Local Coverage Article:
Billing and Coding: Facet Joint Interventions for Pain Management (A58364)

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Please Note: Future Effective Date.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	15101 - MAC A	15101 - MAC A	J - 15	Kentucky
CGS Administrators, LLC	15102 - MAC B	15102 - MAC B	J - 15	Kentucky
CGS Administrators, LLC	15201 - MAC A	15201 - MAC A	J - 15	Ohio
CGS Administrators, LLC	15202 - MAC B	15202 - MAC B	J - 15	Ohio

Article Information

General Information

Article ID
A58364

Article Title
Billing and Coding: Facet Joint Interventions for Pain Management

Article Type
Billing and Coding

AMA CPT / ADA CDT / AHA NUBC Copyright Statement

Original Effective Date
05/02/2021

Revision Effective Date
N/A

Revision Ending Date
N/A

Retirement Date
N/A

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CMS National Coverage Policy

N/A

Article Guidance

Article Text:

Refer to the Local Coverage Determination (LCD) L38773 Facet Joint Interventions for Pain Management, for reasonable and necessary requirements and frequency limitations.

The Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code(s) may be subject to National Correct Coding Initiative (NCCI) edits. This information does not take precedence over NCCI edits. Please refer to NCCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

General Guidelines for Claims submitted to Part A or Part B MAC:

Procedure codes may be subject to National Correct Coding Initiative (NCCI) edits or OPPS packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare. For services requiring a referring/ordering physician, the name and NPI of the referring/ordering physician must be reported on the claim. A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act. The diagnosis code(s) must best describe the patient's condition for which the service was performed. For diagnostic tests, report the result of the test if known; otherwise the symptoms prompting the performance of the test should be reported.

Coding Guidance Providers should refer to the applicable AMA CPT Manual to assist with proper reporting of these services.

This policy applies only to cervical/thoracic or lumbar facet procedures and does not apply to other joint procedures (such as sacral injections, sacroiliitis, epidural or other spinal procedures).

Diagnostic and Therapeutic procedures:

Each facet level in the spinal region is composed of bilateral facet joints (i.e., there are two facet joints per level, one on the right side and one on the left). Unilateral or bilateral facet interventions may be performed during the facet joint procedure (a diagnostic nerve block, a therapeutic facet joint (intraarticular) injection, a medial branch block injection, or the medial branch radiofrequency ablation (neurotomy) in one session. A bilateral intervention is still considered a single level intervention.

Each unilateral or bilateral intervention at any level should be reported as one unit, with bilateral intervention signified by appending the modifier -50.

Regions:

An anatomic spinal region for paravertebral facet joint block (diagnostic or therapeutic), is defined as cervical\thoracic (CPT codes 64490, 64491, 64492) or lumbar\sacral (CPT codes 64493, 64494, 64495) per the AMA CPT Manual.

Levels:

64490 (cervical or thoracic) or 64493 (lumbar or sacral) reports a single level injection performed with image guidance (fluoroscopy or CT). Procedures performed under ultrasound guidance are not covered.

64491 or 64494 describes a second level which should be reported separately in addition to the code for the primary procedure. 64491 should be reported in conjunction with 64490 and 64494 should be reported in conjunction with 64493.

64492 or 64495 describes a third and additional levels and should be listed separately in addition to the code for the primary procedure and the second level procedure and cannot be reported more than once per day. 64492 should be reported in conjunction with 64490/64491 and 64495 should be reported in conjunction with 64493/64494.

Laterality:

Bilateral paravertebral facet injection procedures 64490 through 64495 should be reported with modifier 50.

One to two levels, either unilateral or bilateral, are allowed per session per spine region (i.e., two (2) unilateral or to two (2) bilateral levels per session).

For services performed in the ASC, do not use modifier 50. Report the applicable procedure code on two separate lines, with one unit each and append the -RT and -LT modifiers to each line.

KX modifier requirements:

The KX modifier should be appended to the line for all diagnostic injections. In most cases the KX modifier will only be used for the two initial diagnostic injections. If the initial diagnostic injections do not produce a positive response as defined by the policy and are not indicative of identification of the pain generator, and it is necessary to perform additional diagnostic injections, at a different level, append the KX modifier to the line. Aberrant use of the KX modifier may trigger focused medical review.

Therapeutic injections:

Documentation of why patient is not a candidate for RFA must be submitted for therapeutic treatment.

Chemodenervation of nerve:

Codes 64633, 64634, 64635, 64636 are reported per joint, not per nerve. Although two nerves innervate each facet joint, only one unit per code may be reported for each joint denervated, regardless of the number of nerves treated (AMA CPT Manual 2020).

Each unilateral or bilateral intervention at any level should be reported as one unit, with bilateral intervention signified by appending the modifier -50.

Region:

An anatomic spinal region for thermal facet joint denervation is defined as cervical/thoracic (CPT codes 64633 and 64634) or lumbar/sacral (CPT codes 64635 and 64636) per the AMA CPT Manual.

