BSC 6.03 Facet Joint Injections and Facet Joint Nerve Blocks

Section 7.0 Surgery
Effective Date December 15, 2014

Subsection 7.01 Surgery
Original Policy Date March 16, 1988
Next Review Date December 2015

Description

The facet joints, also known as the zygapophysial joints, are the paired joints on each side of the vertebrae where adjacent vertebrae overlap. These joints have opposing surfaces of cartilage and a surrounding capsule filled with synovial fluid, reducing friction between the vertebrae. A painful facet joint of the cervical, thoracic, or lumbar spine can be blocked by injection into the joint itself (facet joint injection) or by blocking the nerves that supply the painful joint (facet joint nerve block or medial branch block). Facet joint injections or nerve blocks are performed using imaging guidance (i.e., fluoroscopy). Injections or nerve blocks are used diagnostically to determine if the facet joint is the source of pain and therapeutically to manage pain during rehabilitation.

Related Policies

- Facet Arthroplasty
- Facet Joint Denervation
- Sacroiliac Joint Injection

Policy

Diagnostic Facet Joint Injections or Facet Joint Nerve Blocks (Medial Branch Blocks)

A diagnostic facet joint injection or facet joint nerve block performed to assist in the diagnosis of facet joint pain is considered medically necessary when all of the following criteria are met:

- Disabling, continuous or intermittent chronic axial neck or back pain, persisting for at least three months that is suggestive of facet joint origin resulting from disease, injury or surgery
- No evidence of documented radiculopathy at the targeted level. However, if there is a mixed picture with both radicular and axial pain, there must be documentation of an inadequate response to an epidural steroid injection performed at the level in question on a separate date of service.
- Conservative management has failed or is not feasible (e.g., physical therapy modalities with exercises, chiropractic management, non-steroidal anti-inflammatory drugs (NSAIDS)/ analgesia/steroids/relaxant drugs, activity modification)
- Either a facet joint injection or facet joint nerve block (not both) is performed at the same level and all of the following:
  - Both of the following components:
    - Imaging guidance (e.g., fluoroscopy)
- Local anesthetic only (without corticosteroids)
  - No more than three levels injected during the same session/procedure (Note: It may be medically necessary to inject the same level or levels bilaterally during the same procedure)
  - Injection is not performed on the same day of service as another facet joint injection/facet joint nerve block in a different anatomical region (e.g., cervical and lumbar)
  - A maximum of 1.0 ml of local anesthetic is used per facet joint/medial branch nerve
  - Intravenous analgesics are not used (i.e., narcotics, opioids). See policy guideline

A repeat diagnostic facet joint injection or facet joint nerve block at the same level is considered medically necessary when all of the following criteria are met:
- Criteria for a diagnostic facet injection or facet joint nerve block met (as above)
- Prior diagnostic injection or nerve block demonstrated at least 50% improvement for at least the appropriate duration of the local anesthetic used (2-plus hours for Lidocaine and and 3-plus hours for Bupivicaine)
- Performed no sooner than one week after the initial injection
- Maximum of two series of diagnostic injections per level

If it has been less than one year since a prior successful radiofrequency (RF) denervation, additional diagnostic facet joint nerve blocks (medial branch blocks) for the same level of the spine are considered not medically necessary.

Therapeutic Facet Joint Nerve Blocks (Medial Branch Blocks)
A therapeutic facet joint nerve block (medial branch block) is considered not medically necessary.

Therapeutic Facet Joint Injections
An initial therapeutic facet joint injection may be considered medically necessary when all of the following criteria are met:
- One of the following indications:
  - Documented evidence that a prior diagnostic injection provided at least a 50% reduction in pain
  - As an isolated intervention, performed to treat a patient’s axial spinal pain when all of the following criteria are met:
    - Disabling, continuous or intermittent chronic neck or back pain that is suggestive of facet joint origin resulting from disease, injury or surgery
    - No evidence of documented radiculopathy at the targeted level. However, if there is a mixed picture with both radicular and axial pain, there must be documentation of an inadequate response to an epidural steroid injection performed at the level in question on a separate date of service.
    - Conservative management has failed or is not feasible (e.g., physical therapy modalities with exercises, chiropractic management, non-steroidal anti-inflammatories (NSAIDS)/analgesia/steroids/relaxant drugs, activity modification)
• In conjunction with an active rehabilitation program or active home exercise program
• Performed with both of the following components:
  o Imaging guidance (e.g., fluoroscopy)
  o Local anesthetic with a corticosteroid
• Injection is not performed on the same day of service as another facet joint injection/facet joint nerve block in a different anatomical region (e.g., cervical and lumbar on the same day of service) See Policy Guideline**

