OPTUM®

Utilization Management Policy

Facet Joint Block Injection

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Related Policies

Epidural Steroid Injection
Epidural Spinal Cord Stimulator
Sacroiliac Joint Injection

Policy Number	**493**
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Policy Statement

The appropriate use of facet joint block injections can be described by the following components:

Diagnostic use of facet injections for back and neck pain is appropriate when ***all*** of the following criteria are met:

[1] the patient has failed to improve after a minimum of three months of conservative care that includes (but is not limited to):

- Physical therapy and/or chiropractic therapy of adequate duration and content
- Appropriate medications taken for a sufficient period of time, including opioid-type medications.
- Rest and modification of activity

[2] the patient's pain is somatic (non-radicular) in nature (both in its presentation and in the absence of a dermatomal distribution of the pain) and the accompanying manifestations of pain are not compatible with the underlying neuromuscular structures involved.

[3] other significant, important clinical explanations for the symptoms and presentation have been evaluated and not seen to require immediate clinical attention. These include (but are not limited to) early radicular, discogenic or sacroiliac sources of pain as well as other clear explanations for the pain such as bony lesions.

[4] the patient's reported pain level is at least 6 (on a scale of 0-10) and the pain is continuous or intermittent but frequent (occurring at least once a day) with it causing significant functional limitation

[5] It is appropriate to test or treat up to a maximum of two non-fused levels for each region (cervical/thoracic and lumbar) on the same day in the rare clinical situations that need it

Purpose

This process document describes Optum* by OptumHealth Care Solutions, LLC methodology and requirements for the appropriate and safe application of facet joint block injections.

Scope

All in and out of network programs where utilization review determinations are rendered. This policy also serves as a resource for peer-to-peer interactions in describing the position of Optum on the reporting of facet joint block injection services.

Definitions

Appropriateness

Optum's clinical criteria incorporate measures of function, range of motion, strength, pain and other relevant factors (as described more fully below), which will be determined through utilization review that is based on the needs of the individual patient and the characteristics of the local delivery system.

A procedure will be determined to be appropriate for authorization for a patient based on his/her particular clinical history, current clinical status (including objective and subjective data) and the established nature of their diagnosed or presumed clinical condition(s).

Discharge criteria, where appropriate, will have been met [and as such no additional authorizations will be provided] when these measurements and key clinical information, taken as a whole, indicate the member is able to reasonably perform physical tasks related to self-care, home management, and basic activities of daily living, or has reached a plateau in making progress towards these goals. In some clinical circumstances a maintenance or periodic plan of treatment is considered appropriate and may be authorized in accordance with the specifics of the criteria herein.

Unless specifically covered by the member's benefit, covered treatment goals exclude return to sport, recreational or vocational activities. As part of the treatment plan, it is the responsibility of the treating practitioners to instruct the member in the early part of the treatment program, and certainly prior to discharge, in a comprehensive home activity and exercise program, and to set the expectation for the patient's responsibility to perform their exercise or self-care regimen between treatments (when a series is performed) and to maintain an appropriate post-discharge exercise and self-care/activity regimen. These criteria are derived from recognized professional standards that may include those from the American Medical Association, the American Pain Society, American Academy of Orthopedic Surgeons, the North American Spine Society, the Centers for Medicare and Medicaid Services, the American Physical Therapy Association and other recognized clinical organizations.

Background

Facet joint blocks are properly used in the diagnosis of back and neck pain in a controlled fashion, typically with the use of anesthetics with different, predictable durations of action ["comparative anesthetic blocks"].

Alternatively, the diagnostic testing can be done using true placebos (inactive substances) as well as the active agent in a double-blind manner. The underlying premise for these injections is that the facet joints have been shown to be the source of neck and back pain using reliable methods. The pain is mediated through the medial branches of the dorsal rami of the lumbar and cervical exiting nerve roots.

