Local Coverage Determination (LCD): Paravertebral Facet Joint Blocks (L33930)

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Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
First Coast Service Options, Inc.	A and B MAC	09102 - MAC B	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09202 - MAC B	J - N	Puerto Rico
First Coast Service Options, Inc.	A and B MAC	09302 - MAC B	J - N	Virgin Islands

LCD Information

Document Information

LCD ID
L33930

LCD Title
Paravertebral Facet Joint Blocks

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

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CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for Paravertebral Facet Joint Blocks. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for Paravertebral Facet Joint Blocks and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies may be found in the following Internet-Only Manuals (IOMs) published on the CMS Web site.

Internet Only Manual (IOM) Citations:

- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*,
    - Chapter 13, Section 13.5.4 Reasonable and Necessary Provision in an LCD

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Covered Indications

Facet joint blocks will be considered reasonable and necessary for chronic pain (persistent pain for three (3) months or greater) suspected to originate from the facet joint. Facet joint block is one of the methods used to document/confirm suspicions of posterior element biomechanical pain of the spine. Hallmarks of posterior element biomechanical pain are:

- The pain does not have a strong radicular component.
- There is no associated neurological deficit and the pain is aggravated by hyperextension, rotation or lateral bending of the spine, depending on the orientation of the facet joint at that level.

A paravertebral facet joint represents the articulation of the posterior elements of one vertebra with its neighboring vertebrae. For purposes of this Local Coverage Determination (LCD), the facet joint is noted at a specific level, by the vertebrae that form it (e.g., C4-5 or L2-3). It is further noted that there are two (2) facet joints at each level, left and right.

During a paravertebral facet joint block procedure, a needle is placed in the facet joint or along the medial branches that innervate the joints under fluoroscopic guidance and a local anesthetic and/or steroid is injected. After the injection(s) have been performed, the patient is asked to indulge in the activities that usually aggravate his/her pain and to record his/her impressions of the effect of the procedure. Temporary or prolonged abolition of the pain suggests that the facet joints are the source of the symptoms and appropriate treatment may be prescribed in the future. Some patients will have long lasting relief with local anesthetic and steroid, others will require a denervation procedure for more permanent relief. Before proceeding to a denervation treatment the patient should experience at least a 50% reduction in symptoms for the duration of the local anesthetic effect.

Diagnostic or therapeutic injections/nerve blocks may be required for the management of chronic pain. It may take multiple nerve blocks targeting different anatomic structures to establish the etiology of the chronic pain in a given patient. It is standard medical practice to use the modality most likely to establish the diagnosis or treat the presumptive diagnosis. If the first set of procedures fail to produce the desired effect or to rule out the diagnosis, the provider should then proceed to the next logical test or treatment indicated. For the purpose of this paravertebral facet joint block LCD, an anatomic region is defined per CPT as cervical/thoracic or lumbar/sacral.

According to ASIPP guidelines, a positive response to the paravertebral facet joint block is noted when a greater than 50% relief of pain is obtained.

Limitations

It is not expected that an epidural block, or sympathetic block would be provided to a patient on the same day as facet joint injections. Multiple blocks on same day could lead to improper or lack of diagnosis. **Coverage will be extended for only one type of procedure during one day/session of treatment unless the patient has recently discontinued anticoagulant therapy for the purpose of interventional pain management.**

Diagnostic Phase

- Procedures performed during the diagnostic phase should be limited to three (3) levels (whether unilateral or bilateral) for each anatomical region as defined in this LCD on any given date of service.
- A diagnostic block can be repeated once, at any given level, at least one week (preferably 2 weeks) after the first block. If repeated, strong consideration should be given to utilizing administration of an anesthetic of different duration of action. (This helps confirm the validity of the diagnostic facet block, and may reduce the incidence of false positive responses due to placebo effect).
- Once a structure is proven to be negative as a pain generator, no repeat interventions should be directed at

that structure unless there is a new clinical presentation with symptoms, signs, and diagnostic studies of known reliability and validity that implicate the structure.

Therapeutic Phase

- Other interventional pain management procedures done on the same day as paravertebral facet joint blocks should be rare. In certain circumstances a patient may present with both facet and sacroiliac problems. In this case, it is appropriate to perform both facet injections and SI injection at the same session assuming that these are therapeutic injections and that prior diagnostic injections (blocks) have demonstrated that both structures contribute to pain generation.
- The medical record must clearly support both procedures. It is recognized that this is not common and the frequency with which these codes are combined will be monitored. Multiple procedure modifiers will apply to intraarticular sacroiliac injection.

Paravertebral blocks, facet joint injections, and medial branch blocks per "Current Procedural Terminology (CPT)" should be performed utilizing direct visualization with fluoroscopy and documented. Blocks performed without the use of fluoroscopy are considered not medically necessary.

