

# Clinical Policy: Facet Joint Interventions

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[Coding Implications](#)

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## 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

It is the policy of PA Health & Wellness® (PHW) 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.*

- I. Facet Joint Injections, performed under fluoroscopy or computed tomographic (CT) guidance, are considered **medically necessary** for the following indications:
  - A. *Up to two\* controlled medial branch blocks/facet joint injections in the lumbar and cervical regions* when all the following criteria are met:
    1. Intermittent or continuous back or neck pain that interferes with ADLs has lasted for  $\geq 3$  months;
    2. The member has failed to respond to conservative therapy including all of the following:
      - a.  $\geq 6$  weeks chiropractic, physical therapy or prescribed home exercise program;
      - b. NSAID  $\geq 3$  weeks or NSAID contraindicated or not tolerated;
      - c.  $\geq 6$  weeks activity modification;
    3. 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 loading maneuvers or pain worse at night;
    4. No more than three spinal levels (unilateral or bilateral) are to be treated at the same session.
    5. 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;
    6. 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**

- II. Facet joint medial branch conventional radiofrequency neurotomy is considered **medically necessary** for the following indications:
  - A. *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:

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1. Chronic neck or back pain is present;
2. There was a positive response to two diagnostic controlled facet joint injections/medial branch block(s) (at each region to be treated), as indicated by  $\geq 75\%$  pain relief with the ability to perform prior painful movements without significant pain;
3. No more than three spinal levels (unilateral or bilateral) are to be treated at the same session.

**B. Repeat facet joint medial branch conventional radiofrequency neurotomy in the lumbar or cervical regions** when all the following criteria are met:

1. At least 6 months have elapsed since the previous treatment;
2.  $\geq 50\%$  relief was obtained for at least 4 months, with associated functional improvement, following the previous treatment;
3. No more than three spinal levels (unilateral or bilateral) are to be treated at the same session.

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

**IV. Therapeutic facet joint injections** are considered **not medically necessary** because effectiveness has not been established.

**V. 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.

**VI. 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 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.<sup>1</sup> 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.<sup>1,17</sup>

It is recommended that facet joint interventions be performed under fluoroscopy or computed tomographic (CT) guidance.<sup>20</sup> 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.

Studies comparing pulsed radiofrequency neurotomy with conventional radiofrequency neurotomy have had low sample size and poor inclusion criteria.<sup>18</sup> Further research should be conducted to determine safety and efficacy of pulsed radiofrequency neurotomy for low back pain.<sup>8</sup>

### 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 2020, 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) |

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| <b>CPT® Codes</b> | <b>Description</b>                                                                                                                                                                                                                                                                   |
|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 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) |
| 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**

| <b>CPT® Codes</b> | <b>Description</b>                                                                                                                                                                                                                                                        |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 0213T             | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level                                                                                  |
| 0214T             | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)                      |
| 0215T             | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure) |
| 0216T             | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level                                                                                      |
| 0217T             | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)                          |
| 0218T             | Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)     |

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| HCPCS Codes | Description |
|-------------|-------------|
| N/A         |             |

**ICD-10-CM Diagnosis Codes that Support Coverage Criteria**

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

+Indicates a code requiring an additional character

| Reviews, Revisions, and Approvals                                                                                                          | Revision Date | Approval Date |
|--------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|
| Policy split from CP.MP.118 Injections for Pain Management. Minor rewording for clarity.                                                   | 09/18         | 10/18         |
| Moved A.1 to A.5 and clarified that injections must be 2 weeks apart if a second injection is required due to a lack of positive response. | 10/2020       | 12/7/2021     |

| Reviews, Revisions, and Approvals                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Revision Date | Approval Date |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|
| Clarified that facet joint injections of the thoracic region are not medically necessary in III, and reordered not medically necessary statements III-VI.<br>References reviewed and updated. Coding reviewed. Specialty review completed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |               |               |
| 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 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.” Annual review performed, references reviewed and updated. Coding and Specialty review completed. | 9/29/2021     |               |
| Annual review. Background updated with no impact on criteria. References reviewed and updated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 9/22/2022     |               |

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