The diagnostic injections require local anesthetics (in a comparative block or placebo-controlled fashion). The-diagnostic facet injections are used to demonstrate relief of the specific symptoms for the appropriate length of time determined by the choice of anesthetic. *The potential for placebo response is quite high* and these dual diagnostic tests must be done properly to assure valid results. Hence, in general, the use of procedural sedation leads to an invalid test result. Also, changes in pharmacology on the day of the procedure would invalidate the test result. Furthermore, the test needs to be done on a day when patient has substantial pain (e.g., at least 6/10). Only a maximum of two spine levels (bilateral or unilateral joints) may be tested in one session (regardless of the technique used i.e., intra- articular vs mbb). Regardless of the approach and hence the number of shots, the total approvable levels are only two for any given date of service. This targeted approach to testing will assure the most accurate test results.

The initial injections for a patient are intended to be diagnostic procedures. If there is substantial (or even complete) relief of the pain (at least 75 %) and related symptoms, it is reasonable to conclude that the facet joint complex targeted was the principal or a major source of the symptoms being evaluated and treated. Equally, should there be little relief experienced or the relief given not directly related to the symptoms under evaluation, then another source or location for the problem needs to be identified and evaluated/treated. As outlined earlier, the diagnostic injections must be done as double comparative blocks, or true placebo-controlled blocks.

General Procedure Requirements:
Facet joint injections must be performed under fluoroscopic or CT guidance.

Diagnostic Facet Joint Injections
If, after the first intraarticular joint or medial branch block (MBB) injection, the patient experiences >80% relief of their primary axial pain, lasting a time period consistent with the local anesthetic used, the patient may undergo a second, confirmatory MBB. Since the technique relies on the patient's perception of pain relief to establish the diagnosis, the patient must have sufficient pain immediately prior to the injection to be able to detect significant improvement following the injection. Additionally, provocative maneuvers or positions which normally exacerbate the axial pain must be determined before the diagnostic injection. Sacro-iliac joints are not to be confused with facet joints and hence the nerves innervating the sacro-iliac joints are not to be confused with nerves innervating the facet joints. Costo-vertebral joints in the thoracic spine are also not to be confused with thoracic facet joints. Injections around the pedicle screw are not facet injections.

The facets are true synovial joints of the spine, two at each spinal level, connecting the adjacent vertebrae posteriorly. The capsule of the joint blends with ligamentum flavum medially and superiorly. Each facet joint is innervated primarily from a branch of the segmental spinal nerve at the same level and partially from the nerve above. In the lumbar level, for example, the facet joint L4-5 is innervated by L4 median branch and L3 median branch. The L5-S1 joint sometimes is innervated by three nerves to include L4, L5, and S1 but is still considered as only one level for approval.

For the cervical facets the terminology is slightly different. For example, the C3-4 facet is innervated by C3 and C4 median branches and the fluoroscopic target is “waist” of C3 and “waist” of C4. The C2-3 facet joint is innervated by only one nerve called Third Occipital Nerve (TON) which is otherwise known as the “superficial branch of the C3 medial nerve.” The C3-4 joint is innervated by the “deep branch of the C3 medial nerve and the C4 medial nerve.” The C0-C1 joint is known as AO (Atlanto-occipital) joint while the C1-2 joint is known as AA (Atlanto-axial) joint. The nerves of C0-1 and C1-2 cannot be blocked using fluoroscopy but intra-articular injections into the joint can be given using fluoroscopy. C0-1 and C1-2 are

the only two facet joints where injections may be approvable but not RFA.

Clinically, lumbar facet arthropathy is identified by low back pain associated with groin /hip/buttock pain, cramping leg pain above knee, early morning low back stiffness and pain with prolonged sitting or standing. On exam there is well localized paraspinal tenderness, pain with hyperextension, rotation and lateral bending as well as significant corresponding radiographic changes and hip /buttock or back pain with SLR test

For cervical facet arthropathy, findings may include neck pain, upper arm pain, scapula pain, shoulder pain, suprascapular pain or headache. On exam there is decreased ROM of neck, pain on dorsiflexion, improvement with forward flexion and tenderness over affected joint(s).

