

Contractor Name

Wisconsin Physicians Service (WPS)

Contractor Number

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

Contractor Type

Carrier B
Fiscal Intermediary A
MAC A
MAC B

LCD Database ID Number**LCD Version Number****LCD Title**

Paravertebral Facet Joint Block and Facet Joint Denervation

Contractor's Determination Number

NEURO-008

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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

Primary Geographic Jurisdiction

Carrier B: Wisconsin, Illinois, Michigan, Minnesota

Fiscal Intermediary A: Alaska, Alabama, Arizona, Arkansas, California - Entire State, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Iowa, Idaho, Illinois, Indiana,

Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri - Entire State, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming, American Samoa, Guam, Northern Mariana Islands, U.S. Virgin Islands

MAC A/B: Iowa, Missouri, Nebraska, Kansas

Secondary Geographic Jurisdiction

Oversight Region

Region I

Region V

Region VII

Original Determination Effective Date

Revision Effective Date

Indications and Limitations of Coverage and/or Medical Necessity

Facet Joint Blocks:

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 joint or facet joint nerve to temporarily denervate 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 abolition of the back pain suggests that facet joints were the source of the symptoms and appropriate treatment may be prescribed.

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.

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 OPSS 13X must be used for ASC claims submitted for OPSS 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-independent provider based FQHC (eff 10/91)
75x	Clinic-CORF
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 OPSS 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.

Revenue codes only apply to providers who bill these services to the fiscal intermediary. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

Revenue codes 096X, 097X and 098X are to be used only by Critical Access Hospitals (CAHs) choosing the optional payment method (also called Option 2 or Method 2) and only for services performed by physicians or practitioners who have reassigned their billing rights. When a CAH has selected the optional payment method, physicians or other practitioners providing professional services at the CAH may elect to bill their carrier or assign their billing rights to the CAH. When professional services are reassigned to the CAH, the CAH must bill the FI using revenue codes 096X, 097X or 098X.

032X	Radiology diagnostic-general classification
0360	Operating room services-general classification
0361	Operating room services-minor surgery
0369	Operating room services-general classification
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	Treatment or observation room-treatment room (eff 9/93)
096X	Professional fees-general classification

CPT/HCPCS Codes

64470	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level
64472	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, each additional level (list separately in addition to code for primary procedure)
64475	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level
64476	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level (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,

	paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction
77012	Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation.

Does the CPT 30% Rule Apply

No

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 64470, 64472, 64475 and 64476:

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

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 without mention of 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 cervical region
722.82	Postlaminectomy syndrome thoracic region
722.83	Postlaminectomy syndrome 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	Siatica
733.13	Pathological fracture of vertebrae
738.4	Acquired spondylolisthesis
805.00-805.08	Closed fracture of cervical vertebra unspecified-multiple
805.2	Closed fracture of thoracic vertebra without spinal cord injury

805.4	Closed fracture of lumbar vertebra without spinal cord injury
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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

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 without mention of 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 cervical region
722.82	Postlaminectomy syndrome thoracic region
722.83	Postlaminectomy syndrome 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

Diagnoses that DO NOT Support Medical Necessity

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.

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.

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.

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 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
(Published)

Revision History Number/Explanation

Last Reviewed On

Related Documents

[Coding Guideline Neuro-008](#)

LCD Attachments

Does this LCD contain a "Least Costly Alternative" Provision?

No

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Coding Guidelines

LCD Database ID Number

LCD Title

Paravertebral Facet Joint Block and Facet Joint Denervation

Contractor's Determination Number

NEURO-008

Coding Information

General

Paravertebral Facet Joint Injection

1. Each CPT code listed (single level, each additional level) may be billed with a Modifier 50 when injecting a level bilaterally. For one level unilateral or bilateral CPT codes 64470 or 64475 should be used. If the facet joint injection is performed at more than one level unilateral or bilateral CPT codes 64472 or 64476 should be used for the additional level. For bilateral procedures Modifier 50 should be appended to the procedure codes with number of services = one.
2. Use the appropriate CPT code in Item 24D on the CMS-1500 claim form (or electronic equivalent) and link it to the applicable ICD-9-CM code listed above under the ICD-9-CM Codes that Support Medical Necessity section.
3. Use CPT code 77003 for the fluoroscopic guidance of the needle. Note that this code is defined as “for injection procedures” (plural), and so may be billed only once regardless of the number of levels addressed or injections performed.
4. If the injection is made around or into the spinal nerve, the service should be billed as a paravertebral nerve injection.
5. When destruction of the facet joint nerve is performed following the blockage, only the codes for the nerve destruction should be billed since their allowance includes that of the facet nerve blockage procedure.

Paravertebral Facet Joint Denervation

1. If a provider denervates only one level, unilateral or bilateral, CPT codes 64622 or 64626 should be used. If the denervation is performed at more than one level, unilateral or bilateral, CPT codes 64623 and 64627 should be used for each of the subsequent levels. If denervation is performed bilaterally, Modifier 50 should be appended to the procedure code with number of services = one.
2. Use the appropriate CPT code in Item 24D on the CMS-1500 form (or electronic equivalent) and link it to the applicable ICD-9-CM code in Item 24E (or electronic equivalent).
3. Use CPT code 77003 for the fluoroscopic guidance of the needle. Note that this code is defined as “injection procedures” (plural), and so may be billed only once regardless of the number of levels addressed or injections performed.

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

Notes

Open Meeting

An asterisk (*) indicates a revision to that section of the article.

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