Facet Joint Interventions

Checklist Tool

Prior authorization is a condition of payment. It is the act of seeking a provisional affirmation for services before they are rendered. If the answer is "no" to most of the basic requirement statements listed, prior authorization for Facet Joint Interventions may receive a non-affirmed decision, be rejected, or denied.

Basic Requirements			
#	Statement	Yes	No
1	Is the HCPC code for the procedure on the Final List of Outpatient Department Services that Require Prior Authorization table? **Note–if the HCPC code is not listed, the procedure does not require prior authorization.**		
2	Is the primary diagnosis a covered indication for a facet joint intervention procedure?		
3	Is the request for one region/area of the spine? **Note–Two different areas of the spine in one session may receive a non-affirmed decision.**		
4	Is the procedure to be performed in a hospital outpatient department setting? **Note–procedures performed in ambulatory surgery centers and physician's office are not required to submit a prior authorization.**		
5	Is general anesthesia, conscious sedation, or monitored anesthesia care going to be used? **Note–if the answer is "yes," any claims submitted may receive a denial for the anesthesia used.**		
6	Will an anesthetic, corticosteroids, anti-inflammatories and/or contrast agents be used? **Note–injections of biologicals or other substances not designated for FDA use are not considered reasonable and medically necessary.**		
7	Will CT or fluoroscopic guidance be used during the procedure?		

Facet joint intervention procedures provided must meet reasonable and medically necessary requirements as outlined by the local coverage determination (LCD) L38773 Facet Joint Interventions for Pain Management. If the procedure being requested does not meet the criteria outlined by the LCD, the prior authorization request may receive a non-affirmed decision.

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First Diagnostic Injection Coverage Criteria—Medial Branch Block (MBB)			
#	Statement–Must Meet All Listed	Yes	No
1	As outlined in the LCD, does the patient have moderate to severe chronic neck or low back pain, predominately axial that causes functional deficit measured on pain scale or disability scale?		
2	Has the pain been present for 3 months with documented failure to respond to noninvasive conservative management (as tolerated)?		
3	Is there an absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by facet joint synovial cyst?		
4	Is there a non-facet pathology per clinical assessment or radiology studies that could explain the source of the patient's pain, including but not limited to: fractures, tumors, infection, or significant deformity? **Note–answering "yes" to this question may receive a non-affirmed decision.**		

Second Diagnostic Injection Coverage Criteria (MBB #2)			
#	Statement–Must Meet All Listed	Yes	No
1	Does the patient meet all of the criteria listed under First Diagnostic Injection Criteria?		
2	To measure the 80% or greater effectiveness of the first MBB, was the same pain scale used before and after the procedure and documented in the medical record?		

Facet Joint Intraarticular (IA) MBB Procedures Coverage Criteria			
#	Statement–Must Meet All Listed	Yes	No
1	Is there clear documentation explaining why the patient is not a candidate for MBB and/or radiofrequency ablation (for example: spinal deformity, spinal pseudarthrosis, implanted electrical device, or a medical condition that would inhibit performing an MBB/RFA)?		
2	Has the patient had 2 medically reasonable and necessary diagnostic facet joint procedures with each providing a consistent minimum of 80% relief of primary index pain with the duration of relief being consistent with the agent used? Was the same pain scale used before and after?		
3	Using the same pain measurement scale and compared to baseline, did the subsequent therapeutic facet joint procedures at the same anatomic site result in at least 50% consistent pain relief for at least 3 months from the prior therapeutic procedure or at least 50% consistent improvement in ADLs?		

Currently, there are only 3 types of facet joint intervention procedures that require prior authorization: intraarticular (IA) facet joint injections, medial branch block (MBB), and radiofrequency ablations (RFA). Each procedure must meet the criteria listed for first diagnostic, second diagnostic, or therapeutic (IA) interventions criteria. Diagnostic procedures should be performed, if successful, RFA would be considered the primary treatment goal. There are a limited number of procedures/sessions allowed in a 12 rolling month period.

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Facet Joint Intervention Procedures				
#	Statement	N/A	Yes	No
1	Can a **medial branch block (MBB)** be safely performed and the patient meets all criteria listed for the first diagnostic or second diagnostic procedure? **Note–if the answer is "no," skip to question #7 in this section on intervention procedures. If request is for RFA skip to question 3.**			
2	Has it been 2 weeks since the last MBB was performed and you are requesting a 2nd MBB? **Note–if the answer is "no," the prior authorization request may receive a non-affirmed decision. If "yes" skip to question 10.**			
3	For initial treatment with **radiofrequency ablation (RFA)**, has the patient received at least 2 diagnostic MBBs with each one providing consistent 80% relief as demonstrated by the use of the same pain scale before and after? **Note–if the answer is "no," the prior authorization request may receive a non-affirmed decision.**			
4	**For a repeat of facet joint RFA** at the same anatomic site: Using the same pain measurement scale compared to baseline, has the patient had a minimum of consistent 50% improvement in pain for at least 6 months or at least 50% consistent improvement in the ability to perform their ADLs? **Note–if the answer is "no," the prior authorization request may receive a non-affirmed decision. Subsequent office visit notes which indicate moderate to severe pain in the area of the previous RFA may result in a non-affirmed decision.**			
5	Has the patient received 2 **RFA** procedures within the past 12 rolling months? **Note–if answer is "yes," the prior authorization request may receive a non-affirmed decision. A session can be unilateral or bilateral.**			
6	Has it been 2 years or more since the patient last received an **RFA** treatment or is there a question about the source of the pain? **Note–if the answer is "yes," diagnostic procedures need to be repeated. The prior authorization request may receive a non-affirmed decision.**			
7	If this is for a **third MBB or intraarticular (IA) procedure**, is there documentation to explain why a third MBB or IA? **Note–if there is no specific documentation explaining a third MBB or an IA procedure, the request may receive a non-affirmed decision.**			
8	Can an **intraarticular (IA) joint** procedure be safely performed and the patient meets all the criteria listed for the first diagnostic, second diagnostic, or therapeutic facet joint (IA) procedures?			
9	Has it been at least 2 weeks since the last IA procedure was performed? **Note–if the answer is "no," the prior authorization request may receive a non-affirmed decision.**			
10	Has the patient received **4 MBB facet joint sessions** within the past 12 rolling months? **Note–If the answer is "yes," the prior authorization request may receive a non-affirmed decision.**			