Repeat therapeutic facet joint injections are considered medically necessary when all of the following criteria are met:

• Documented evidence that the previous therapeutic injection provided at least a 50% reduction in pain relief lasting at least six weeks
• A maximum of four therapeutic injections are provided per year per anatomical region
• Injections are not provided more frequently than a minimum of two months per anatomical region
• Injection is not performed on the same day of service as another facet joint injection/facet joint nerve block in a different anatomical region (e.g., cervical and lumbar on the same day of service). See Policy Guideline.**

The use of homeopathic substances or medications not approved by the U.S. Food and Drug Administration are considered not medically necessary.

**Policy Guidelines**

A successful (positive) diagnostic facet joint injection or facet joint nerve block (medial branch block) is one that results in at least 50% reduction in pain for the duration of the local anesthetic used (e.g., 2-plus hours for Lidocaine and and 3-plus hours for Bipvicaicne).

**Anesthesia**

• Anesthesia is included in the fee for the injection when being billed by the same provider on the same day of service
• Separate anesthesia, billed by a different provider on the same day of service, is generally not separately reimbursable unless there is clinical documentation to support medical necessity

*The use of monitored anesthesia care (MAC) is not indicated in interventional pain procedures in patients at average risk related to use of anesthesia and sedation. See Blue Shield Medical Policy: Monitored Anesthesia Care for medical necessity criteria.

**Note: If another spinal procedure (e.g., epidural steroid injection, sacroiliac joint injection) is performed on the same day of service as a facet joint injection/block, both procedures will be reviewed for medical necessity based on applicable Blue Shield Medical Policy criteria. (See Index/Cross Reference Section of Related BSC Medical Policies in the Appendix).
Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program (FEP)) prohibit Plans from denying Food and Drug Administration (FDA) - approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Rationale

Spinal facet joint injections with a local anesthetic injected into the target joint or onto the medial branches of the dorsal rami are useful in confirming the source of back pain. Rationale for facet joint injections is based on the observation that if a particular joint is determined to be the pain generator, long term relief can be sought by directing therapeutic interventions at that joint. Local anesthetic injection into the facet joint or interruption of the nerve supply to the facet joints is accepted as a standard for diagnosis of facet joint pain. A single facet joint may be innervated by at least two medial branches; therefore two adjacent levels should be blocked. The goal of facet joint injections is to provide temporary relief from motion-limiting pain to allow the patient to participate in an appropriate exercise or rehabilitation program and/or perform activities of daily living. They may also help focus treatment on a specific spinal segment.

Spinal facet joint injections and nerve blocks have become a standard for managing non-acute spinal pain which allows patients to become more functional in activities of daily living.

According to the 2008 American Academy of Physical Medicine and Rehabilitation Educational Guidelines for Interventional Spinal Procedures(1), facet joint injections or facet joint nerve blocks (medial branch blocks) are both diagnostic and therapeutic and may facilitate other treatment options such as manual or physical therapy. Injection should be limited to those with back pain who failed to respond to conservative treatments including non-steroidal anti-inflammatories (NSAIDS), corticosteroids, or therapies. The objective of the injection is to deliver up to 1 milliliter (ml) of injectate, including contrast, anesthetic and possibly corticosteroid, into the zygapophysial (facet) joint space to both test the hypothesis that the joint is the source of pain and to decrease intraarticular inflammation. Fluoroscopy is considered mandatory. Further, no role exists for a series of any type of injection given without regard to the response of the initial or previous injection.

The 2009 American Society of Interventional Pain Physicians (ASIPP) Interventional Techniques evidence-based practice guidelines (2) describe two phases of facet joint injection therapy; the diagnostic phase and the therapeutic phase. Diagnostic facet joint injections are used to verify the specific area generating pain prior to a facet joint denervation procedure or other medical management. Further, the duration of spinal pain must be at least three months before a facet joint intervention is initiated.(2) During this diagnostic phase of the procedure, a needle is placed in the facet joint or at the median branch nerve under fluoroscopic guidance and contrast material is then
injected to confirm the position of the needle in the joint space. Once confirmed, a long acting local anesthetic agent and/or corticosteroid is injected in the joint or at the nerve to temporarily denervate the facet joint. After a satisfactory blockade of pain has been obtained, the patient is instructed to perform activities that historically aggravate the pain. The patient reports effectiveness of the procedure on pain relief four to eight hours after the injection. Pain relief suggests that the facet joint is the pain source. Steroid effects, such as reduced inflammation, may not be experienced for several days and the medication effect may last from weeks to months.

