Policy Number	**SUR702.015**
Policy Effective Date	**02/01/2025**
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Facet Joint Injections

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Related Policies (if applicable)
None

Disclaimer

Carefully check state regulations and/or the member contract.
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

Facet joint injections that are performed under fluoroscopic or computerized tomography (CT) guidance **may be considered medically necessary** according to the ***schedule** outlined below when the following criteria are met:

- The lumbar back or cervical neck pain is chronic (i.e., persisting for more than three [3] months); **AND**
- Six weeks of conservative therapy (e.g., physical and/or chiropractic therapy, oral analgesia and/or steroids and/or relaxants, activity modification) fails or conservative therapy is not feasible; **AND**
- Predominant axial pain that is not attributable to radiculopathy (with the exception of synovial cysts, see Therapeutic Phase section below), myelopathy, or neurogenic claudication; **AND**
- Physical exam findings which are consistent with the facet joint as the presumed source of pain; **AND**
- Absence of non-facet pathology that could explain the source of the patient's pain, such as fracture, tumor, or infection; **AND**

- Absence of prior surgical fusion at the proposed level; **AND**
- Absence of an unexplained neurological deficit; **AND**
- Repeat interventions only upon return of pain and deterioration in functional status.

***Schedule: When the above criteria are met,** the following **schedule** for diagnostic and therapeutic facet joint injection(s) that are performed under fluoroscopic guidance **may be considered medically necessary:**

DIAGNOSTIC PHASE (to determine origin of patient's pain)

- A diagnostic block of the joint, or nerves innervating the joints, using a local anesthetic without corticosteroids is given initially.
- For each covered spinal region, a maximum of four (4) diagnostic joint sessions per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure.
- In the diagnostic phase, a patient may receive one (1) injection per level per side in a seven (7) day period to determine the origin of the patient's pain.
- If the diagnostic block provides pain relief (defined as at least 80% or more relief in primary pain index), therapeutic facet injections are given no sooner than one week after a successful diagnostic block at that spinal region, (i.e., cervical, thoracic or lumbar).

THERAPEUTIC PHASE (after the diagnostic phase is completed)

- Therapeutic facet joint injection at the same anatomic site for recurrent pain may be repeated if the prior injection provided at least 50% reduction in pain with functional improvement of at least 3 months duration.
- Therapeutic facet joint injections should be repeated only as necessary according to the medical necessity criteria to a maximum of four (4) therapeutic facet joint (intra-articular [IA]) injection sessions per rolling 12 months.
- If therapeutic facet injections are to be performed at a different spinal region:
  - A positive diagnostic block is required at that region; **AND**
  - The therapeutic frequency is limited to every three (3) months per spinal region; **AND**
  - Therapeutic improvement is required for additional facet injections; **AND**
  - All regions should be treated at the same time whenever possible, provided all procedures can be performed safely.
- Therapeutic facet joint injections when the following criteria are met:
  - Evidence of nerve root compression due to a facet synovial cyst when seen on an advanced imaging study (magnetic resonance imaging [MRI] or CT) performed within the previous 12 months that correlates with the clinical findings; **AND**
  - Associated moderate-to-severe radicular pain and functional limitations.

Facet injections **are considered not medically necessary** for the following:

- When the above criteria are not met; **OR**
- When there is a history of coagulopathy, systemic and/or local infection, or unstable medical conditions; **OR**
- Additional therapeutic facet injections in the absence of an improvement in pain or function; **OR**

- Therapeutic facet injections more frequently than every three (3) months *per spinal region;* **OR**
- Therapeutic facet injections more frequently than four (4) times per year *per spinal region*; **OR**
- In the presence of an unexplained neurological deficit.

Ultrasound (US) guidance of either facet or transforaminal injections **is considered experimental, investigational and/or unproven.**

Policy Guidelines

None.

