Cohere Medical Policy - Facet Injections

Clinical Guidelines for Medical Necessity Review

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Important Notices

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Guideline Information:

Specialty Area: Disorders of the Musculoskeletal System
Guideline Name: Cohere Medical Policy - Facet Joint Injections
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Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Service: Facet Joint Injections

Recommended Clinical Approach

The facet joint is the articulating bridge between adjacent vertebral bodies. It is innervated by two medial branch nerves from the corresponding dorsal rami, one from the spinal nerve above the joint and one from the spinal nerve below the joint. Facet injections, also known as facet joint intraarticular injections, facet blocks, or medial branch blocks (MBB), are local anesthetic injections, with or without a steroid medication, into the facet joints or near the medial branch nerve that innervates the facet joint. Facet injections are intended for diagnostic or therapeutic purposes and must be performed under CT or fluoroscopy guidance. If such a block relieves pain, radiofrequency ablation may be considered for longer relief.[1-3,7-12]

Medical Necessity Criteria

Indications

- ➔ A **facet injection** is appropriate if **ANY** of the following is **TRUE**:
  - ◆ The injection is an initial diagnostic injection, and **ALL** of the following are **TRUE**:[1,3-4]
    - The pain is predominantly axial neck or back pain; **AND**
    - **ANY** of the following are **TRUE**:
      - The patient's pain level is greater than or equal to 4 out of 10 on a scale of 0 to 10; **OR**
      - The pain is causing a functional disability; **AND**
    - Failure of conservative management for greater than 3 months, including **ALL** of the following[8]:
      - Anti-inflammatory medications, analgesics, or prescription medications (e.g., oral steroids, narcotics, neuropathic pain medications) if not contraindicated; **AND**
      - Physical therapy; **AND**
    - The patient does not have untreated radiculopathy (except caused by facet joint synovial cyst) as the primary pain generator; **AND**

- Physical exam findings are suggestive of facet-mediated pain (e.g., pain exacerbated by extension, rotation, facet loading, etc.); **AND**
- A radiology study has ruled out non-facet pathology that can explain the source of the patient's pain; **AND**
- Frequency limitation indicated by **ALL** of the following:
    - No more than 1 spinal region (cervical, thoracic, or lumbosacral) is injected per session; **AND**
    - No more than 2 facet joint levels (either unilateral or bilateral) are injected per spine region per session; **AND**
    - No more than 4 diagnostic facet injections per cervical, thoracic, or lumbar spinal region in 12 consecutive months (unilateral injections performed at the same level on the right vs. left within 1 month of each other are considered one procedure toward the total number of facet procedures allowed per 12 months); **OR**

◆ The injection is a subsequent confirmatory diagnostic injection and **ALL** of the following are **TRUE**:[5]

- The first injection provided greater than or equal to 80% pain relief; **AND**
- The injection is being performed at the same level as the initial diagnostic injection; **AND**
- Frequency limitation indicated by **ALL** of the following:
    - No more than 1 spinal region (cervical, thoracic, or lumbosacral) is injected per session; **AND**
    - No more than 2 facet joint levels (either unilateral or bilateral) are injected per spine region per session; **AND**
    - No more than 4 diagnostic facet injections per cervical, thoracic, or lumbar spinal region in 12 consecutive months (unilateral injections performed at the same level on the right vs. left within 1 month of each other are considered one procedure toward the total number of facet procedures allowed per 12 months); **OR**

◆ The injection is a therapeutic facet injection, and **ALL** of the following are **TRUE**:[5]

- Medical necessity justification documented regarding why radiofrequency ablation (RFA) cannot be performed; **AND**
- The pain is predominantly axial neck or back pain; **AND**
- **ANY** of the following is **TRUE:**
  - The patient's pain level is greater than or equal to 4 out of 10 on a scale of 0 to 10; **OR**
  - The pain is causing a functional disability; **AND**
- **ANY** of the following is **TRUE** regarding prior facet injection(s)**:**
  - Two diagnostic facet injections provided greater than or equal to 80% pain relief; **OR**
  - Prior therapeutic facet injection has provided greater than or equal to 50% pain relief for greater than or equal to 3 months; **AND**
- The patient is participating in ongoing rehabilitative approaches (e.g., physical therapy, chiropractic care, or physician-guided home exercise program); **AND**
- The patient has not had greater than 3 therapeutic injections at that level per year (unilateral injections performed at the same level on the right vs. left within 1 month of each other are considered one procedure toward the total number of facet procedures allowed per 12 months); **OR**

◆ Intra-articular facet joint injection and synovial cyst aspiration/rupture when **ALL** of the following are **TRUE**[6,14]:
- Advanced diagnostic imaging confirms a facet joint synovial cyst; **AND**
- Documentation shows clinical and physical symptoms related to synovial facet cyst; **AND**
- Cyst aspiration or rupture may be repeated once per individual cyst and only if there is 50% or more consistent improvement in pain for at least 3 months; **OR**

◆ A diagnostic injection (pars injection) to confirm a stress fracture in the pars interarticularis or pars defect as the primary pain generator for low back pain if **ALL** of the following are **TRUE**:
- Imaging studies confirm the presence of pars defect or pars interarticularis fracture; **AND**
- **ANY** of the following is **TRUE**:

    - The patient's pain level is greater than or equal to 4 out of 10 on a scale of 0 to 10; **OR**
    - The pain is causing a functional disability; **AND**
- No more than two diagnostic injections.

