controlled facet joint injections/medial branch blocks (at each region to be treated), as indicated by ≥ 80% pain relief;
   2. Subsequent therapeutic facet joint procedures at the same anatomic site result in ≥ 50% pain relief for at least three months from the prior therapeutic procedure or at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale;
   3. Documentation explains why member/enrollee is not a candidate for radiofrequency neurotomy (such as established spinal pseudarthrosis or implanted electrical device);
   4. No more than three spinal levels (unilateral or bilateral) are to be treated at the same session.

E. *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.

F. *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

Nearly 80% of people experience low back pain in their lifetime, with lumbar facet pain, also known as lumbar facet syndrome, accounting for 15% to 45% of low back pain cases.[1] Neck pain is the sixth leading cause of years lived with disability in the United States. The reported annual prevalence rates of neck pain range from 15% to 50% with a higher prevalence and peak impact in middle age for all genders.[2] 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.[3]

The body of evidence for facet joint injection equivocally supports the 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 two to six months.[3]

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.[4]

It is recommended that facet joint interventions be performed under fluoroscopy or computed tomographic (CT) guidance. The evidence evaluating ultrasound guidance for facet joint interventions is limited and inconclusive at this time.[4,5]

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.[6]

Studies comparing pulsed radiofrequency neurotomy with conventional radiofrequency neurotomy have had low sample size and poor inclusion criteria.[6] A recent search of published peer-reviewed literature identified five abstracts evaluating pulsed radiofrequency in adults for treatment of lumbar facet joint pain, including one randomized controlled trial (RCT), three

comparative studies, and one systematic review/meta-analysis.[1] Although this procedure is considered to be a less destructive and safer alternative to conventional radiofrequency neurotomy, further research is needed to determine the long term outcomes and clinical efficacy of pulsed radiofrequency neurotomy for low back pain.[1,7]

According to the American Society of Interventional Pain Physicians (ASIPP) and the American Society of Pain and Neuroscience (ASPN) guidelines, further studies are needed to assess pulsed radiofrequency for lumbar facet joint pain; however, conventional radiofrequency is recommended.[1] Furthermore, a study of patients who experienced complete pain relief following diagnostic medial branch blocks, and were subsequently treated with radiofrequency neurotomy, noted the patients experienced 80-100% pain relief for at least six months with complete return to work and activities of daily living following treatment.[6]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, 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.

CPT codes that support coverage criteria

CPT® Codes	Description
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	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)
64492	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)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	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)
64495	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)

CPT® Codes	Description
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	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)
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	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)

CPT codes that do not support coverage criteria

CPT® Codes	Description
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Reviewed in CP.MP.118 Injections for Pain Management: Added that injections are indicated in cervical and lumbar region.	04/18	04/18
Added to policy statements that interventions should be performed under fluoroscopy or computed tomographic (CT) guidance. Revised language in I.A. 5 for clarity. Added criteria I.A.6 requiring that radiofrequency joint denervation/ablation procedure is being considered. Added the following CPT codes as investigational: 0213T, 0214T, 0215T, 0216T, 0217T, and 0218T and noted in background that there is insufficient evidence to support US guided interventions. References reviewed and updated.	06/20	07/20
Annual review. References reviewed and reformatted for AMA style. Changed "review date" in the header to "date of last revision" and "date" in the revision log header to "revision date." Replaced "member(s)" with "member(s)/enrollee(s)" throughout policy. Specialty review completed.	07/21	07/21
Annual review. Description updated to single spacing. Grammatical updates added to Description, first paragraph in Policy/Criteria and in Criteria I., II., V., and VI. Background updated with no impact on criteria. References reviewed and updated.	07/22	07/22
Annual review completed. Minor rewording with no clinical significance. Background updated with no impact to criteria. ICD-10-	07/23	07/23

Reviews, Revisions, and Approvals	Revision Date	Approval Date
CM Diagnosis Code table removed. References reviewed and updated. External specialist reviewed.		
Annual review. Clarifying language added to Criteria I.A. to specify diagnostic facet joint injections. Minor rewording in Criteria I.A.1.a. Updated to include ≥ four weeks of physical therapy or prescribed home exercise program and ≥ four weeks activity modification. Removed Criteria I.A.1.c. regarding ≥ six weeks chiropractic, physical therapy, or prescribed home exercise program. Removed Criteria I.A.1.d. and added to Criteria I.A.1.b. Removed Criteria I.A.1.e. regarding ≥ six weeks activity modification. Criteria I.A.1.c. updated to replace disc herniation, radiculitis, discogenic or sacroiliac pain with fracture, tumor, infection, and extraspinal lesion and updated to include pain not associated with radiculopathy or myelopathy and removed pain worse at night. Pain relief updated from > 75% to ≥ 80 % in Criteria I.A.1.e. Note at end of Criteria I. updated to pain relief of < 80% instead of < 75% and updated to specify a second block at the same level is not medically necessary. Criteria I.B. updated to specify neck or back pain present for ≥ three months. Pain relief updated from > 75% to ≥ 80 % in Criteria I.B.1.b. and removed ability to perform prior painful movements without significant pain. Criteria I.B.2.b. updated from at least four months to at least six months. Criteria I.D. updated to include medical necessity for therapeutic facet joint injections when meeting criteria I.D.1 through I.D.4. Removed CPT codes 0214T, 0215T, 0217T, and 0218T from coding table. References reviewed and updated. Reviewed by internal specialist.	06/24	06/24
Annual review. Updated Criteria I.A.1.b.i. regarding physical therapy. Note added under Criteria I.A.1.b.i. regarding physical therapy or prescribed home exercise program in the presence of a facet joint synovial cyst. Removed Criteria I.A.1.b.ii. regarding activity modification. Updated Criteria I.A.1.c. to include notation about facet joint synovial cyst. Coding and descriptions reviewed. References reviewed and updated. Reviewed by internal specialists and external specialist.	05/25	05/25

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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 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.

Note: For Medicaid members/enrollees, 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.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.