Description

Back pain is one of most common reasons people see a doctor or miss days at work. Most occurrences of low back pain go away within a few days; others may take much longer to resolve or may lead to more serious conditions. Acute, or short-term back pain lasts a few days to a few weeks. Most low back pain is acute. It tends to resolve on its own within a few days with self-care and there is no residual loss of function. In some cases, a few months are required for the symptoms to disappear. Chronic back pain is defined as pain that continues for 12 weeks or longer, even after an initial injury or underlying cause of acute low back pain has been treated. About 20 percent of people affected by acute low back pain develop chronic low back pain with persistent symptoms at one year. Even if pain persists, it does not always mean there is a medically serious underlying cause or one that can be easily identified and treated. In some cases, 2 treatments successfully relieve chronic low back pain, but in other cases pain continues despite medical and surgical treatment. (1)

Facet joints, also called zygapophysial or "Z" joints, are located on the posterior spine on each side of each vertebra, where they overlap the neighboring vertebrae. The facet joints provide stability and give the spine the ability to bend and twist. (2) A facet joint injection is an injection of a long-acting local anesthetic agent and/or steroid into the paravertebral facet joint, medial branch nerve or facet joint nerve under fluoroscopic guidance. When optimally performed, the injection is made directly into the joint space, though for generations anesthesiologists have been successful in injecting around the joint. Pain relief following a precise intra-articular injection confirms the facet joint as the source of pain.

Cysts can arise from the facet joints, primarily in the lumbar spine, causing both mechanical and biochemical irritation of the adjacent nerves. (3) These cysts most commonly arise from the L4-5 Z-joints and typically can be histologically divided into synovial and ganglion cysts. Ganglion cysts, the less common of the two, lack a synovial lining, are typically multiloculated and do not communicate with the adjacent Z-joint. Synovial cysts, which represent about 75% of Z-joint cysts, have a synovial lining and communicate with the Z-joint, making them amenable to

fluoroscopic visualization and rupture though needle entry into the Z-joint. Z-joint injection and cyst rupture is performed to treat not only the Z-joint arthropathy and associated pain but also is performed to rupture the associated facet cyst, thereby decompressing the nerve root in an attempt to avoid the need for a more invasive, open surgical decompression.

The 2007 ASIPP (American Society of Interventional Pain Physicians) Guidelines (updated in 2013 and 2020) describes two phases of facet joint injection therapy: the diagnostic and the therapeutic phases. Diagnostic facet joint injections with a local anesthetic are used in the cervical, thoracic or lumbar spine to verify the specific area generating pain prior to a facet joint denervation procedure or other medical management. (11, 12) Therapeutic facet joint injections are based on the outcome of a diagnostic facet joint injection with the patient obtaining sufficient relief for a meaningful period of time. When pain recurs, a repeat injection with long-acting local anesthetic and steroid will generally provide pain relief for four to eight weeks.

In addition to fluoroscopic or computed tomography (CT) guidance, ultrasound-guided imaging may also be used in facet or transforaminal injections. Proposed advantages of ultrasound (US) guidance are:

- Real time monitoring without ionizing radiation,
- Noninvasive,
- More cost effective, and
- Convenience.

Rationale

Pain management presents a major challenge to healthcare providers due to complex natural history and unclear etiology of spinal pain. Clinical decision making for diagnosing and treating chronic pain is difficult due to the subjective nature of pain. Although there are clinical studies for facet joint steroid injections, the results vary in respect to the degree and duration of pain relief, and it is difficult to standardize treatment models.