The 2007 American College of Occupational and Environmental Medicine (ACOEM) evidence-based practice guideline for low back disorders advised one diagnostic facet injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity, and is not alleviated with other conservative treatment.(3)

The 2009 ASIPP evidence-based guidelines(2) recommended the following indications for diagnostic facet joint injections/nerve blocks:

- Suspected facet joint pain
- Somatic or non-radicular neck or back pain with a duration of pain of at least three months
- Average pain levels of greater than 6 on a scale of 0 to 10
- Pain is at least intermittent or continuous causing functional disability
- Condition has failed to respond to more conservative management, including physical therapy modalities with exercises, chiropractic management, and NSAID use
- Lack of preponderance of evidence of discogenic pain, disc herniation, or evidence of radiculitis
- No evidence of contraindications for the needle placement and injection of local anesthetics
- Presence of contraindications or inability to undergo physical therapy, chiropractic management, or inability to tolerate NSAIDs

A positive response to a diagnostic facet joint injection or nerve block was based on the following evidence:

- Patient met the above indications
- Patient responds positively to controlled local anesthetic blocks with either placebo control or comparative local anesthetic blocks with appropriate response to each local anesthetic with <1 ml of local anesthetic
- At least 80% relief as criterion standard with ability to perform previously painful movement without deterioration of the relief (i.e., extension, overhead activity, lateral rotation, flexion, etc.)
- The patient's response should be recorded independently by the assessor—generally a registered nurse familiar with the patient or another physician

For a diagnostic facet joint injection or facet joint nerve block (medial branch block) to have face validity it must be shown that the block does what it actually is supposed to do in an anatomical and a physiological sense.(4) While there is no conventional criterion standard to evaluate the construct validity (measuring if the extent to which a test correctly distinguishes the presence, but also the absence, of the condition that the test is supposed to detect) of a true-positive diagnostic facet joint injection or nerve block, long-term relief may be used to provide a criterion standard.(2) The most
commonly used approach in the United States is comparative local anesthetic blocks. The diagnostic blocks are performed on separate occasions using local anesthetic agents with different durations of action. Using this approach, the consistency and duration of the response are tested. Failure to respond to a second block establishes inconsistency, and indicates the first response was false-positive. A response that is congruent with the duration of action of the active agent (i.e., anesthetic) used, is strongly suggestive of a real, physiologic response.(4, 2) Once the offending facet joint has been identified with comparative diagnostic blocks, it may be appropriate to proceed with medial branch neuroablation (also known as facet joint denervation or facet neurotomy).

The ASIPP guidelines(2) advised that a patient may receive injections at intervals of no sooner than one week and preferably two weeks apart, during the diagnostic or stabilization phase. Temporary or prolonged abolition of low back pain suggests that the facet joints were the source of the symptoms and appropriate treatment may be prescribed in the future. In contrast, the ACOEM(3) advised that while a diagnostic injection may determine whether specific interventions targeting the facet joint; repeated diagnostic injections in the same location were not recommended.

According to(5), the etiology of a false-positive block may include use of sedation, liberal use of local anesthetic, and spread of injectate to other pain generators. The concomitant use of sedative during the block can also interfere with an accurate diagnosis. The Official Disability Guidelines (ODG, 2009) advises that the use of intravenous sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. No pain medication from home should be taken for at least four hours prior to the diagnostic block and for four to six hours afterward. Additionally, opioids should not be given as a “sedative” during the injection procedure.(6)

General anesthesia is also contraindicated for diagnostic blocks.(7) Further, monitored anesthesia care or heavy sedation may provide false-positive results.

Because facet joint injections or facet joint nerve blocks (medial branch blocks) are used to diagnose the source of pain, performing other pain management injections at the same time does not allow the physician to definitively determine which of the injections was effective in alleviating the symptoms. Further, multiple injections/nerve blocks on the same day may lead to improper or lack of diagnosis. It is generally not recommended that facet joint injections or nerve blocks be used in conjunction with other pain management injections.