The goal of these injections is to identify the selected facet complex(es) as the source of the symptoms under evaluation. Once this identification is established, some patients may experience pain relief that lasts for weeks even though diagnostic test was performed with local anesthetic. If the pain returns, for the patients who experienced relief following a concordant double diagnostic block without sedation, radiofrequency (RF) denervation (greater than 80 degrees Celsius) of the medial branch nerves is recommended to provide substantial relief for an extended period. Other denervation techniques are used but have not been demonstrated as effective in the recognized peer-reviewed medical literature. Neurolytic agents such as alcohol have been used in the past but are now not considered appropriate.

With relief of the symptoms, the injections will hopefully allow the patient to progress with their rehabilitation program. Studies report that a modest portion of patients achieve relatively long-lasting relief from these injections. For example, 45 % of those who were carefully selected based on the above criteria and treated based on evidence, experienced 50% relief with mean duration of 3.2 yrs. Other patients achieve modest, more short-term relief and yet others attain little apparent benefit from these injections.

While the use of facet injections is common in pain management practice, there is considerable debate in the literature about the effectiveness of therapeutic facet injections in the treatment of back and neck pain. The BMJ Clinical Evidence [2007] concluded that these injections are of unknown effectiveness and the Cochrane Collaboration Review [2008] cited the findings that there are no clear differences between placebo and active facet joint injections. Up To Date [2009] similarly states the evidence is simply not available to demonstrate the effectiveness of these injections for chronic low back pain [i.e., therapeutic use].

The peer-reviewed effectiveness literature does not support the use of additional facet joint injections (with anesthetic and/or steroids) for the treatment of chronic back and neck pain. The interventional pain professional community [ASIPP and IPM] believes that there is ample evidence to support both diagnostic and therapeutic use of facet blocks [Pain Physician 12 (2009):699-802]. They also are supportive of the use of facet joint denervation (not discussed in this document).

Following strict criteria of double diagnostic blocks and utilizing the ≥ 75% pain relief criteria as a cutoff will lead to improved diagnostic accuracy and appropriate use of this procedure.

Description

Indications of Coverage:

- At least 3 months of moderate to severe pain with functional impairment inadequately responsive to conservative care such as NSAIDS, acetaminophen, physical therapy
- Predominant axial spine pain that is not associated with radiculopathy or neurogenic claudication.

- Absence of Non-facet pathology that could explain the source of the patient's pain such as myofascial pain, sacro-iliac joint pain, somatoform disorders, fracture, tumor, infection, or significant deformity
- Clinical assessment that implicates the facet joint as the putative source of pain.

The diagnostic phase must consist of two injections sessions (no more or no less) at intervals of no sooner than one week. If the diagnostic phase is completed and unsuccessful because of insufficient expected clinical response to the intervention, no further facet injections or radiofrequency/neurotomy is necessary. Historically, facet injections have been administered in pre-planned groups of multiple level bilateral joints requiring many injections at one sitting. Although commonly proposed, this practice pattern is not supported by well-designed medical literature.

Current practice requires the use of fluoroscopic imaging to help assure the correct placement of the needle. While suggested by some practitioners as a suitable alternative imaging guidance technique, ultrasound is not yet established as effective for this particular clinical circumstance.

A positive response to a diagnostic block is based on all of the following being present [Pain Physician, ibid, p. 709]:

- Patient was an appropriate candidate for the diagnostic block
- Patient response to controlled local or placebo blocks were appropriate (and small volume injections, 0.5 cc or less, were used to assure improved ability to identify patient response)
- Patient had at least 75% relief of pain along with the expected ability to resume previously painful movements and for a least the anticipated duration of the local anesthetic used for the procedure.
- The patient's responses were recorded independently by a skilled assessor and that these assessments were made with attention to avoid influencing the patient's responses.

Therapeutic use of facet joint denervation (Neurotomy or RFA)

These may be appropriate after the successful completion of two diagnostic injections and the documentation of sustained relief of the treated non-radicular symptoms. These requirements are met when ***all*** of the following are satisfied:

[1] At least two weeks have elapsed (ideally much more) since the completion of the two successful diagnostic injections.