Provider Qualifications

The CMS manual System, Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, Section 13.5.4, outlines that "reasonable and necessary" services are "ordered and furnished by qualified personnel." Services will be considered medically reasonable and necessary only if performed by appropriately trained providers. A qualified physician for this service/procedure is defined as follows: A) Physician is properly enrolled in Medicare. B) Training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty in the United States or must reflect equivalent education, training, and expertise endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States.

As published in the CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 13, Section 13.5.4, an item or service may be covered by a contractor LCD if it is reasonable and necessary under the Social Security Act Section 1862 (a)(1)(A). Contractors shall determine and describe the circumstances under which the item or service is considered reasonable and necessary.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

General Information

Associated Information

Documentation Requirements

Please refer to the Local Coverage Article: Billing and Coding: Paravertebral Facet Joint Blocks (A57787) for documentation requirements that apply to the reasonable and necessary provisions outlined in this LCD.

Utilization Guidelines

Please refer to the Local Coverage Article: Billing and Coding: Paravertebral Facet Joint Blocks (A57787) for utilization guidelines that apply to the reasonable and necessary provisions outlined in this LCD.

Sources of Information

First Coast Service Options Inc. reference LCD number – L29378

Boswell, M.V., Trescot, A. M., & et al. (2007). Interventional Guidelines: Evidence based practice guidelines in the management of chronic spinal pain. *Pain Physician* (10) 7-1111.

Manchikanti, L., Singh, V., Kloth, D., Slipman, C.W., Jasper, J., Trescot, A.M., Varley, K.G., Alturi, S.L., Giron, C., Curran, M.J., Rivera, J., Baha, A.G., Bakhit, C.E., and Reuter, M.W. (2001). Interventional techniques in the management of chronic pain. *Pain Physician* (1) 24-98.

Manchikanti, L., Singh, V. (2002). Review of chronic low back pain of facet joint origin. *Pain Physician.* 5(1) 83-101.

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Miller, R.D. (2005). Nerve blocks in *Miller: Miller's Anesthesia,* 6th ed. Philadelphia: Churchill Livingstone.

Bibliography

N/A

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
01/08/2019	R3	Revision Number: 3 Publication: April 2020 Connection LCR B2020-008 Explanation of Revision: Based on CR 10901, the LCD was	• Other

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		revised to remove CPT codes 64490, 64491, 64492, 64493, 64494 and 64495 from the ”Coverage Indications” section. The effective date of this revision is for claims processed on or after January 8, 2019, for dates of service on or after October 3, 2018.	
01/08/2019	R2	Revision Number: 2 Publication: November 2019 Connection LCR B2019-031 Explanation of Revision: Based on Change Request (CR) 10901, the LCD was revised to remove all billing and coding and all language not related to reasonable and necessary provisions (“Bill Type Codes,” “Revenue Codes,” “CPT/HCPCS Codes,” “ICD-10 Codes that Support Medical Necessity,” “Documentation Requirements” and “Utilization Guidelines” sections of the LCD) and place them into a newly created billing and coding article. During the process of moving the ICD-10-CM diagnosis codes to the billing and coding article, the ICD-10-CM diagnosis code ranges were broken out and listed individually. In addition, the Social Security Act and IOM reference sections were updated. The effective date of this revision is for claims processed on or after January 8, 2019, for dates of service on or after October 3, 2018. At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this LCD.	• Other (Revision based on CR 10901)
03/01/2018	R1	Revision Number: 1 Publication: March 2018 Connection LCR B2018-006 Explanation of Revision: Based on an annual review of the LCD, it was determined that the language in the “Indications and Limitations of Coverage and/or Medical Necessity” section of the LCD does not represent direct quotation from the CMS sources; therefore, this LCD is being revised to assure consistency with the manual language. The effective date of this revision is based on date of service.	• Other (Revisions based on annual review completed on 12/07/2017.)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		03/01/2018: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination and therefore not all the fields included on the LCD are applicable as noted in this policy.	

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)
A57787 - Billing and Coding: Paravertebral Facet Joint Blocks
A58105 - Paravertebral facet joint blocks – revision to the Part B LCD

Related National Coverage Documents

N/A

Public Version(s)

Updated on 04/14/2020 with effective dates 01/08/2019 - N/A
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Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

N/A

Local Coverage Article:
Billing and Coding: Paravertebral Facet Joint Blocks (A57787)

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Article Information

General Information

Article ID
A57787

Article Title
Billing and Coding: Paravertebral Facet Joint Blocks

Article Type
Billing and Coding

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Original Effective Date
10/03/2018

Revision Effective Date
N/A

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N/A

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CMS National Coverage Policy

N/A

Article Guidance

Article Text:

This First Coast Billing and Coding Article for Local Coverage Determination (LCD) L33930 Paravertebral Facet Joint Blocks provides billing and coding guidance for frequency limitations as well as diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in the LCD, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

Refer to the LCD for reasonable and necessary requirements and limitations.

The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements in the LCD.

