LCD for Paravertebral Facet Joint Block and Facet Joint Denervation (L30483)

Contractor Information

Contractor Name

Wisconsin Physicians Service Insurance Corporation

Contractor Number

00951, 00952, 00953, 00954, 52280, 05101, 05201, 05301, 05401, 05102, 05202, 05302, 05402

Contractor Type

Carrier - FI - MAC

LCD Information

LCD ID Number

L30483

LCD Title

Paravertebral Facet Joint Block and Facet Joint Denervation

Contractor's Determination Number

NEURO-008

AMA CPT / ADA CDT Copyright Statement

CMS National Coverage Policy

Title XVIII of the Social Security Act, section 1862(a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, section 1833(e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

PUB 100-03 Medicare National Coverage Determinations (NCD) Manual- Chapter 1 Section:
30.3 – Acupuncture
150.7 - Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents

Primary Geographic Jurisdiction

Oversight Region

Region V

Original Determination Effective Date

For services performed on or after 03/18/2010

Original Determination Ending Date

Revision Effective Date

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

Facet Joint Blocks:
The paravertebral facet joint, known as the zygapophysial joint is made up of two superior processes (extensions of bone projecting upward), interconnecting with two inferior processes (which project downward) from the vertebra directly above.

A paravertebral facet joint represents the articulation of the posterior elements of one vertebra with its neighboring vertebra. For the purposes of this Local Coverage Determination (LCD), the facet joint is noted at a specific level, by the vertebrae that form it (e.g., C4-5 or L2-3). There are two (2) facet joints at each level, left and right.

For the purpose of this LCD an anatomical region is defined as cervical/thoracic (64490, 64491, 64492) or lumbar/sacral (64493, 64494, 64495). A facet joint level refers to the facet joint or the nerves (e.g., medial branch nerves) innervating that joint.

Facet joint block is one of the methods used to document/confirm suspicions of posterior elemental biomechanical pain of the back. The patient with this condition usually has back pain that does not have a strong radicular component, no associated neurologic deficit and the pain is aggravated by hyperextension of the spine.

Facet joint injections are considered medically necessary for the diagnosis or treatment of chronic pain that has failed conservative therapy.

During this procedure a needle is placed in the facet joint under fluoroscopic or CT guidance and a long acting local anesthetic agent is injected in the facet joint or around or into the nerve supplying the joint, to temporarily anesthetize the facet joint. After satisfactory blockade of the pain has been obtained, the patient is asked to indulge in the activities that usually aggravated his/her pain and to record his/her impressions of the effect of the procedure 4-8 hours after the injection. Temporary or prolonged significant pain relief of the back pain suggests that facet joints were the source of the symptoms and appropriate treatment may be prescribed.

A series of two injections may be medically necessary for diagnostic blocks to establish consistency of results, particularly if diagnostic blocks are to be followed by facet joint denervation.

Multiple nerve blocks may be necessary for proper evaluation and management of chronic pain in a given patient. It is reasonable to use the modality most likely to establish the diagnosis or treat the presumptive diagnosis. If the first procedure fails to produce the desired effect or rules out the diagnosis, the provider may proceed to the next logical test or treatment if desired.

Accordingly, providing a combination of epidural block, facet joint blocks, bilateral sacroiliac joint injections, lumbar sympathetic blocks or providing more than three levels of facet joint blocks to a patient on the same day is considered not reasonable or necessary. Such therapy can lead to an improper diagnosis or unnecessary treatment.

Indications:
Suspicion of facet joint pain.

Limitations:
Radiculopathy should be ruled out by physical or electrophysiologic examination.

Monitored Anesthesia Care (MAC) is rarely necessary for these procedures.

Given that a facet joint receives nerves from three levels, it may be appropriate to block up to three levels when one level of facet joint involvement is suspected.

Facet Joint Denervation:

If the patient gets sufficient relief of pain from a facet joint block for a meaningful period of time but the pain recurs, one of the options is to denervate the facet joint. This procedure requires placement of a needle in the facet joint under fluoroscopic or CT guidance, injection of a local anesthetic agent, and if the pain is relieved (confirming that the needle is in the area desired to be denervated), injection of a neurolytic agent to destroy the facet joint nerve. This denervation can also be achieved by passing an electric current through a similarly placed electrode, by applying heat or by using radiofrequency.