[2] Patient has not undergone a prior lumbar medial branch /RFA at the same joint within the preceding 6 months.

[3] The symptoms are identical as when the diagnostic testing was done in quality, distribution, pattern and depth.

Therapeutic Facet Joint Nerve Blocks:
When two diagnostic facet joint or (MBBs) provide greater than 75% relief of the primary axial pain consistent with the expected physiological effects of the agents utilized, with the ability to perform previously painful movements consistent with the expected physiological effects of the local anesthetic utilized, then therapeutic facet injections with steroids targeting either MBBs or the joint itself may be considered

Therapeutic facet joint or (MBBs) injections involving the same joint or the same region will only be considered medically necessary if the patient experienced greater than 50% improvement of pain and improvement in patient specific ADLs for at least 10 weeks.

Repeat therapeutic facet joint or (MBBs) to treat recurrent facet joint pain in a patient who has failed other conservative measures may be covered without repeating the diagnostic injections if the patient has experienced expected or prolonged pain relief with improvement in function for at least 10 weeks in the past following therapeutic facet joint injections.

Thermal Medial Branch Radiofrequency Neurotomy:

- If adequate, but short-term pain relief occurs following MBBs or facet joint injections (See Diagnostic Facet Joint Injections), RF neurotomy may be a reasonable treatment option. Thermo coagulation with radiofrequency energy may achieve long –lasting pain relief via axonotmesis of the sensory afferent medial branch nerve.

- Only when two diagnostic injections provide > 80% relief of the primary axial pain, with ability to perform previously painful movements consistent with the expected physiologic effects of the agents utilized will RF (> 80 Celsius) medial branch neurotomy be considered.

- Repeat denervation procedures involving the same joints for the same region will only be considered medically necessary if the patient experienced >50% improvement of pain and patient specific ADLs documented for at least 5 months.

- Repeat RF neurotomy to treat recurrent facet joint pain in a patient who has failed other conservative measures may be covered without repeating diagnostic MBB injections if the patient has experienced significant and prolonged (> 5 months) relief of pain and improvement of function in the past following RF ablation.

Non-Appropriate Use of Facet Injections

Non appropriate use of facet injections are those for any indications other than those listed above. Some of the more common non-appropriate situations include:

[1] A pre-planned treatment program (e.g., a series of three injections) that does not involve reassessment of patient response after each individual injection and adjustment of the treatment plan if either excellent response is achieved with one or two injections or alternatively if little or no response is achieved after one or two injections. Repeat facet injections are not appropriate when significant improvement has occurred after the initial injection or any specific subsequent injections. Repeat injections should only be performed upon return of pain and associated deterioration in the functional status' and after expected period of relief. Success of the diagnostic facet injection using the criteria outlined above should lead to the consideration of the use of radio-frequency ablation.

[2] Therapeutic facet joint denervation or neurotomy in the absence of clinical improvement in pain and function with diagnostic testing or in prior denervation/neurotomy.

[3] Diagnostic injections that are not performed in either a double-blind placebo or comparative fashion.

[4] When other types of injections are performed on the same date of service [or a day or two immediately before or after this date], including but not limited to, epidural injections, sacroiliac joint injections, sympathetic block and/or trigger point injections.

[5] When bilateral, multiple level (greater than two spine levels) facet joint blocks are performed at the same session

[6] Exceeding a total of 2 adjacent facet joint levels for diagnostic or therapeutic purposes.

[7] The diagnostic sessions are performed less than 1week apart.

[8] Substantive pharmacological changes were made in between diagnostic sessions.

[9] Testing or treating facet joints which have undergone prior fusion at the same vertebral levels

[10] The facet procedures are generally not appropriate after an advanced pain management treatment such as an implanted SCS or an implanted spinal infusion pump has been initiated. This is because it is widely accepted advanced pain therapies are provided only when it has been proven that more conservative procedures such as facets or epidurals have become ineffective. Clinical exception may be allowed for facet procedures in the cervical spine in the presence of a functioning intrathecal infusion pump infusing a hydrophobic intrathecal medicine or a functioning SCS treating lumbar symptoms.