In 2010, Manchikanti et al. published a randomized, double-blind, controlled trial to evaluate the clinical outcomes of therapeutic cervical medial branch blocks with local anesthetic with or without steroids in managing chronic neck pain of facet joint origin. (4) All of 120 patients included met the diagnostic criteria of cervical facet joint pain by means of comparative, controlled diagnostic blocks, with at least 80% relief. Administered therapeutic cervical medial branch blocks with bupivacaine only for Group I and Group II consisted of cervical medial branch blocks with bupivacaine and steroid. Primary outcome measures included numeric pain scores, Neck Disability Index (NDI), opioid intake, and work status evaluated at baseline, 6, 12, 18, and 24 months. The one-year results of outcomes were published in 2008. This manuscript describes the 2-year results. Significant improvement was defined as at least 50% improvement in pain relief and/or functional status improvement. Patient outcomes were measured at baseline, 3, 6, 12, 18, and 24 months post-treatment with the Numeric Rating Scale (NRS), the

NDI, employment status, and opioid intake. Decrease of ≥ 50% of NRS scores and Oswestry scores were considered significant. The results included 85 percent of patients in Group I and 93% of patients in Group II showed significant pain relief (≥ 50%) at 2 years. The average number of treatments for 2 years was 5.7. The duration of average pain relief with each procedure was 17-19 weeks on average in both groups. Significant improvement of pain and function was demonstrated for 83 to 89 weeks over a period of 2 years. The reviewers concluded that this trial, therapeutic cervical medial branch blocks instituted after the diagnosis, with controlled comparative local anesthetic blocks with 80% concordant pain relief, repeated approximately 6 times over a period of 2 years, provided significant improvement over a period of 2 years.

In 2012, Falco et al. published an update of a systematic review of the therapeutic effectiveness of cervical facet joint interventions to determine and update the clinical utility of therapeutic cervical facet joint interventions in the management of chronic neck pain. (5) The authors indicated that the prevalence of chronic, recurrent neck pain is approximately 15% of the adult general population. Controlled studies have supported the existence of cervical facet or zygapophysial joint pain in 36% to 67% of these patients, when disc herniation, radiculitis, and discogenic are not pathognomonic. However, these studies also have shown false-positive results in 27% to 63% of the patients with a single diagnostic block. There is also a paucity of literature investigating therapeutic interventions of cervical facet joint pain. The available literature for utility of facet joint interventions in therapeutic management of cervical facet joint pain was reviewed. The quality assessment and clinical relevance criteria utilized were the Cochrane Musculoskeletal Review Group criteria as utilized for interventional techniques for randomized trials and the criteria developed by the Newcastle-Ottawa Scale criteria for observational studies. The level of evidence was classified as good, fair, and limited or poor based on the quality of evidence developed by the U.S. Preventive Services Task Force (USPSTF). Data sources included relevant literature identified through searches of PubMed and EMBASE from 1966 to June 2012, and manual searches of the bibliographies of known primary and review articles. The primary outcome measure was pain relief (short-term relief = up to 6 months and long-term > 6 months). Secondary outcome measures were improvement in functional status, psychological status, return to work, and reduction in opioid intake. In this systematic review, 32 manuscripts were considered for inclusion. For final analysis, 4 randomized trials and 6 observational studies met the inclusion criteria and were included in the evidence synthesis. Based on one randomized, sham-controlled, double-blind trial and 5 observational studies, the indicated evidence for cervical radiofrequency neurotomy is fair. Based on one randomized, double-blind, active-controlled trial and one prospective evaluation, the indicated evidence for cervical medial branch blocks is fair. Based on 2 randomized controlled trials, the evidence for cervical intra-articular injections is limited. The limitations included paucity of the overall published literature and specifically lack of literature for intra-articular cervical facet joint injections. The authors concluded that the indicated evidence for cervical medial branch blocks is fair. The indicated evidence for cervical intra-articular injections with local anesthetic and steroids is limited.

