

## Clinical Policy: Facet Joint Interventions

Reference Number: CP.MP.171

Last Review Date: 07/18

[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 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. Injections are given at least 2 weeks apart;
    2. Intermittent or continuous back or neck pain that interferes with ADLs has lasted for  $\geq 3$  months;
    3. 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.

\*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;

## CLINICAL POLICY

### Facet Joint Interventions

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.<sup>1</sup> 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.<sup>1</sup>

## CLINICAL POLICY

### Facet Joint Interventions

#### *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.<sup>2</sup>

Few randomized controlled trials have evaluated pulsed radiofrequency neurotomy versus sham therapy, and have reached differing conclusions.<sup>2</sup> 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®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, 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	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)

<b>CPT® Codes</b>	<b>Description</b>
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)

<b>HCPCS Codes</b>	<b>Description</b>
N/A	

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

<b>ICD-10-CM Code</b>	<b>Description</b>
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

ICD-10-CM Code	Description
M53.86	Other specified dorsopathies, lumbar region
M54.2	Cervicalgia
M54.30- M54.32	Sciatica
M54.40- 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	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
Reviewed in CP.MP.118 Injections for Pain Management: Revised criteria to state the levels treated can be unilateral or bilateral	07/18	07/18
Policy split from CP.MP.118 Injections for Pain Management. Minor rewording for clarity.	09/18	

**References**

1. Hayes Medical Technology Directory. Intra-articular facet joint injections for the treatment of chronic nonmalignant spinal pain of facet joint origin. April 19, 2018. Accessed Sep 13, 2018.
2. Hayes Medical Technology Directory. Radiofrequency ablation for facet joint denervation for chronic low back pain. Dec 1, 2016. Accessed Sep. 13, 2018.
3. Chou R, Hashimoto R, Friedly J, Fu Rochelle, Dana T, Sullivan S, Bougatsos C, Jarvik J. Pain Management Injection Therapies for Low Back Pain. Technology Assessment Report ESIB0813. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. HHS 290-2012-00014-I.) Rockville, MD: Agency for Healthcare Research and Quality; March 2015.
4. Chou R. Subacute and chronic low back pain: Nonsurgical interventional treatment. In: UpToDate, Atlas SJ (Ed), UpToDate, Waltham, MA. Accessed 8/8/18.
5. Chou R, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Ann Intern Med.* 2007;147:478-491.
6. Chou R et al. Diagnostic imaging for low back pain: advice for high-value health care from the American College of Physicians. *Ann Intern Med* 2011; 154:181-189.
7. Chou R et al. Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain. An evidence-based clinical practice guideline from the American Pain Society. *Spine* 2009; 34: 1066-1077.
8. Heggeness MH. AAOS endorses back pain guidelines. *AAOS Now.* Sept 2010.

## CLINICAL POLICY

### Facet Joint Interventions

9. Maas ET, Ostelo RW, Niemisto L, et al. Radiofrequency denervation for chronic low back pain. *Cochrane Database Syst Rev.* 2015; Oct 23; (10)
10. Manchikanti L et al. A Critical Review of the American Pain Society Clinical Practice Guidelines for Interventional Techniques: Part 1. Diagnostic Interventions. *Pain Physician* 2010; 13:E141-E174.
11. Manchikanti L et al. A Critical Review of the American Pain Society Clinical Practice Guidelines for Interventional Techniques: Part 2. Therapeutic Interventions. *Pain Physician* 2010; 13:E215-E264.
12. Soloman M, Mekhail MN, Mekhail N. Radiofrequency treatment in chronic pain. *Expert Rev Neurother.* 2010;10(3):469-474. Accessed online at: [http://www.medscape.com/viewarticle/718292\\_1](http://www.medscape.com/viewarticle/718292_1)
13. Staal JB et al. Injection therapy for subacute and chronic low-back pain. *Cochrane Database of Systematic Reviews* 2008, Issue 3. Art. No. CD001824. DOI: 10.1002/14651858.CD001824.pub3.
14. Work Loss Data Institute. Low back – lumbar & thoracic (acute & chronic). Encinitas (CA): Work Loss Data Institute; 2011. Various p.
15. Manchikanti L, Kaye AD, Boswell MV, et al. A Systematic Review and Best Evidence Synthesis of Therapeutic Facet Joint Interventions in Managing Chronic Spinal Pain. *Pain Physician* 2015; 18:E535-E582.
16. Manchikanti L, Hirsch JA, Kaye AD, Boswell MB. Cervical zygapophysial (facet) joint pain: effectiveness of interventional management strategies. *Postgrad Med.* 2016 Jan;128(1):54-68. Doi: 10.1080/00325481.2016.1105092.
17. McCormick ZL, Marshall B, Walker J, McCarthy R, Walega DR. Long-Term Function, Pain and Medication Use Outcomes of Radiofrequency Ablation for Lumbar Facet Syndrome. *Int J Anesth.* 2015; 2(2): 028.

#### **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. This clinical policy is not intended to recommend treatment for members. Members 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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**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> for additional information.

©2018 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.