BSC_NIA_CG_301	Paravertebral Facet Joint Injections or Blocks		
Original Policy Date:	January 1, 2017	**Effective Date:**	July 1, 2024
Section:	7.0 Surgery	**Page:**	Page 1 of 8

Policy Statement

INDICATIONS

FACET JOINT INJECTIONS OR MEDIAL BRANCH NERVE BLOCKS [1, 2]

To confirm non-radicular pain suggestive of facet joint or pars interarticularis origin, **ALL** the following must be met:

- History of mainly axial or non-radicular pain unless stenosis is caused by synovial cyst [3]
- Lack of evidence that the primary source of pain being treated is from sacroiliac joint pain, discogenic pain, disc herniation, or radiculitis
- Chronic lumbar spondylolysis
  - Imaging studies confirming the presence of a pars interarticularis fracture/defect are required
- Pain causing functional disability or average pain level of ≥ 6 (scale of 0 to 10) related to the requested spinal region.
- Duration of pain for at least **3 months**
- Failure of conservative treatment* for a minimum of six (6) weeks within the last six (6) months

NOTE: Failure of conservative treatment is defined as one of the following:
- Lack of meaningful improvement after a full course of treatment; **OR**
- Progression or worsening of symptoms during treatment; **OR**
- Documentation of a medical reason the member is unable to participate in the treatment (*Closure of medical or therapy offices, patient inconvenience, or noncompliance without explanation does not constitute 'inability to complete' treatment*)

IMAGING GUIDANCE [4, 5, 6, 7]

The facet joint is commonly identified under image guidance by Computed tomography (CT) or Fluoroscopy. Medial Branch Blocks are commonly identified by Fluoroscopy. With proper use by skilled interventional pain physicians with ultrasound experience, the use of ultrasound guidance is similar to CT or Fluoroscopy but can have a lower accuracy of needle placement.

Ultrasound guidance can be an effective alternative if CT or fluoroscopy guided techniques are contraindicated; however, individual patient factors such as poor visualization due to deeper tissue layers (e.g., increased Body Mass Index (BMI) may contribute to substandard image resolution.

NOTE: ALL procedures must be performed under imaging guidance

REPEAT INJECTIONS [1, 7]

Facet joint injections and medial branch nerve blocks may be repeated only as medically necessary. **Each** injection requires an authorization, and the following criteria must be met for repeat injections:

- Up to 2 injections may be performed in the initial diagnostic phase, no sooner than 2 weeks apart, provided at least 50% pain relief or significant documented functional improvement is obtained
  - If the most recent injection was a diagnostic block with local anesthetic only, there must be at least 7 days between injections
- If the first injection is unsuccessful, a second injection may be performed at a different spinal level or with a change in technique (e.g., from an intra-articular facet injection to a medial

branch nerve block) given there is a question about the pain generator or evidence of multi-level pathology

- Facet joint injections may only be repeated after the initial diagnostic phase if the individual has had at least 50% pain relief or significant documented functional improvement for a **minimum of 2 months** after each therapeutic injection
- The individual continues to have pain causing functional disability or average pain level ≥ 6 on a scale of 0 to 10 related to the requested spinal region.
- The individual is engaged in ongoing active conservative therapy*, unless the medical reason this treatment cannot be done is clearly documented [8]
  - Diagnostic injections within 1 month of the previous injection do not require documentation of ongoing active conservative therapy
- In the diagnostic phase, a maximum of 2 procedures may be performed. Repeat diagnostic injections after prior radiofrequency neurolysis are allowable if there is a question about the pain generator, different levels are to be targeted, or if there is surgery in the same spinal region.
- A maximum of 4 facet injections may be performed in a 12-month period **per spinal region** (except under unusual circumstances, such as a recurrent injury)
  - Unilateral injections performed at the same level on the right vs. left within 1 month of each other would be considered as one procedure toward the total number of facet procedures allowed per 12 months
- If different spinal regions are being treated, injections should be administered at intervals of no sooner than 7 days unless a medical reason is provided to necessitate injecting multiple regions on the same date of service (see NOTE)

NOTE: Radiofrequency neurolysis procedures should be considered in individuals with a successful medial branch nerve block (at least 70% pain relief or improved ability to function), but with insufficient sustained relief (less than 2-3 months improvement).

EXCLUSIONS

These requests are excluded from consideration under this guideline:

- Sacral lateral branch blocks (S1, S2, S3)
- Atlantoaxial joint injections (C1-2)
- Occipital nerve blocks
- Hardware injection or block for diagnosis or treatment of post-surgical or other spine pain

CONTRAINDICATIONS

Although there are no absolute contraindications there are relative contraindications that include;

- Active systemic or spinal infection
- Skin infection at the site of needle puncture
- Inability to obtain percutaneous access to the target facet joint

Policy Guidelines

*CONSERVATIVE TREATMENT [11, 7]

Non-operative treatment should include a multimodality approach consisting of at least one (1) active and one (1) inactive component targeting the affected spinal region.