In 2015, Boswell et al. published a systematic review to determine the diagnostic accuracy of

spinal facet joint nerve blocks in chronic spinal pain. (13) The search strategy emphasized chronic cervical, midback, and low back pain, facet or zygapophysial joint pain, cervical, thoracic, and lumbar facet injections, and cervical, thoracic, and lumbar facet joint nerve blocks. The final selected studies had their quality and applicability assessed with a 12-item checklist conducted by expert methodologists who signed off on the checklist's face validity. The available evidence is Level I for lumbar facet joint nerve blocks with the inclusion of a total of 17 studies with dual diagnostic blocks, with at least 75% pain relief with an average prevalence of 16% to 41% and false-positive rates of 25% to 44%. The evidence for diagnosis of cervical facet joint pain with cervical facet joint nerve blocks is Level II based on a total of 11 controlled diagnostic accuracy studies, with significant variability among the prevalence in a heterogeneous population with internal inconsistency. The prevalence rates ranged from 36% to 67% with at least 80% pain relief as the criterion standard and a false-positive rate of 27% to 63%. The level of evidence for the diagnostic accuracy of thoracic facet joint nerve blocks is Level II with 80% or higher pain relief as the criterion standard with a prevalence ranging from 34% to 48% and false-positive rates ranging from 42% to 48%. The reviewers concluded the evidence is Level I for the diagnostic accuracy of lumbar facet joint nerve blocks, Level II for cervical facet joint nerve blocks, and Level II for thoracic facet joint nerve blocks in assessment of chronic spinal pain.

In 2016, Manchikanti et al. published a systematic review to assess the diagnostic accuracy of lumbar facet joint nerve blocks and the therapeutic effectiveness of multiple interventional techniques based on a best evidence synthesis. (14) The inclusion criteria included all facet joint interventions performed in a controlled fashion. The pain relief of greater than 50% was the outcome measure for diagnostic accuracy assessment of the controlled studies. The outcome measures included pain relief as the primary criterion for diagnostic accuracy studies concordant with the local anesthetic used and the ability to perform previously painful movements. The primary outcome parameter for randomized controlled trials (RCTs) of efficacy was pain relief with short-term defined up to 6 months and long-term defined as longer than 6 months with functional improvement as the secondary outcome measure. The reviewers included 14 RCTs and reported results that evidence for the diagnostic validity of lumbar facet joint nerve blocks with at least 75% pain relief with ability to perform previously painful movements was level I, based on a range of level I to V derived from a best evidence synthesis. For therapeutic interventions, the evidence was variable from level II to III with level II evidence for lumbar facet joint nerve blocks. The reviewers stated that this review provided significant evidence for the diagnostic validity of facet joint nerve blocks and therapeutic facet joint nerve blocks in managing chronic low back pain.

Although ultrasound (US) guidance has several expected advantages, there are few clinical studies to support the use of US guidance in clinical practice. In a 2007 literature review on the utility of facet injections, Sehgal et al. (8) state, "Ultrasound guided injections are used for regional blocks. There is interest in applying this technology in chronic pain. A few papers have described ultrasound guided facet joint and nerve injections in cadavers and human subjects. Some have attempted face validity studies by confirming needle placement with fluoroscopic or CT imaging. Although there are obvious benefits to using ultrasound guidance, there are

insufficient data for critical analysis and conclusions."

In 2009, Narouze et al. (9) reported a feasibility study of a prospective series of 10 patients who received cervical nerve root transforaminal injections using US as the primary imaging tool, with fluoroscopic confirmation. The authors determined that US may facilitate identifying critical vessels at unexpected locations relative to the intervertebral foramen and avoiding injury to such vessels, which is the leading cause of the reported complications from cervical nerve root injections. They concluded that a randomized controlled trial to compare the effectiveness and safety of US imaging against other imaging techniques seems warranted.

ClinicalTrials.gov lists a study on US guided cervical medial branch block (NCT00896688) (10); as of December 14, 2018, this study was withdrawn (The principal investigator has been unable to continue with the study). The study stated that the diagnostic cervical branch block for neck pain due to cervical facet joint pain has been traditionally done under fluoroscopic guidance; its diagnostic value and technique have been well established. However, recently some studies have shown that the diagnostic cervical and lumbar medial branch block can be done under US guidance. The primary outcome was to determine the efficacy of the use of US for diagnostic cervical medial branch block on pain patients who have developed neck pain, cervicogenic headache, or shoulder pain.