According to the ASIPP guidelines(2), the common indications for therapeutic facet joint interventions are based on meeting diagnostic indications and a positive response to controlled local anesthetic blocks (less than 1 ml per nerve) with a criterion standard of 80% pain relief, along with the ability to perform prior painful movements without any significant pain. The ASIPP guidelines further recommend the interval between therapeutic injections be two to three months or longer, provided that greater than or equal to 50% relief is obtained for eight weeks. It is also suggested these injections be limited to a maximum of four to six times per year.

Literature Review

Recent studies in the area of facet joint injections and facet joint nerve blocks (medial branch blocks) are mixed. Some reviews report little or no therapeutic effect on lower or upper back pain.(8,9,10) Others report moderate evidence that controlled local anesthetic blocks provide a management option in therapeutic pain relief for chronic
Medical Policy

low back pain felt to be facet joint origin.(11,12,13) However, most authors reported shortcomings in their systematic reviews due to the paucity of published literature.

Diagnostic Facet Joint Injections and Facet Joint Nerve Blocks

The American Association of Neurological Surgeons (AANS) guideline on injection therapies, low back pain, and lumbar fusion(14) concluded there is evidence that suggests facet joint injections can be used to predict outcomes of radiofrequency ablation of a facet joint.

Rubinstein and van Tulder(24) in a best evidence review of diagnostic procedures for neck and low back pain concluded there was strong evidence for the diagnostic accuracy of cervical and lumbar facet joint blocks in evaluating spine pain. (26)

A Hayes Inc., Medical Technology Directory report(15) on facet joint blocks for chronic back pain advised there was insufficient evidence to satisfactorily evaluate the use of facet joint blocks for the diagnosis or cause of chronic back pain, as there is no gold standard for facet syndrome. The authors concluded that facet joint blocks are likely more useful for ruling out the facet joints as the pain trigger instead of providing a definitive diagnosis.

The 2009 ASIPP evidence-based practice guidelines(2) reported the indicated evidence for accuracy of diagnostic facet joint nerve blocks was Level I or II-1 based on the United States Preventative Services Task Force (USPSTF) criteria.

- Level I: Evidence obtained from at least one properly randomized controlled trial [RCT] or multiple properly conducted diagnostic accuracy studies
- Level II-1: Evidence obtained from one well-designed controlled trial without randomization or at least one properly conducted diagnostic accuracy study of accurate size

The Washington State Health Care Authority published a Health Technology Assessment Evidence Report in 2011(16) regarding the efficacy of spinal injections. The committee concluded there was "insufficient evidence to recommend facet joint injections and medial branch blocks [facet joint nerve blocks]." Diagnostic injections were recommended only on a very limited basis.

While the current evidence is conflicting, facet joint injections and facet joint nerve blocks are generally accepted when used for the diagnosis of facet joint symptoms. There is more controversy in respect to use of these interventions in the therapeutic setting.

Therapeutic Facet Joint Injections

The AANS guideline(14) advised there was no evidence to support the effectiveness of facet joint injections in the treatment of patients with chronic low back pain. In addition, the ACOEM (2007) practice guidelines state that therapeutic facet joint injections are not recommended for acute, subacute, or chronic low back pain or for any radicular pain syndrome.(3)

A Cochrane systematic review(17) was performed to determine if injection therapy is more effective than placebo or other treatments for patients with subacute or chronic low back pain. The review evaluated 18 RCTs of injection therapy involving epidural, facet, or local sites in patients with non-radicular pain. The authors indicated there was no strong evidence to support the use of injection therapy in subacute and chronic low back pain, however, it could not be ruled out that specific subgroups of patients may respond to a specific type of injection therapy.
The Official Disability Guidelines (ODG), in reference to facet joint intra-articular injections, advised that evidence is conflicting, and no more than one therapeutic intra-articular injection is suggested. If successful (pain relief of at least 50% of duration of at least six weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). If a therapeutic facet joint intra-articular injection is undertaken, it is suggested that it be used in conjunction with other evidence-based conservative care (activity, exercise, etc.) to facilitate functional improvement. (6)

A report prepared by the Canadian Agency for Drugs and Technologies in Health (2011) addressed facet joint injections as diagnostic and therapeutic tools for pain of the spine. The authors advised there was some evidence of short term benefit of therapeutic facet joint injections for relief of low back pain, and the potential to provide longer-term pain relief, but the long-term response rate (e.g., up to six months) was variable and unclear. (18)

In spite of the lack of evidence and controversy in regard to the long-term effectiveness of facet joint injections and use as a therapeutic procedure, this remains a popular treatment modality. The therapeutic facet joint injections described as medically necessary in this policy are injections of an anesthetic combined with a steroid under imaging guidance, performed as an isolated intervention or when a diagnostic injection has provided moderate pain reduction, in conjunction with an active exercise program, and are intended to provide temporary pain relief.