When facet joint block has been effective in managing the back pain under consideration, then a permanent denervation may be considered, but should be restricted only to the level or levels that, from the results of the blocks, can be reasonably considered the source of the pain. This may not include all the levels that were blocked.

CPT codes mentioned in this policy may not be used to treat patients with acupuncture techniques or variations of those techniques.

Limitations:
The effects of denervation should last from six months to one year or longer. In some instances the effects may be permanent. Repeat denervation procedures at the same joint/nerve level will only be considered medically necessary when the patient has had significant improvement of pain after the initial facet joint nerve destruction that lasted an appropriate period of time (greater than or equal to six months.)

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

11x	Hospital-inpatient (including Part A)
12x	Hospital-inpatient or home health visits (Part B only)
13x	Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
21x	SNF-inpatient, Part A
22x	SNF-inpatient or home health visits (Part B only)
23x	SNF-outpatient (HHA-A also)
71x	Clinic-rural health
73x	Clinic - Free-standing
75x	Clinic-CORF
77x	Clinic - Federally Qualified Health Center (FQHC)
83x	Special facility or ASC surgery-ambulatory surgical center (Discontinued for Hospitals Subject to Outpatient PPS; hospitals must use 13X for ASC claims submitted for OPPS payment -- eff. 7/00)
85x	Special facility or ASC surgery-rural primary care hospital (eff 10/94)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

032X	Radiology diagnostic-general classification
0360	Operating room services-general classification
0361	Operating room services-minor surgery
0369	Operating room services-other operating room services
040X	Other imaging services-general classification
0450	Emergency room-general classification
049X	Ambulatory surgical care-general classification
050X	Outpatient services-general classification (deleted 9/93)
051X	Clinic-general classification

052X	Free-standing clinic-general classification
0761	Specialty Services - Treatment Room (effective 08/10/09)
096X	Professional fees-general classification

CPT/HCPCS Codes

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)
64622	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; LUMBAR OR SACRAL, SINGLE LEVEL
64623	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; LUMBAR OR SACRAL, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64626	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; CERVICAL OR THORACIC, SINGLE LEVEL
64627	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE; CERVICAL OR THORACIC, EACH ADDITIONAL LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
77003	FLUOROSCOPIC GUIDANCE AND LOCALIZATION OF NEEDLE OR CATHETER TIP FOR SPINE OR PARASPINOUS DIAGNOSTIC OR THERAPEUTIC INJECTION PROCEDURES (EPIDURAL, TRANSFORAMINAL EPIDURAL, SUBARACHNOID, OR SACROILIAC JOINT), INCLUDING NEUROLYTIC AGENT DESTRUCTION
77012	COMPUTED TOMOGRAPHY GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), RADIOLOGICAL SUPERVISION AND INTERPRETATION

ICD-9 Codes that Support Medical Necessity

Note: ICD-9 codes must be coded to the highest level of specificity.

Group 1
These are the only covered ICD-9-CM codes that support medical necessity for CPT codes 64490, 64491, 64492, 64493, 64494 and 64495:

Note: Diagnostic restrictions do not apply to CPT code 77003 or 77012.

716.98	UNSPECIFIED ARTHROPATHY INVOLVING OTHER SPECIFIED SITES

720.1	SPINAL ENTHESOPATHY
721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.2	THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.41	SPONDYLOSIS WITH MYELOPATHY THORACIC REGION
721.42	SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
721.90	SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MYELOPATHY
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.71	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY CERVICAL REGION
722.72	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY THORACIC REGION
722.73	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82	POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
723.1	CERVICALGIA
724.00	SPINAL STENOSIS OF UNSPECIFIED REGION
724.01	SPINAL STENOSIS OF THORACIC REGION
724.02	SPINAL STENOSIS OF LUMBAR REGION
724.09	SPINAL STENOSIS OF OTHER REGION
724.1	PAIN IN THORACIC SPINE
724.2	LUMBAGO

724.3	SCIATICA
733.13	PATHOLOGICAL FRACTURE OF VERTEBRAE
738.4	ACQUIRED SPONDYLOLISTHESIS
805.00 - 805.08	CLOSED FRACTURE OF CERVICAL VERTEBRA UNSPECIFIED LEVEL - CLOSED FRACTURE OF MULTIPLE CERVICAL VERTEBRAE
805.2	CLOSED FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT SPINAL CORD INJURY
805.4	CLOSED FRACTURE OF LUMBAR VERTEBRA WITHOUT SPINAL CORD INJURY

Group 2
These are the only covered ICD-9-CM codes that support medical necessity for CPT codes 64622, 64623, 64626 and 64627.