Practice Guidelines and Position Statements

Association of Pain Management Anesthesiologists

In their 2000 Practice Guidelines, the Association of Pain Management Anesthesiologists (APMA) (6) reported the following regarding facet joint blocks: “The specific rationale for facet-joint blocks is based on the observation that, if a particular joint is determined to be the source of pain generation, long-term relief can be sought by directing therapeutic interventions at that joint. In managing low back pain, local anesthetic injection into the facet joints or interruption of the nerve supply to the facet joints has been accepted as the standard for diagnosis of facet-joint mediated pain. Since a single joint is innervated by at least two medial branches, two adjacent levels should always be blocked. Effectiveness of facet-joint injections, facet-joint nerve blocks, and facet-joint neurolysis has been reasonably studied, though the results have varied widely. The evidence for lumbar intra-articular injections of steroids with or without local anesthetic is in favor of the injections in well-controlled studies, even though the evidence is not unequivocal. Studies of intra-articular injections showed short-term relief in 46% to 75% of the patients, while long-term relief was seen only in 20% to 36% of the patients following a single injection. The role of medial branch blocks in the diagnosis of facet-joint pain has been well described and is considered superior to intra-articular comparative local anesthetic blocks. However, for therapeutic purposes, the literature is sparse and the few studies which do exist have reported that facet-joint injections and medial branch blocks are of equal value. Multiple reports showing the effectiveness of radiofrequency neurolysis were encouraging. In contrast, most of the positive results of cervical intra-articular injection of corticosteroids and medial branch blocks were from uncontrolled reports.”

American Society of Interventional Pain Physicians

In 2007, the American Society of Interventional Pain Physicians (ASIPP) published evidence-based practice guidelines (7) in which the following conclusions were made concerning facet joint injections:

- Among the diagnostic interventions, the accuracy of facet joint nerve blocks is strong in the diagnosis of lumbar and cervical facet joint pain, whereas, it is moderate in the diagnosis of thoracic facet joint pain.
- The evidence for therapeutic lumbar intra-articular facet injections is moderate for short-term and long-term improvement, whereas, it is limited for cervical facet joint injections.

In 2013 and recently in 2020, the American Society of Interventional Pain Physicians (ASIPP) updated their evidence-based practice guidelines (11, 12), which include the following conclusions concerning the evidence for facet joint injections:

Diagnostic:

- The level of evidence is I to II with moderate to strong strength of recommendation for lumbar diagnostic facet joint nerve blocks.
- The level of evidence is II with moderate strength of recommendation for cervical diagnostic facet joint nerve blocks.
- The level of evidence is II with moderate strength of recommendation for thoracic diagnostic facet joint nerve blocks.

Therapeutic:

- The level of evidence is II with moderate strength of recommendation for therapeutic lumbar facet joint nerve blocks.
- The level of evidence is II with moderate strength of recommendation for therapeutic cervical facet joint nerve blocks.
- The level of evidence is III with weak to moderate strength of recommendation for thoracic intra-articular facet joint injections.

Imaging:

The level of evidence is I with strong strength of recommendation, for mandatory fluoroscopic or computed tomography (CT) guidance for all facet joint interventions.

Level I: Strong-Evidence obtained from multiple relevant high quality randomized controlled trials or Evidence obtained from multiple high-quality diagnostic accuracy studies.
Level II: Moderate-Evidence obtained from at least one relevant high quality randomized controlled trial or multiple relevant moderate or low quality randomized controlled trials Or Evidence obtained from at least one high quality diagnostic accuracy study or multiple moderate or low-quality diagnostic accuracy studies.
Level III: Fair-Evidence obtained from at least one relevant moderate or low quality randomized controlled trial study or Evidence obtained from at least one relevant high quality non-randomized trial or observational study with multiple moderate or low quality observational studies or Evidence obtained from at least one moderate quality diagnostic accuracy study in addition to low quality studies.