- Active components
  - Physical Therapy
  - Physician-supervised home exercise program**
  - Chiropractic Care
- Inactive Modalities
  - Medications (e.g., NSAIDs, steroids, analgesics)

- Injections (e.g., epidural steroid injection, selective nerve root block)
- Medical Devices (e.g., TENS unit, bracing)

****HOME EXERCISE PROGRAM (HEP) [12, 7]**
The following two elements are required to meet conservative therapy guidelines for HEP:

- Documentation of an exercise prescription/plan provided by a physician, physical therapist, or chiropractor
  AND
- Follow-up documentation regarding completion of HEP after the required 6-week timeframe or inability to complete HEP due to a documented medical reason (e.g., increased pain or inability to physically perform exercises).

CPT Codes:
Cervical Thoracic Region:

- 64490 (+ 64491, +64492) 0213T, +0214T, +0215T

Lumbar Region:

- 64493 (+64494, +64495) 0216T, +0217T, +0218T

General Information
It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

Description

Background
Facet joints may refer pain to adjacent structures, making the underlying diagnosis difficult as referred pain may assume a pseudoradicular pattern. Lumbar facet joints may refer pain to the back, buttocks, and lower extremities while cervical facet joints may refer pain to the head, neck, and shoulders.

Imaging studies may detect changes in facet joint architecture, but correlation between radiologic findings and symptoms is unreliable. Although clinical signs are also unsuitable for diagnosing facet joint-mediated pain, they may be of value in selecting individuals for controlled local anesthetic blocks of either the medial branches or the facet joint itself.

Facet joint interventions include intraarticular injections and medial branch nerve blocks in the lumbar, cervical, and thoracic spine. Prior to performing this procedure, shared decision-making between patient and physician must occur, and the patient must understand the procedure and its potential risks and results. Facet joint injections or medial branch nerve blocks require guidance imaging.

Related Policies

- N/A

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

- N/A

Rationale

SPECIAL NOTE
Any injection performed at least two years from prior injections in the same region will be considered a new episode of care and the **INITIAL** injection requirements must be met for approval. Events such as surgery on the same spinal region or any new pathology would also prompt a new episode of care.

MEDICAL NECESSITY
Medical necessity management for paravertebral facet injections includes an initial evaluation including history and physical examination and a psychosocial and functional assessment. The following must be determined: nature of the suspected organic problem; non-responsiveness to conservative treatment*; level of pain and functional disability; conditions which may be contraindications to paravertebral facet injections; and responsiveness to prior interventions.

Note: It is generally considered **not medically necessary** to perform multiple interventional pain procedures on the same date of service. Documentation of a medical reason to perform injections in different regions on the same day can be provided and will be considered on a case-by-case basis (e.g., holding anticoagulation therapy on two separate dates creates undue risk for the patient). Different types of injections in the same spinal region (cervical, thoracic, or lumbar) should not be done on the same day with the exception of a facet injection and ESI performed during the same session for a synovial cyst confirmed on imaging.

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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
  - Diagnosis, history and duration of pain
  - Duration and response to conservative therapy (specify type)
  - Previous injection(s) (if applicable) including: date(s), type(s), location(s)/level(s), and responses
  - Treatment plan
- Injection(s) planned or performed including:
  - Location(s)/Level(s)
  - Type of injection (i.e., facet joint injection or block, diagnostic, therapeutic) and type of injectate solution(s)
  - Whether intravenous (IV) sedation/narcotic analgesia/ monitored anesthesia care (MAC) is planned or used (if applicable)
- Type of imaging guidance (i.e., fluoroscopy)
- Radiology report(s)

Post Service (in addition to the above, please include the following):

- Procedure report(s) including: description and procedure effects

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	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)

Type	Code	Description
	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)
	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)
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
01/01/2017	Adoption of National Imaging Associates (NIA) Clinical Guidelines
07/01/2018	NIA Clinical Guideline update
07/01/2019	NIA Clinical Guideline update
07/01/2020	Annual NIA clinical guideline update.
03/01/2021	Annual NIA clinical guideline update. Policy title changed Paravertebral Facet Joint Injections or Blocks to current one.
01/01/2022	Annual NIA clinical guideline update.
01/01/2023	Annual NIA clinical guideline update. Policy title changed Paravertebral Facet Joint Injections or Blocks (no U/S) to current one.
01/01/2024	Annual NIA clinical guideline update.
07/01/2024	Semi-annual NIA clinical guideline update.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to

treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.