Coding Guidelines

It is expected that use of the facet codes (CPT 64490-64495) would require radiologic localization (i.e., fluoroscopy). Imaging guidance (fluoroscopy, CT) and any injection of contrast are inclusive components of 64490-64495 and not paid separately.

An injection may be placed in the facet joint itself or around the medial branch nerve innervating the joint. In general, it is believed that two to three medial branch nerves innervate each lumbar facet joint and two nerves innervate each cervical or thoracic facet joint. These nerves are the branches of the posterior division of the spinal nerves, located immediately above and below the joint. The CPT codes 64490 and 64493 are intended to be used to report all of the nerves that innervate the first level paravertebral facet joint and not each nerve. Likewise, CPT codes 64491, 64492 and 64494, 64495 are intended to report second and third additional levels paravertebral facet joints and not each additional nerve. Facet joint levels refer to the joints that are blocked and not the number of medial branches that innervate them as defined by the AMA CPT Committee.

Codes 64490-64495 are unilateral procedures. When bilateral injections are performed (e.g., injections performed at

both the left and right paravertebral facet joints), then the bilateral modifier 50 should be appended to the appropriate code. Note that the multiple procedures modifier 51 should not be appended to the add-on codes 64491, 64492, 64494 or 64495 because these are add-on codes and exempt from multiple procedure concept.

The cervical/thoracic facet injection codes (64490, 64491 and 64492) and lumbar/sacral facet joint injection codes (64493, 64494 and 64495) are reported once when the injection procedure is performed irrespective of whether a single or multiple puncture is required to anesthetize the target joint at a given level and side. To clarify, only one facet injection code should be reported at a specific level and side injected (e.g., right L4-5 facet joint), regardless of the number of needle(s) inserted or number of drug(s) injected at that specific level.

ICD-10-CM code Z79.01 (Long-term (current) use of anticoagulants) should be used only as a supplementary code in addition to the primary diagnosis. This code should be reported when the use of anticoagulants has been temporarily discontinued to facilitate multiple interventional therapeutic modalities (e.g., facet joint blocks, trigger point injections, lumbar sympathetic blocks) for pain management.

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by the entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service[s]). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-10-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. Assessment of the outcome of this procedure depends on the patient’s responses, therefore documentation should include:
    - Whether the block was a diagnostic or therapeutic injection
    - Pre and postoperative evaluation of patient
    - Patient education
    - Subjective and objective responses from the patient regarding pain, including facet pain provocative maneuvers documented by pre and post-operative measurement
5. Placement of the needle at the facet joint must be performed under the fluoroscopic guidance to ensure safety and accuracy of the injection procedure, and this must be documented in the patient’s medical record.

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Compliance with the provisions in LCD L33930 Paravertebral Facet Joint Blocks may be monitored and addressed through post payment data analysis and subsequent medical review audits.

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

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)

CPT/HCPCS Modifiers

N/A

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:

The following ICD-10-CM codes support medical necessity and provide limited coverage for CPT codes: 64490, 64491, 64492, 64493, 64494, and 64495.

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
M25.50	Pain in unspecified joint
M47.14	Other spondylosis with myelopathy, thoracic region
M47.15	Other spondylosis with myelopathy, thoracolumbar region
M47.16	Other spondylosis with myelopathy, lumbar region
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.891	Other spondylosis, occipito-atlanto-axial region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M54.03	Panniculitis affecting regions of neck and back, cervicothoracic region

ICD-10 CODE	DESCRIPTION
M54.04	Panniculitis affecting regions of neck and back, thoracic region
M54.05	Panniculitis affecting regions of neck and back, thoracolumbar region
M54.06	Panniculitis affecting regions of neck and back, lumbar region
M54.07	Panniculitis affecting regions of neck and back, lumbosacral region
M54.08	Panniculitis affecting regions of neck and back, sacral and sacrococcygeal region
M54.09	Panniculitis affecting regions, neck and back, multiple sites in spine
M54.2	Cervicalgia
M54.5	Low back pain
M54.6	Pain in thoracic spine
M62.830	Muscle spasm of back
M96.1	Postlaminectomy syndrome, not elsewhere classified
Z79.01*	Long term (current) use of anticoagulants

Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation:

*** ICD-10-CM code Z79.01 is used only as a supplemental code in addition to a primary diagnosis, when anticoagulant therapy has been discontinued to facilitate therapeutic injections for pain management.**

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

All those not listed under the "ICD-10 Codes that Support Medical Necessity" section of this article.

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
XX000	Not Applicable

Additional ICD-10 Information

N/A

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type.Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

CODE	DESCRIPTION
999x	Not Applicable

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

CODE	DESCRIPTION
99999	Not Applicable

Other Coding Information

N/A

Revision History Information

N/A

Associated Documents

Related Local Coverage Document(s)

LCD(s)
L33930 - Paravertebral Facet Joint Blocks

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A

Public Version(s)

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