Clinical Policy: Facet Joint Interventions

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 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.

I. Facet Joint Injections 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 ≥ 3 months;
      2. The member has failed to respond to conservative therapy including all of the following:
         a. ≥ 6 weeks chiropractic, physical therapy or prescribed home exercise program;
         b. NSAID ≥ 3 weeks or NSAID contraindicated or not tolerated;
         c. ≥ 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 due to lack of positive response*, the injections should be given at least 2 weeks apart.

   *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:
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. 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.

IV. 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.

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

**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.\(^1\) It is
unclear whether improvements from facet joint injections last beyond three to six months.

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.\(^1\)
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**

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<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>64490</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; single level</td>
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<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>
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<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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<td>64493</td>
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</tbody>
</table>
CPT® Codes | Description
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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)

HCPCS Codes | Description
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N/A | 

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+Indicates a code requiring an additional character

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
## CLINICAL POLICY

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<thead>
<tr>
<th>ICD-10-CM Code</th>
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<tr>
<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>
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### Reviews, Revisions, and Approvals

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<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Approval Date</th>
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<tr>
<td>Reviewed in CP.MP.118 Injections for Pain Management: Added that injections are indicated in cervical and lumbar region.</td>
<td>04/18</td>
<td>04/18</td>
</tr>
<tr>
<td>Reviewed in CP.MP.118 Injections for Pain Management: Revised criteria to state the levels treated can be unilateral or bilateral</td>
<td>07/18</td>
<td>07/18</td>
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<tr>
<td>Policy split from CP.MP.118 Injections for Pain Management. Minor rewording for clarity.</td>
<td>09/18</td>
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<td>References reviewed and updated. Coding reviewed. Specialty review completed.</td>
<td>07/19</td>
<td>07/19</td>
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<tr>
<td>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.</td>
<td>11/19</td>
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### References


**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.

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**Note: For Medicaid members**, 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**, 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](http://www.cms.gov) for additional information.

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