North American Spine Society

In 2016, the North American Spine Society (NASS) published coverage policy recommendations. (3) The NASS include the following as part of the scope and clinical indications. Injections involving the zygapophysial joints (Z-joints) can be indicated for diagnostic or therapeutic purposes. Therapeutic injections typically involve administration of corticosteroids, with or without local anesthetics, while diagnostic injections use anesthetic alone. This document also includes the diagnostic and therapeutic uses of intra-articular Z-joint injections and of diagnostic medial branch blocks (MBB).

The pain referral patterns of the cervical Z-joints are described and can include pain in the neck, and/or the head, and/or the periscapular and shoulder region. The pain referral patterns of the lumbar Z-joints are similarly described and can include pain in the back, gluteal area and leg. For patients with such pain, the procedures covered in this report may be considered when ALL of the following criteria are met:

1. The patient's pain is severe enough to cause some degree of functional deficit.
2. Failure of at least 4 weeks of noninvasive care.
3. There is no other significant pathology that could explain the source of the patient's pain, such as fracture, tumor, infection or significant extraspinal lesion.
4. Pain is predominantly axial, and not associated with radiculopathy or myelopathy.
5. Clinical assessment implicates the Z-joint as the putative source of pain.

The rationale includes the following:

- There is no literature addressing the use of intra-articular (IA) injections for thoracic pain, and literature for the use of MBB or radiofrequency ablation for persistent pain in the thoracic spine is limited to lower level evidence from retrospective studies and case series.
- Image guidance is considered mandatory for successful needle placement for both IA and MBBs. The majority of studies have used fluoroscopy during needle placement. Ultrasound is experiencing increasing popularity in the cervical spine due to the proximity of the target structures to the skin and thus the ability to visualize these structures; however, at the time of this publication, the use of ultrasound to perform any of these procedures is considered experimental, and NASS does not recommend coverage at this time. CT guidance has also been used to direct needle placement, particularly for intra-articular injections.

Of note, any and all cervical spine injections should be performed with some form of image guidance (e.g., fluoroscopy or CT).

World Federation of Neurosurgical Societies (WFNS)

In 2020, the WFNS published the Spine Committee Recommendations on Conservative Treatment and Percutaneous Pain Relief in Patients with Lumbar Spinal Stenosis (15). They state that facet joint injections provide a useful diagnostic tool for low back pain.

Cervical Joint Working Group

In 2021, consensus practice guidelines on interventions for cervical spine facet joint pain from a multispecialty, international working group approved by the American Society of Regional Anesthesia and Pain Medicine and the American Academy of Pain Medicine makes the

following recommendations and observations: (16)

- History and physical examination cannot reliably identify painful atlanto–occipital (C0–C1) (AO) or atlanto–axial (C1–C2) (AA) joints but can guide injection decisions which could confirm the joints as pain generators.
- When selecting targets for blocks, levels should be determined based on clinical presentation (tenderness on palpation [preferably performed under fluoroscopy], pain referral patterns).
- Conservative management before prognostic blocks in patients with at least 3 months of neck pain.
    - At least a 6-week trial of conservative therapy, which may vary based on a personalized medicine paradigm.
    - Concomitant use of conservative measures to accompany prognostic blocks.
- Pre-procedural advanced imaging of the cervical spine with either CT or MRI should be obtained prior to performing AO and AA joint injections to ascertain pathology and help guide needle trajectory.
- ≥ 50% reduction in pain should be considered a positive prognostic block.
    - Non-pain measures such as activity level should not be used as the sole criterion to determine the success or failure of a prognostic block, but may be used in conjunction with pain assessment.
- Fluoroscopy or US should be used for cervical MBB.