Non-Indications

➔ A **facet injection** is not considered appropriate if **ANY** of the following is **TRUE**:

- Facet joint injection performed without computed tomography [CT] or fluoroscopic guidance; **OR**
- Facet joint injection performed with ultrasound guidance; **OR**
- Diagnostic or therapeutic facet injection at the same level as a previously successful radiofrequency ablation (RFA); **OR**
- When other types of spine injections (e.g., ESI, sacroiliac joint injections, facet injections to other spinal regions, etc.) are performed on the same date of service unless medical necessity to perform multiple injections is documented in a chart (e.g., risk of holding anticoagulant multiple times, presence of facet cyst causing radicular symptoms for which ESI and facet injection can be allowed at the same time, etc.); **OR**
- Facet injections performed with biologics (e.g., platelet-rich plasma, stem cells, amniotic fluid, etc.); **OR**
- Facet joint prolotherapy injections**; OR**
- Facet injections at the atlanto-occipital joint (C0-C1) or atlanto-axial joint (C1-C2).

Level of Care Criteria

Inpatient and outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code 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)
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)

64999	Unlisted procedure, nervous system
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)
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)

Medical Evidence

Appeadu et al. (2022) performed a systematic review and meta-analysis on the effectiveness of intraarticular cervical facet steroid injections as a treatment for cervicogenic headache. From an analysis of 3 studies with a total of 64 patients, the authors concluded intraarticular cervical facet injections demonstrated improvement in the mean pain score from baseline to post-intervention. The overall effect size, defined as the pooled mean difference in the visual analog scale (VAS) for pain scores, was 3.299 (95% confidence interval: 2.045 to 4.552, P less than 0.001).[12]

Viva et al. (2024) conducted a systematic review to assess the efficacy, accuracy, and feasibility of ultrasound (US)-guided cervical facet injections for chronic neck pain. From an analysis of 9 studies with a total of 958 patients, the authors concluded that US-guided cervical facet injection for the treatment of cervical facet joint syndrome (CFJS) shows a high degree of accuracy (92% to 98%) and efficiency (i.e. the procedure relieves pain with a decrease in the procedure time and fewer needle passes compared to the X-ray-guided technique, which also involves radiation exposure). However, the authors note the procedure strictly depends on the operator's expertise.[13]

Ashmore et al. (2022) performed a systematic review and meta-analysis on the use of fluoroscopy to confirm needle placement when performing lumbar medial branch blocks (MBB) and facet joint injections (FJI). The authors note a high risk of incorrect needle placement using ultrasound-guided MMB and FJI when fluoroscopy or CT is used to confirm.[7]

Bodor et al. (2022) studied 36 patients (60 cervical facet joints) with facet pain. Ultrasound was used to guide the injections: C2-3 (22%), C3-4 (40%), C4-5 (33%) and C5-6 (5%). The accuracy rate was high (92% to 98%), and patient outcomes were good.[8]

Kershen et al. (2018) performed a comparative study on intraarticular injections' short- and long-term efficacy for lumbar pain. A total of 77 patients

were examined, including 100 procedures with 205 total facet joints injected. Pain improvement scores were high immediately following injection and at the 1-week follow-up.[9]

Manchikanti et al. (2015) performed a systematic review to analyze the clinical efficacy of therapeutic facet joint interventions for individuals with chronic spinal pain. A literature review from 1966 through March 2015 yielded 21 randomized control trials (RCTs) that met inclusion criteria; a total of 5 observational studies were evaluated. Long-term efficacy is supported by Level II evidence of radiofrequency ablation (RFA) neurotomy and facet joint nerve blocks for the lumbar, cervical, and lumbar spine. Intraarticular injections had an evidence Level III for lumbar injection and an evidence Level IV for cervical and thoracic injections. The primary outcome measure was short-term (6 months or less) and long-term (6 months or more) pain relief. Secondary outcome measures included functional status improvement, psychological status, ability to return to work, and reduced opioid usage.[10]

In 2020, the American Society of Interventional Pain Physicians (ASIPP) published a guideline on *Facet Joint Interventions in the Management of Chronic Spinal Pain*. The level of evidence is weak for the use of lumbar, cervical, and thoracic intraarticular facet joint injections.[2]

The American Society of Regional Anesthesia and Pain Medicine (ASRM) published a guideline on interventions for lumbar facet joint pain. Prior to RFA, MBB is recommended. Intraarticular injections are recommended for diagnostic and therapeutic purposes in certain patients. Therapeutic MBB and intraarticular injections are not recommended in most clinical scenarios (e.g., prolonged relief from prognostic blocks, contraindications to RFA).[1]

Guidelines are also available on interventions for cervical spine (facet) joint pain. The ASRM does not recommend the use of therapeutic intraarticular injections. A high technical failure rate is noted for intraarticular injections. In addition, MBB may be more clinically useful for RFA outcomes versus intraarticular injections.[3]

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Clinical Guideline Revision History/Information

Original Date: April 21, 2021		
Review History		
Version 2	12/1/2023	
Version 3	9/20/2024	Updated language regarding conservative treatment.
Version 4	12/19/2024	• Annual review • Aligned to current policy guidelines. • Medical evidence updated. • References updated. • CPT codes and descriptions updated; temporary codes verified. • Indications and non-indications were updated