Therapeutic Facet Joint Nerve Blocks (Medial Branch Blocks)

Facet joint nerve blocks (medial branch blocks) have also been evaluated as a therapeutic intervention. However, no RCTs were identified that compared anesthetic nerve blocks with placebo injections. Placebo-controlled studies are important for treatments for which the primary outcome is a measurement of pain in order to account for the potential placebo effect of an intervention.

A Hayes Inc., Medical Technology Directory report (15) on facet joint blocks for chronic back pain advised that while there were positive results from some studies that indicated the therapeutic facet joint blocks would provide at least modest reduction in pain or increase in function for some chronic back pain patients, there were conflicting results in other studies with failure to establish any therapeutic effect beyond what is seen with a placebo block. This suggested there was a small, if any, true-positive treatment effect.

According to the ASIPP guidelines (2), the evidence was Level II-1 or II-2 for therapeutic cervical, thoracic, and lumbar facet joint nerve blocks.

- Level II-1: Evidence obtained from one well-designed controlled trial without randomization or at least one properly conducted diagnostic accuracy study of accurate size
- Level II-2: Evidence obtained from at least one properly designed small diagnostic accuracy study

Based on the evidence, the ASIPP guideline recommendation was IB (strong recommendation, moderate quality evidence) or IC (strong recommendation, low-quality or very low-quality evidence) for the use of therapeutic cervical, thoracic, and lumbar facet joint nerve blocks to provide both short-term and long-term relief in the treatment of chronic facet joint pain.

The American Society of Anesthesiologists Practice Guidelines for Chronic Pain Management (19) indicates in its practice guidelines for chronic pain management that
medial branch nerve blocks may be used for the treatment of facet-mediated spinal pain. However, Levin(25) has argued that the rationale for medial branch nerve blocks is flawed. The author notes that the site of the pathology is the joint, with the pain merely being transmitted through the nerve, and contends that it is not logical to perform an injection on a nerve that is not pathologic.

Three randomized double-blind controlled trials were identified that compared the therapeutic effect of medial branch blocks with bupivacaine alone to bupivacaine and steroid (betamethasone).(20,21,22) Patients included had a diagnosis of facet joint pain (cervical, thoracic, and lumbar) with an 80% reduction in pain following two diagnostic anesthetic blocks of the medial branches. Patient outcomes were measured at 3, 6, 12, 18, and 24 months with a Numeric Rating Scale for pain and with the Oswestry Disability Index (ODI). Significant pain relief was considered to be a decrease of equal to or greater than 50% on the Numeric Rating Scale. Opioid intake and work status were also evaluated.

One of the randomized trials included 120 patients meeting the diagnostic criteria for cervical facet joint pain. (20) The two groups were further subdivided, with half of the patients in each group receiving Sarapin. Patients were followed at three-month intervals, and the cervical medial branch blocks were repeated only when reported pain levels decreased to below 50% with significant pain relief after the previous block. Injections were repeated an average of 5.7 times over a period of two years. Sarapin did not affect the outcome, and the data were reported only for the two main conditions. At two-year follow-up, 85% of patients in the bupivacaine group and 93% of patients in the steroid group were reported to have significant pain relief, based on intent-to-treat analysis. The average duration of pain relief with each procedure was 17 to 19 weeks. At least 50% improvement in the Neck Disability Index was seen in 70% of patients in the bupivacaine group and 75% of patients in the bupivacaine plus steroid group. There was no significant change in the intake of opioids. There was a loss of 38% of data for the 24-month evaluation. Sensitivity analysis using the last follow-up score, best case scenario, and worst case scenario were not significantly different, and intent-to-treat analysis with the last follow-up visit was utilized.