Centers for Medicare & Medicaid Services

A Local Coverage Determination (L38841) revised 2023 that includes facet joint injections and medical branch blocks lists the following indications (17):

- Moderate to severe chronic neck or low back pain, predominantly axial, that causes functional deficit measured on pain or disability scale.
- Pain present for minimum of 3 months with documented failure to respond to noninvasive conservative management (as tolerated).
- Absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by facet joint synovial cyst).
- There is no non-facet pathology per clinical assessment or radiology studies that could explain the source of the patient's pain, including but not limited to fracture, tumor, infection, or significant deformity.

Ongoing and Unpublished Clinical Trials

Currently, ongoing and unpublished trials that might influence this policy are listed in Table 1.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			

NCT03871192	Comparison of Facet Nerve Block Versus Intra-articular Injection in the Diagnosis and Treatment of Lumbar Facet Syndrome	100	Recruiting
Unpublished			
NCT03770585	Comparative Study Between Fluoroscopy Guided Lumbar Facet Joint Injection Versus Ultrasound Guided Injection in Patients With Low Back Pain Due to Facet Syndrome	80	Jul 2018

NCT: national clinical trial.

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	64490, 64491, 64492, 64493, 64494, 64495, 77003, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T
HCPCS Codes	None

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

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Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

Policy History/Revision	
Date	**Description of Change**
02/01/2025	Reviewed. No changes.
11/01/2023	Document updated with literature review. The following changes were made to Coverage: 1) Diagnostic Phase Section: Added "For each covered spinal region, a maximum of four (4) diagnostic joint sessions per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure" to the criteria and defined pain relief as at least 80% or more relief in primary pain index 2) Therapeutic Phase Section: The first bullet was replaced with "Therapeutic facet joint injection at the same anatomic site for recurrent pain may be repeated if the prior injection provided at least 50% reduction in pain with functional improvement of at least 3 months duration", the second bullet revised to include "a maximum of four (4) therapeutic facet joint (intra-articular [IA]) injection sessions per rolling 12 months", the therapeutic frequency is now limited to every three (3) months per spinal region 3) The facet injections not medically necessary statements revised to state more frequently than "every three (3) months" or "four times" per year per spinal region. Added references 15 and 16; others updated.
1/15/2023	Reviewed. No changes.
9/15/2021	Document updated with literature review. The following changes were made to Coverage: computerized tomography (CT) was added to the facet joint injections medically necessary statement; six weeks for conservative therapy; Some criteria were replaced with 1) Predominant axial pain that is not attributable to radiculopathy (with the exception of synovial cysts, see Therapeutic Phase section below), myelopathy, or neurogenic claudication 2) Physical exam findings which are consistent with the facet joint as the presumed source of pain 3) Absence of non-facet pathology that could explain the source of the patient's pain, such as fracture, tumor, or infection; and Therapeutic facet joint injections when the following criteria are met: Evidence of nerve root compression due to a facet synovial cyst when seen on an advanced imaging study (magnetic resonance imaging [MRI] or CT) performed within the previous 12 months that correlates with the clinical findings; AND Associated moderate-to-severe radicular pain and functional limitations was added to the Therapeutic phase. References 3, 5, 12, and 15 were added and some removed.
3/1/2020	Document updated with literature review. The following change was made: removed wording "radiculopathy has been ruled out by a magnetic resonance imaging (MRI) from the fourth bullet of the first medically necessary coverage statement. References 6 and 14-15 were added.

4/15/2017	Reviewed. No changes.
3/15/2016	Document updated with literature review. Coverage unchanged.
4/15/2015	Reviewed. No changes.
12/15/2014	Document updated with literature review. Coverage unchanged.
7/15/2012	Document updated with literature review. Coverage unchanged.
7/15/2010	Document updated with literature review. CPT/HCPCS code(s) updated. Document number changed from SUR702.015bu. The following was added: Ultrasound guidance of either facet or transforaminal injections is considered experimental, investigational and unproven.
1/15/2010	New medical document; facet joint injections may be considered medically necessary when specific criteria are met.