Medical Policy
Facet Joint Denervation

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Policy Number: 140
BCBSA Reference Number: 7.01.116
NCD/LCD: Local Coverage Determination (LCD): Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L35936)

Related Policies
None

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Non-pulsed radiofrequency denervation of cervical facet joints (C3-4 and below) and lumbar facet joints may be MEDICALLY NECESSARY when all of the following criteria are met:
• No prior spinal fusion surgery in the vertebral level being treated, AND
• Disabling low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations; and the pain is not radicular, AND
• Pain has failed to respond to three (3) months of conservative management which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program, AND
• A trial of controlled diagnostic medial branch blocks (2 separate positive blocks or placebo controlled series of blocks) under fluoroscopic guidance has resulted in at least a 50% reduction in pain, AND
• If there has been a prior successful radiofrequency (RF) denervation, a minimum time of six (6) months has elapsed since prior RF treatment (per side, per anatomical level of the spine.)

Radiofrequency denervation is INVESTIGATIONAL for the treatment of chronic spinal/back pain for all uses that do not meet the criteria listed above, including but not limited to treatment of thoracic facet joint pain.

All other methods of denervation are INVESTIGATIONAL for the treatment of chronic spinal/back pain, including, but not limited to pulsed radiofrequency denervation, laser denervation, chemodenervation (e.g., alcohol, phenol, or high-concentration local anesthetics), and cryodenervation.

Therapeutic medial branch blocks are INVESTIGATIONAL.
If there has been a prior successful radiofrequency (RF) denervation, additional diagnostic medial branch blocks for the same level of the spine are **NOT MEDICALLY NECESSARY**.

**Medicare HMO BlueSM and Medicare PPO BlueSM Members**

Medical necessity criteria and coding guidance for Medicare Advantage members living in **Massachusetts** can be found through the link(s) below.

Local Coverage Determinations (LCDs) for National Government Services, Inc.

Local Coverage Determination (LCD): Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L35936)

**Note:** To review the specific LCD, please remember to click “accept” on the CMS licensing agreement at the bottom of the CMS webpage.

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of **Massachusetts**, please see the Centers for Medicare and Medicaid Services website at [https://www.cms.gov](https://www.cms.gov) for information regarding your specific jurisdiction.

**Prior Authorization Information**

**Inpatient**
- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

**Outpatient**
- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

<table>
<thead>
<tr>
<th></th>
<th>Outpatient</th>
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</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>Prior authorization is <strong>not required</strong>.</td>
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<tr>
<td>Commercial PPO and Indemnity</td>
<td>Prior authorization is <strong>not required</strong>.</td>
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<tr>
<td>Medicare HMO BlueSM</td>
<td>Prior authorization is <strong>not required</strong>.</td>
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<tr>
<td>Medicare PPO BlueSM</td>
<td>Prior authorization is <strong>not required</strong>.</td>
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**CPT Codes / HCPCS Codes / ICD Codes**

*Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.*

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

*The following codes are included below for informational purposes only; this is not an all-inclusive list.*

The above **medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:**

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT codes</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>64633</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint</td>
</tr>
<tr>
<td>64634</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint</td>
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</table>
Description
Percutaneous radiofrequency (RF) facet denervation is used to treat neck or back pain originating in facet joints with degenerative changes. The goal of facet denervation is long-term pain relief. However, the nerves regenerate, and repeat procedures may be required.

Summary
The evidence for diagnostic testing consists mainly of studies using single or double blocks and experiencing at least 50% or at least 80% improvement in pain and function. There is considerable controversy about the role of the blocks, the number of positive blocks required, and the extent of pain relief obtained. Based on review of the evidence and clinical input, the statement in the Policy Guidelines section states that at least 50% improvement on 2 positive blocks (or a placebo-controlled series of blocks) is required.

While evidence is limited to a few comparative studies with small sample sizes, RF facet denervation appears to provide at least 50% pain relief in carefully selected patients. Diagnosis of facet joint pain is difficult; however, response to controlled medial branch blocks and the presence of tenderness over the facet joint appear to be reliable predictors of success.

When RF facet denervation is successful, repeat treatments appear to have similar success rates and duration of pain relief. Thus, the data indicate that in carefully selected individuals with lumbar or cervical facet joint pain, RF treatments can result in improved outcomes.

Pulsed radiofrequency does not appear to be as effective as nonpulsed radiofrequency denervation, and there is insufficient evidence to evaluate the efficacy of other methods of denervation (e.g., alcohol, laser or cryodenervation) for facet joint pain. Therefore, these techniques are considered investigational.

There is insufficient evidence to evaluate the effect of therapeutic medial branch blocks on facet joint pain. This treatment is considered investigational.

Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>1/2018</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>7/2016</td>
<td>Local Coverage Determination (LCD): Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L35936) added.</td>
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<tr>
<td>1/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>9/2015</td>
<td>Local Coverage Determination (LCD): Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L35336) added.</td>
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<tr>
<td>1/2015</td>
<td>Clarified coding information.</td>
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<td>12/2014</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>6/2014</td>
<td>Updated Coding section with ICD10 procedure and diagnosis codes. Effective 10/2015.</td>
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<tr>
<td>5/2011</td>
<td>Updated description based on update to BCBSA National policy.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References