[11] Using the results of a diagnostic facet injection to plan for a spine fusion surgery or predict the outcome of a spine fusion surgery when there is a radiographic evidence of degenerative spondylolisthesis

Limitations of Coverage:

- Facet joint or MBB nerve injections for the treatment of acute, non-recurrent neck or back pain (< 3 months duration) are not considered medically necessary
- New onset radiculopathy precludes coverage of facet injections except radicular pain caused by a facet joint synovial cyst in the lumbar spine. MRI should clearly show that the synovial cyst is anteriorly situated not posterior. It is not expected that a posterior cyst will ever cause radicular pain.
- Intraarticular facet block will not be reimbursed as a diagnostic test unless medial branch blocks cannot be performed due to anatomic restrictions
- A repeat facet procedure (intra-articular or medial branch block technique) at the exact same joint or the nerves to that joint of a previously treated joint or the nerves to that joint (involving the use of either a shot or an RFA) will not be counted as a diagnostic block even if it is labeled as such. The only clinical exception would be when the reported symptoms are distinctly different in quality, location, radiation etc.
- For each covered spinal region (cervical/thoracic or lumbar), no more than two (2) thermal RF sessions will be reimbursed in any rolling calendar year.
- Repeat neurotomy procedures involving the same joint will only be considered medically necessary when the patient had > 50% improvement of pain and documented improvement in patient specific ADLs documented for at least 5 to 6 months.
- Repeat therapeutic facet joint or medial branch injections (local anesthetic/steroid) involving the same joint will only be considered medically necessary when the patient had >50% improvement of pain and improvement in patient specific ADLs for at least 10 weeks.
- Neither conscious sedation nor Monitored Anesthesia Care (MAC) is routinely necessary for facet joint or MBBs and are therefore not reimbursable. Individual consideration may be given for

payment in rare unique circumstance if the medical necessity of sedation is unequivocal and clearly documented.

- Non-thermal RF modalities for medial branch denervation including chemical, low grade thermal energy (<80 degrees Celsius), as well as pulsed RF are not covered.

- Endoscopic rhizotomies or medial branch neurotomies in the treatment of facet mediated pain is unproven and investigational. These are not covered.

- Regardless of FDA approval status, any injections of PRP (platelet rich plasma) or stem cells (any origin) or amniotic membrane products or any of the versions of bone bowel used for minimally invasive facet fusion (e.g., TruFUSE) is investigational and unproven. These are not covered.

- Use of thermal RFA to destroy any spinal structure other than medial branch nerve is considered investigational and hence not covered

- Intraarticular or extraarticular facet joint prolotherapy is not covered.

- Regardless of any of the above scenarios and clinical exceptions, a maximum of five (5) facet joint injection sessions inclusive of medial branch blocks or intraarticular injections (either of these two given for diagnostic or therapeutic purposes), or facet cyst rupture and RF ablations may be performed per year in the cervical/thoracic spine and five (5) in the lumbar spine. Only in the first year of diagnosis –treatment cycle, an exception to allow six (instead of five) will be made on a case-by-case basis.

Frequency with criteria:

- Two diagnostic facet joint or associated MBB injections are allowed per region irrespective of the joints injected with maximum of two spinal levels (unilateral or bilateral joints) per session.

- No more than 4 therapeutic facet joint sessions per year are allowed per region provided there is pain relief and functional improvement of at least 50% for 10 weeks.

- One radiofrequency neurotomy session per year per region may be performed at 6-month intervals with appropriate documentation of 5 to 6 months of pain relief and functional improvement. There are only two regions. Cervical and Thoracic is considered one region and Lumbar is considered another region.

Technology/treatment is considered experimental/investigational or NOT medically necessary if it is not utilized in accordance with nationally recognized standards of medical practice and/or identified as safe, widely used, and generally accepted as ejective for the proposed use as reported in nationally recognized peer-reviewed medical literature published in the English language.