A second randomized double-blind trial(21) evaluated the efficacy of facet joint nerve blocks in 120 patients with chronic low back pain. In addition to the two main conditions, half of the patients in each group received Sarapin. Sarapin did not affect the outcome and the data were reported only for the two main conditions. Patients received about five to six treatments over the course of the study. At two-year follow-up, significant pain relief (>50%) was observed in 85% of the patients treated with bupivacaine alone and 90% of the patients treated with bupivacaine and steroid. The proportion of patients with significant functional status improvement (>40% on the ODI) was 87% for bupivacaine and 88% for the control group. The average duration of pain relief with each procedure was 19 weeks. There was no significant change in opioid intake. Twenty-four month results were missing for 20% of the subjects. Sensitivity analysis of Numeric Pain Rating scores using the last follow-up score, best case scenario, and worst case scenario were not significantly different.

One-year results were reported from the randomized double-blind trial of the efficacy of thoracic medial branch blocks.(22) The 100 patients in this study received an average of 3.5 treatments per year. Intent-to-treat analysis at 12 months showed a decrease in average pain scores from 7.9 at baseline to 3.2 in the bupivacaine group and from 7.8 to 3.1 in the bupivacaine plus steroid group. At least 50% improvement in the ODI was observed in 80% and 84% of participants, respectively. In both groups, 90% of participants
showed significant pain relief (>50%) at 12 months. The average relief per procedure was 16 weeks for bupivacaine and 14 weeks for bupivacaine plus betamethasone. There was no significant change in the intake of opioids.

The longer term outcomes from these three randomized double-blind trials are intriguing, given the apparent long duration of efficacy of this short-acting anesthetic and the lack of a known mechanism. However, placebo-controlled studies are important for treatments in which the primary outcome is a measurement of pain. No trials were identified that compare medial branch nerve blocks with placebo. Randomized controlled trials comparing therapeutic facet joint nerve blocks with placebo injections and the current standard of care (radiofrequency denervation) are needed to fully evaluate this treatment approach.

A Hayes Inc., Technology Medical Directory report(23) regarding the treatment of chronic non-malignant pain with nerve blocks, included the evaluation of lumbar facet joint nerve blocks, thoracic and cervical medial nerve branch blocks for back pain of facet joint origin. The authors cited low-quality evidence and concluded there was insufficient evidence and unproven benefit regarding the safety and health outcomes of these nerve blocks due to substantial study limitations including, but not limited to, the same study researchers, small numbers of patients, and lack of appropriate control groups (placebo or active) to accurately assess the intervention.

Summary

There is limited evidence for the use of diagnostic and therapeutic facet injections or facet joint nerve blocks (medial branch blocks) for the treatment of back pain. Diagnostic facet joint injections or nerve blocks provide an acceptable pain management option for guidance on whether specific interventions targeting the facet joint are indicated. While evidence is conflicting, therapeutic facet joint injections may be medically necessary under certain situations for temporary pain relief. There is insufficient evidence to evaluate the effect of therapeutic facet joint nerve blocks (medial branch blocks) on facet joint pain.

References


Documentation Required for Clinical Review

- History and physical and/or consultation note(s) and/or progress notes including:
  - Diagnosis, history and duration of pain
  - Duration and response to conservative therapy (specify type(s))
  - Previous injection(s) (if applicable) including: date(s), type(s), location(s)/level(s), and responses
  - Treatment plan
- Injection(s) planned or performed including:
  - Location(s)/Level(s)
  - Type of injection (i.e., facet joint injection or block, diagnostic, therapeutic) and type of injectate solution(s)
  - Whether intravenous (IV) sedation/narcotic analgesia/ monitored anesthesia care (MAC) is planned or used (if applicable)
  - Type of imaging guidance (i.e., fluoroscopy)
  - Radiology report(s)
- Post Service
  - Procedure report(s) including: description and procedure effects

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.
The following service/procedure may be considered medically necessary in certain instances and investigational in others. Services may be medically necessary when policy criteria are met. Services are considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

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**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

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<td>7/7/2008</td>
<td>Policy Revision with literature search and peer review. Added medical necessity criteria and codes. Title changed from; Facet Injections for Back Pain.</td>
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<td>Administrative Review</td>
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Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California / Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a Split Evaluation, where a treatment, procedure or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

**Prior Authorization Requirements**

This service (or procedure) is considered **medically necessary** in certain instances and **investigational** in others (refer to policy for details).

For instances when the indication is **medically necessary**, clinical evidence is required to determine **medical necessity**.

For instances when the indication is **investigational**, you may submit additional information to the Prior Authorization Department.

Within five days before the actual date of service, the Provider MUST confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.
Questions regarding the applicability of this policy should also be directed to the Prior Authorization Department. Please call 1-800-541-6652 or visit the Provider Portal www.blueshieldca.com/provider.

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.