Note: Diagnostic restrictions do not apply to CPT code 77003 or 77012

721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.2	THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.41	SPONDYLOSIS WITH MYELOPATHY THORACIC REGION
721.42	SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
721.90	SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MYELOPATHY
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82	POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
733.13	PATHOLOGICAL FRACTURE OF VERTEBRAE
738.4	ACQUIRED SPONDYLOLISTHESIS

Diagnoses that Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

General Information

Documentation Requirements

The medical record must include documentation of the duration of the chronic pain and any conservative treatments that have been tried.

The pre-operative evaluation leading to suspicion of the presence of the facet joint pathology must be clearly documented in the patient's medical records along with the post-operative conclusions.

Documentation in the patient's medical record should indicate how the provider arrived at the suspected diagnosis. As an example, the patient had back pain without a strong radicular component, no associated neurological deficit and the pain was aggravated by hyperextension of the spine.

The medically necessary reason for the use of CT guided imaging rather than fluoroscopy must be documented in the medical record.

The medical record must be made available to Medicare upon request.

When, the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as "not reasonable and necessary" under Section 1862(a)(1) of the Social Security Act.

When requesting a written redetermination (formerly appeal), providers must include all relevant documentation with the request.

Appendices

Utilization Guidelines

The number of injections in the diagnostic phase should be limited to no more than two times, and should be limited to three levels whether unilateral or bilateral for each region on any given date of service. The second diagnostic injection should be done no sooner than one week following the first diagnostic injection.

In the treatment or therapeutic phase the intervention procedures should be repeated only as medically necessary. No more than four therapeutic injections per region per patient would be expected for the majority of patients during a one year period.

Significant pain relief is defined as greater than or equal to 80% initially with the ability to perform previously painful maneuvers.

Injection of phenol or alcohol or pulsed radiofrequency ablation of the facet joint is considered experimental or investigative.

Prolotherapy, joint sclerotherapy and ligamentous injections with sclerosing agents are not covered services per National Coverage Determinations 150.7.

Physicians typically perform facet joint injections using radiological guidance to ensure correct needle placement and avoid nerve or other injury. Facet joint injections performed without the use of fluoroscopy or CT guidance are considered not medically necessary.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

Sources of Information and Basis for Decision

Other Medicare Contractors' Local Coverage Determinations

Tollison, CD, ed. Handbook of Pain Management. 2nd ed. Baltimore: Williams & Wilkins; 1994.

The Pain Clinic. "Facet Joint Injections." (n.d.) Available online at http://www.painclinic.org/treatment-facetjointinjections.htm. Accessed on March 2, 2009

Boswell et al. Interventional Techniques: Evidence-based Practice Guidelines in the Management of Chronic Spinal Pain. Pain Physician. 2007; 10:7-111

OIG Report OEI-05-07-00200 Medicare payments for Facet Joint Injection Services; Published Sept 2008

CR 6317 Facet Joints Implementation March 9, 2009

Advisory Committee Meeting Notes

Meeting Date:
Wisconsin 9/25/09
Illinois 9/16/09
Michigan 9/09/09
Minnesota 09/24/09
J5 MAC 10/08/09

Open Meeting Date 8/19/2009

Start Date of Comment Period

10/08/2009

End Date of Comment Period

11/23/2009

Start Date of Notice Period

02/01/2010

Revision History Number

Revision History Explanation

3/7/2010 - The description for Bill Type Code 73 was changed
3/7/2010 - The description for Bill Type Code 77 was changed

Reason for Change

Last Reviewed On Date

Related Documents

This LCD has no Related Documents.

LCD Attachments

Coding and Billing (PDF - 12,560 bytes)

All Versions

Updated on 03/07/2010 with effective dates 03/18/2010 - N/A

Updated on 01/13/2010 with effective dates 03/18/2010 - N/A