Clinical Policy: Facet Joint Interventions

Reference Number: WNC.CP.267 Coding Implications
Last Review Date: Revision Log

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

Note: 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.

Description[1]

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

I. It is the policy of WellCare of North Carolina® 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 (3) months;
   b. The member/enrollee has failed to respond to conservative therapy within the past year including **all** of the following:
      i. ≥ four (4) 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.*

      ii. Nonsteroidal anti-inflammatory drugs (NSAIDs) ≥ three weeks (3) 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 2 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 (3) 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 6 months have elapsed since the previous treatment;
   b. ≥ 50% pain relief was obtained for at least 6 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

I. *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]

II. *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 2025, 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
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)
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

CPT®* Codes	Description
	sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
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)
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	Reviewed Date	Approval Date
Original approval date	09/21	01/22
Annual Review. Verbiage added to I.D. for "Therapeutic facet joint injections are considered not medically necessary." References reviewed & updated.	09/22	09/22
NCHC verbiage removed from NC Guidance Verbiage.	04/23	04/23
Annual Review. ICD-10-CM and CPT codes reviewed. References updated.	08/23	08/23
Background updated with no impact to criteria. ICD-10-CM Diagnosis Code & HCPCS tables removed. References reviewed and updated.	11/23	11/23
Annual review. Criteria I.A. Added "diagnostic" to specify diagnostic facet joint injections. Criteria I.A.1.b. added 'within the past year." Criteria I.A.1.b.i. Deleted Chiropractic, and Changed 6 to 4 weeks for physical therapy, home exercise and activity modification. 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. Changed 'disc herniation, radiculitis, discogenic or sacroiliac pain" to "fracture, tumor, infection, and extraspinal lesion' Added 'pain not associated with radiculopathy or myelopathy' and removed 'pain worse at night.' Criteria I.A.1.e. Pain relief updated from > 75% to ≥ 80 %." Note at end of Criteria I.A. Changed pain relief from <75% to <80%. Criteria I.B.1.a. Changed "chronic neck or back pain is present" to 'Neck or	08/24	08/24

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
back pain present for ≥ three months.' Criteria I.B.1.b. Pain relief updated from > 75% to ≥ 80 % 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. Added CPT codes that do not support coverage criteria table. References reviewed and updated.		
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. Codes reviewed. Under NC Guidance/Claims related information, updated state web address.		

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North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
Professional (CMS-1500/837P transaction)
Institutional (UB-04/837I transaction)
Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

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.

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/enrollees, 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/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.