It is not appropriate to use ultrasound guidance for needle placement for facet injections as this technology is considered experimental/investigational as it is not identified as widely used and generally accepted for the proposed use as reported in nationally recognized peer-reviewed medical literature published in the English language.

With the diagnostic injections, it is not necessary to use monitored anesthesia care (MAC) or other similar therapies for facet injections as standard medical practice consists of local anesthesia and, if needed, slight sedation (mild sedation or anxiolysis). But if conscious or moderate (procedural) sedation is used, it may make the test result invalid. Procedural (Conscious or Moderate) sedation (not MAC) may be used during

the therapeutic neurotomy /RFA procedure.

The use of therapeutic injections, particularly therapeutic rhizotomy, may no longer be appropriate prior to the achievement of established goals in certain instances (these include but are not limited to):

- The patient or family (if relevant) declines to continue treatment.
- The patient is unable to continue to make progress towards goals secondary to medical or psychosocial complications.
- Objective clinical data demonstrates that the patient is not benefiting from skilled therapeutic intervention as evidenced by minimal or no significant measurable change in a reasonable time frame. This will be related to appropriate clinical measures that are patient and diagnosis specific.
- Following a reasonable period of appropriate therapeutic intervention it is evident that a negative trend has occurred in some or all of the relevant objective functional data. Generally accepted standards of practice suggest that therapy be suspended at this time and appropriate medical re-evaluation performed.
- The member is significantly non-adherent with their specific therapeutic protocol. This includes, but is not limited to:

- Insufficient attendance at therapy sessions as outlined by the therapist's plan of care.
- Not appropriately involved during treatment.
- Non-compliance with therapist instructions related to:
  i. Home exercise program.
  ii. Activity and environmental modification to prevent re-injury or re-inflammation.
  iii. Self-management of symptoms or acute episodes.

In addition to these general criteria, individual benefit plan contracts may vary. **The member's specific contract language will govern all final determinations.** Some common circumstances that are not eligible for benefit coverage under many plans include therapy to return to specific vocational and/or occupational activities.

Functional Outcomes

Improved functional outcomes are a key desired goal of these therapies. These outcomes will be affected by individual patient variables (age, anthropometric characteristics, and pre-morbid status) and the nature of the condition (previous history of injury or surgery to the affected region). Functional assessment will, therefore, be individually meaningful and measured, where relevant, using an appropriate, valid, and reliable assessment tool.

a. Functional scales will be considered in utilization review, however, given the diverse nature of these scales, no arbitrary threshold can translate into an absolute endpoint for an episode of care. In general, regular significant measurable changes will be seen in a reasonable time frame in relation to baseline performance.

b. Given the above parameters describing pain, range of motion and function, some of the following activities may be demonstrated as applicable:

- Basic ADLs such as positioning, mobility, self-maintenance tasks, communication

- Instrumental ADLs such as home management, community living skills and occupational activities

A reasonable return, safely, efficiently, and at a maximum level of independence (with or without assistive devices) to customary basic ADL, as well as general suitability for common work activities. Some of the elements of instrumental ADLs are beyond the scope of the benefit plan. These might include, for example:

- modifications of a home environment including kitchen, bath, and other modifications
- adaptations to facilitate handling money, shopping, safety preparedness, auto travel and parking, building accessibility, etc

- occupational activities which generally span both work and leisure time pursuits and often involve significant modifications and adaptations to meet specific patient needs

Coding Information

Note: The Current Procedural Terminology (CPT) codes listed in this policy may not be all inclusive and are for reference purposes only. The listing of a service code in this policy does not imply that the service described by the code is a covered or non-covered health service. Coverage is determined by the member's benefit document.

Code	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
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)
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)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint.
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging

	guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint.
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint

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Policy History/Revision Information

Date	Action/Description
4/27/2023	Quality Improvement Committee approved activation of the policy

Contact Information

Please forward any commentary or feedback on Optum utilization management policies to: phpolicy_inquiry@optum.com with the word "Policy" in the subject line.

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