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#	Statement	N/A	Yes	No
11	Does the procedure involve 1-2 levels only?			
12	Does the procedure involve 3 or more levels? **Note–procedures involving 3 or more levels may receive a partial affirmation decision if all criteria is met for the first two levels.**			
13	Is the patient expected to receive multiple blocks on the same day the facet joint intervention procedure is to be performed? **Note–if the answer is "yes," the prior authorization request may receive a non-affirmed decision.**			
14	Does the patient have an implanted electrical device? **Note–if the answer is "yes," providers need to follow manufacturer instructions and do extra planning to ensure the patient's safety.**			

The following types of procedures are considered unreasonable and not medically necessary for prior authorization and claim reviews:

- Intraarticular and extraarticular facet joint prolotherapy
- Non-thermal modalities for facet joint denervation including chemical, low-grade thermal energy < 80 degrees Celsius, laser neurolysis, and cryoablation
- Intra-facet implants
- Facet joint procedure performed after anterior interbody fusion or ALIF
- Definitive clinical and/or image findings pointing to another diagnosis other than facet joint syndrome
- Diagnostic injections or MBB at the same level as the previously successful RFA procedure

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Medical documentation for facet joint interventions needs to support reasonable and medically necessary criteria as outlined in the local coverage determination (LCD) L38773 Facet Joint Interventions for Pain Management and local coverage article (LCA) A58364 Billing and Coding: Facet Joint Interventions for Pain Management.

General Medical Documentation				
#	Requirements	N/A	Yes	No
1	The **same pain scale** will be or has been used to measure baseline and following each procedure or between office visits related to RFA procedures.			
2	The H&P, office visit note, or physician's progress note contains information on patient signs and symptoms and complaints.			
3	For subsequent RFA requests, documentation shows a good documented history of the previous RFA, the results and how long the patient received relief.			
4	If applicable, there is specific documentation explaining why an MBB cannot be performed. **Be sure to review LCD limitations.**			
5	If applicable, there is specific documentation explaining why an RFA cannot be performed. **Be sure to review LCD limitations.**			
6	Documentation on previous conservative treatments tried and the patient's responses.			
7	Documentation on relevant operative reports—signed and dated office visit record/ operative report. **Note–all services ordered or rendered to Medicare beneficiaries must be signed.**			
8	Documentation of the agent or medication being used.			
9	Results of pertinent tests, radiological studies, or procedures.			
10	Documentation indicating the region of the back to receive the intervention. **Note–if the documentation is for a different region of the spine or area of the body than what is being requested, the request may receive a non-affirmed decision.**			

All relevant medical documentation needs to be submitted with the prior authorization request. Any medical documentation that may be missing to support reasonable and medically necessary requirements may receive a non-affirmed decision. Providers will then need to resubmit their request again with all of the documentation including anything that was missing or newly acquired.

Created April 25, 2024

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The Facet joint Intervention prior authorization request form needs to be completed in its entirety and legible. Incomplete forms or missing information on the form may result in a rejection or non-affirmed decision.

Completing the Prior Authorization Request Form			
#	Requirements	Yes	No
1	A primary HCPC code (64490, 64493, 64633, or 64635) has been selected from the Requested HCPC drop down field. **Note–there can only be one code selected in this field.**		
2	If applicable, related codes (64491, 64494, 64634, and 64636) have been selected with the appropriate primary code for the region of the back.		
3	If applicable, related codes (64492 and 64495) have been selected with the appropriate related code and primary code for the region of the back.		
4	For expedited request, is there documentation demonstrating that any delays can jeopardize the life and overall well being of the patient? **Note–if there is no supporting documentation for expedited, the request will be reviewed in 10 business days instead of 2.**		
5	An anticipated date has been provided in the *Date of Service* field. **Note–please allow enough time for the request to be reviewed in the allowed 10 business days. Requests submitted the day of or the day before a procedure there is no guarantee the request will be reviewed in time.**		
6	For resubmission requests, has the latest non-affirmed UTN been applied to the UTN field on the form?		
7	Appropriate covered diagnosis code written/typed in the *Primary Diagnosis* field.		
8	Correct hospital outpatient department information complete and accurate with correct PTAN (6 digit number), fax number, NPI, etc. in the facility information fields.		
9	Correct beneficiary information with a correct MBI number. **Note–please do not provide the beneficiary's HICN number.**		
10	Correct attending physician information is complete and accurate with their NPI number and a valid fax number.		
11	Requestor information is complete and accurate with an appropriate email and contact phone number.		

The following are some reasons a prior authorization request may receive a non-affirmed decision or rejection:

- Incomplete/wrong information on the request form
- Duplicate request
- The request form does not include a primary HCPC code
- Medical documentation is not current and up-to-date
- Medical documentation does not support subsequent interventions or the patient does not meet all the criteria listed for diagnostic or therapeutic interventions
- The documentation does not include reasons why the MBB cannot be performed
- The documentation does not support a covered diagnosis
- HCPC codes involving 3 or more levels will receive a non-affirmed decision or denial; with appropriate medical documentation, these may be considered under unique circumstances on appeal

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