CLINICAL PAYMENT AND CODING POLICY

If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. “Plan documents” include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (“HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Paravertebral Facet Injection Procedure Coding & Billing Policy

Policy Number: CPCP036

Version 8.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: November 2, 2021

Plan Effective Date: February 24, 2022 (Blue Cross and Blue Shield of Texas Only)

Description

Facet joints may cause axial spinal pain and referred pain in the extremities. Therefore, facet joint interventions may be used for pain management for chronic cervical/thoracic and back pain stemming from the paravertebral facet joints. Facet block procedures are injections of local anesthetic, with or without the use of a steroid medication, either in the facet joint or outside the joint space around the nerve supply to the joint known as medial branch block (MBB). For purposes of this policy, a facet joint, or zygapophysial joint level refers to the facet joint or the two medial branch (MB) nerves that innervate that facet joint. Imaging guidance is used to assure accurate placement of the needle for the injection.

This policy is not intended to impact care decisions or medical practice. Additionally, this policy applies to In-Network and Out-of-Network professional providers and facilities.

Definitions

Chronic pain: The temporal definition of pain persisting for greater than or equal to 12 weeks after the onset of pain.

Facet joint: A diarthrodial joint in the spinal column (also called the zygapophysial joint or z-joint), producing the articulation of the posterior elements of one vertebra with its neighboring vertebra. They are bilateral superior and inferior articular surfaces at each spinal level. The terminology or nomenclature of the facet joint is classified by the specific vertebrae level that forms it (e.g., C4-5 or L2-3). There are two (2) facet joints, right and left, at each spinal level.

Facet injection (also called facet block): A general term used to describe the injection of local anesthetic and possibly a corticosteroid in the facet joint capsule or along the medial branch nerves supplying the facet joints from C2-3 to L5-S1.

Medial Branch: The dorsal ramus is the dorsal branch of a spinal nerve that forms from the dorsal root of the nerve after it emerges from the spinal cord.

Medial Branch Block (MBB): The placement of local anesthetic and possibly a corticosteroid near the medial branch nerve which supplies the sensory innervation to a specific facet joint.

Zygapophysial joint or Z-joint: See Facet joint

Reimbursement Information:

The plan reserves the right to request supporting documentation. Claim(s) that do not adhere to coding and billing guidelines may result in a denial or reassigned payment rate. Claims may be reviewed on a case-by-case basis.

For information on when facet joint injections that are performed under fluoroscopic guidance may be considered medically necessary, providers should refer to Plan's Medical Policies and AIM Specialty Health Clinical Guidelines which can be located under ***Medical Policies*** on the ***Provider*** tab of the Plan's website.

Documentation Requirements

Documentation must include, but not limited to:

- Substantiate the suspected diagnosis;
- Include care that was rendered on the day of service;
- The member's relevant medical history, e.g., prior tried and failed interventions;
- Physical examination;
- Results of the diagnostic tests and/or procedures.

Billing and Coding

Facet joint interventions (diagnostic and/or therapeutic) must be performed under fluoroscopic or computed tomographic (CT) guidance. Image guidance and any injection of contrast are inclusive components of CPT codes 64490-64495. Therefore, providers should not report guidance codes, such as 77001-77003 and 77012, for services in which fluoroscopic or CT guidance is included in the descriptor.

CPT codes 64490-64495 should only be reported once per level, per side, regardless of the number of needle placements that are required. For example, if an injection is performed on both sides of one vertebral level, providers should report the primary injection code (64490 or 64493) with modifier -50. If a second level is injected bilaterally, providers should report the add-on code (64491 or 64494), also with modifier -50.

Bilateral procedures billed with CPT codes 64491, 64492, 64494 or 64495 should only be billed with modifier -50, with a number of services reported as one (1). Appending modifiers RT, LT and -59 to these codes is not appropriate billing and claims will be denied.

Procedures may require prior authorization. Benefit coverage for services is determined by the member specific benefit plan and any applicable laws that may require coverage for a specific service. The following list may not be all inclusive. Inclusion of a code below does not guarantee reimbursement, nor does it imply that a code is a covered or non-covered service.

CPT Code	Description	Appropriate Usage
64490	INJ PARAVERT F JNT C/T 1 LEV	This code should not be reported more than once per day (primary code).
+ 64491	INJ PARAVERT F JNT C/T 2 LEV	Use in conjunction with 64490 (+add on code).
+ 64492	INJ PARAVERT F JNT C/T 3 LEV	Use in conjunction with 64490, 64491. This code should not be reported more than once per day (+add on code).
64493	INJ PARAVERT F JNT L/S 1 LEV	This code should not be reported more than once per day (primary code).
+ 64494	INJ PARAVERT F JNT L/S 2 LEV	Use in conjunction with 64493 (+add on code).
+ 64495	INJ PARAVERT F JNT L/S 3 LEV	Use in conjunction with 64493, 64494. This code should not be reported more than once per day (+add on code).

BlueCross BlueShield of Texas

Modifier -50 & Appropriate Usage

Modifier	Description	Appropriate Usage
50	Bilateral procedure	• Used to report bilateral procedures that are performed during the same service. • The use of modifier 50 is applicable only to services and/or procedures performed on identical anatomical sites, aspects, or organs. • Should only be reported with one line with one unit of service. • Should only be used when the code descriptor does NOT indicate unilateral or bilateral.

Category III CPT Codes

The following codes may be eligible for reimbursement. Inclusion of a code below does **NOT** guarantee reimbursement. Note, CPT category III codes 0213T-0218T are performed under ultrasound guidance. Therefore, providers should not report ultrasound guidance codes, such as 76942, for services in which ultrasound guidance is included in the descriptor.

CPT Code	Description
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

Additional Information

Providers should refer to Medical Policy SUR702.015, as well as any additional related Medical Policies and CMS for additional information, such as, any further documentation requirements, provider qualifications, limitations of coverage, indications of coverage and frequency with criteria.'

References:

'Centers for Medicare & Medicaid Services, Local Coverage Determination (LCD): Facet Joint Interventions for Pain Management (L38773). Accessed July 8, 2021.

CPT copyright 2020 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

Medical Policy SUR702.015

Clinical Payment and Coding Policies: **CPCP023 Modifier Reference Guideline**

AIM Specialty Health, Musculoskeletal Program

Policy Update History:

10/14/2021	New policy
11/2/2021	Revisions to verbiage of new policy