For neurolytic destruction of the nerves innervating the T12-L1 paravertebral facet joint, use 64633

Levels:

64633 or 64635 describes a single level destruction by neurolytic agent performed with image guidance (fluoroscopy or CT)

64634 or 64636 describes each additional level which should be reported separately in addition to the code for the primary procedure. 64634 should be used in conjunction with 64633 and 64636 should be used in conjunction with 64635.

Laterality:

For bilateral procedures report modifier 50 on each line in which the intervention was of a bilateral nature.

For services performed in the ASC, do not use modifier 50. Report the applicable procedure code on two separate lines, with one unit each and append the -RT and -LT modifiers to each line.

Non-thermal facet joint denervation (including chemical, low grade thermal energy (<80 degrees Celsius or any other form of pulsed radiofrequency) should not be reported with CPT codes 64633, 64634, 64635 or 64636. These services should be reported with CPT code 64999. Code 64999 is non-covered when used to report non-thermal facet joint denervation.

If facet joints are injected with biologicals or other substances not designated for this use the entire claim will deny per Benefit Policy Manual Chapter 16: Section 180.

Documentation Requirements

The patient's medical record should include but is not limited to:

- The assessment of the patient by the performing provider as it relates to the complaint of the patient for that visit,
- Relevant medical history
- Results of pertinent tests/procedures
- Signed and dated office visit record/operative report (Please note that all services ordered or rendered to Medicare beneficiaries must be signed.)

Coding Information

CPT/HCPCS Codes

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
64490	Inj paravert f jnt c/t 1 lev
64491	Inj paravert f jnt c/t 2 lev
64493	Inj paravert f jnt l/s 1 lev
64494	Inj paravert f jnt l/s 2 lev
64633	Destroy cerv/thor facet jnt

CODE	DESCRIPTION
64634	Destroy c/th facet jnt addl
64635	Destroy lumb/sac facet jnt
64636	Destroy l/s facet jnt addl

Group 2 Paragraph:

The following CPT/HCPCS codes are non-covered*:

* this is not an inclusive list of non-covered codes

*Note: 64492 or 64495 describes a third and additional levels and should be listed separately in addition to the code for the primary procedure and the second level procedure and cannot be reported more than once per day. 64492 should be reported in conjunction with 64490/64491 and 64495 should be reported in conjunction with 64493/64494. Codes 64492 and 64495 will only be covered upon appeal if sufficient documentation of medical necessity is present.

Group 2 Codes:

CODE	DESCRIPTION
64492	Inj paravert f jnt c/t 3 lev
64495	Inj paravert f jnt l/s 3 lev
0213T	Njx paravert w/us cer/thor
0214T	Njx paravert w/us cer/thor
0215T	Njx paravert w/us cer/thor
0216T	Njx paravert w/us lumb/sac
0217T	Njx paravert w/us lumb/sac
0218T	Njx paravert w/us lumb/sac
0219T	Plmt post facet implt cerv
0220T	Plmt post facet implt thor
0221T	Plmt post facet implt lumb
0222T	Plmt post facet implt addl

CPT/HCPCS Modifiers

Group 1 Paragraph:

N/A

Group 1 Codes:

CODE	DESCRIPTION
50	BILATERAL PROCEDURE: UNLESS OTHERWISE IDENTIFIED IN THE LISTINGS,

CODE	DESCRIPTION
	BILATERAL PROCEDURES THAT ARE PERFORMED AT THE SAME OPERATIVE SESSION SHOULD BE IDENTIFIED BY ADDING THE MODIFIER -50 TO THE APPROPRIATE FIVE DIGIT CODE OR BY USE OF THE SEPARATE FIVE DIGIT MODIFIER CODE 09950
KX	REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET
LT	LEFT SIDE (USED TO IDENTIFY PROCEDURES PERFORMED ON THE LEFT SIDE OF THE BODY)
RT	RIGHT SIDE (USED TO IDENTIFY PROCEDURES PERFORMED ON THE RIGHT SIDE OF THE BODY)

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:

Note: 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.

Medicare is establishing the following limited coverage for CPT/HCPCS codes: **64490, 64491, 64493, 64494, 64633, 64634, 64635, and 64636.**

Note: ICD-10 Codes M71.30 or M71.38 are allowed for facet cyst rupture procedures only.

Group 1 Codes:

ICD-10 CODE	DESCRIPTION
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
M47.892	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
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region

ICD-10 CODE	DESCRIPTION
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M71.30	Other bursal cyst, unspecified site
M71.38	Other bursal cyst, other site

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

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
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
071x	Clinic - Rural Health
073x	Clinic - Freestanding
083x	Ambulatory Surgery Center
085x	Critical Access Hospital

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 article, 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 article should be assumed to apply equally to all Revenue Codes.

CODE	DESCRIPTION
032X	Radiology - Diagnostic - General Classification
036X	Operating Room Services - General Classification
045X	Emergency Room - General Classification

CODE	DESCRIPTION
049X	Ambulatory Surgical Care - General Classification
051X	Clinic - General Classification
052X	Freestanding Clinic - General Classification
076X	Specialty Services - General Classification

Other Coding Information

N/A

Revision History Information

N/A

Associated Documents

Related Local Coverage Document(s)

LCD(s)

L38773 - Facet Joint Interventions for Pain Management

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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N/A