CareSource

# REIMBURSEMENT POLICY STATEMENT
# GEORGIA MEDICAID

| Policy Name | | Policy Number | Effective Date |
|---|---|---|---|
| Facet Joint Interventions | | PY-1162 | 09/01/2020 |
| **Policy Type** | | | |
| Medical | Administrative | Pharmacy | **REIMBURSEMENT** |

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

## Table of Contents

## A. Subject

**Facet Joint Interventions**

## B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Interventional procedures for management of acute and chronic pain are part of a comprehensive pain management care plan that incorporates conservative treatment in a multimodality approach. Multidisciplinary treatments include promoting patient self-management and aim to reduce the impact of pain on a patient's daily life, even if the pain cannot be relieved completely. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by physicians qualified to deliver these health services.

## C. Definitions

- **Zygapophyseal (aka facet) Joint "Level"** refers to the zygapophyseal joint or the two medial branch (MB) nerves that innervate that zygapophyseal joint.
- **Diagnostic Medial Branch Nerve Block Injection** refers to the diagnosis of facet-mediated pain requiring the establishment of pain relief following medial branch blocks (MBB) or intra-articular injections (IA). Neither physical exam nor imaging has adequate diagnostic power to confidently distinguish the facet joint as the pain source.
- **Radiofrequency Facet Ablation (RFA)** is performed using percutaneous introduction of an electrode under fluoroscopic guidance to thermocoagulate medial branches of the dorsal spinal nerves.

## D. Policy

I. Facet Joint Interventions
   A. A prior authorization (PA) is required for each facet joint intervention for pain management..

II. Diagnostic Medial Branch Nerve Block Injections
   A. An initial medial branch nerve block injection in the lumbar and cervical/thoracic region is required for diagnosis. Diagnostic injections are necessary due to the high false positive rates of single injections.

1. The member must meet the medically necessary criteria in the corresponding Facet Joint Interventions medical policy, MM-0967, before a diagnostic injection is performed.

III. Medial Branch Nerve Block Injections
   A. Once a positive diagnostic medial branch nerve block injection has been established, a maximum of six (6) injections may be performed in the cervical/thoracic spine and six (6) in the lumbar spine per rolling twelve (12) month period.
   B. Per CPT guidelines, imaging guidance and any injection of contrast are inclusive components of all facet medial branch nerve blocks and are not reimbursed separately.

IV. Radiofrequency Facet Ablation
   A. Radiofrequency Facet Ablations are considered medically necessary when the member meets ALL of the medically necessary criteria in the corresponding Facet Joint Interventions medical policy, MM-0967.
   B. A maximum of two (2) radiofrequency facet ablations per rolling 12 months for each spinal region (cervical/thoracic or lumbar) involving no more than four (4) joints per session (e.g., two (2) bilateral levels or four (4) unilateral levels).
      1. Repeat Radiofrequency Facet Ablation in the same spinal region and vertebral location is considered medically necessary when ALL of the criteria in the corresponding Facet Joint Interventions medical policy, MM-0967 has been met.

V. Sedation
   A. Neither conscious sedation nor Monitored Anesthesia Care (MAC) is routinely necessary for intra-articular facet joint injections or medial branch blocks and are not routinely reimbursable.
      1. Individual consideration may be given for payment in rare unique circumstances if the medical necessity of sedation is unequivocal and clearly documented.

## E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

## F. Related Policies/Rules

Facet Joint Interventions MM-0974

## G. Review/Revision History

| | DATE | ACTION |
|---|---|---|
| **Date Issued** | 05/13/2020 | This policy replaces the Facet Medial Branch Nerve Block MM-1061 and Radiofrequency Facet Ablation MM-1082 policies. |
| **Date Revised** | | |
| **Date Effective** | 09/01/2020 | |
| **Date Archived** | | |

## H. References

1. Georgia Department of Community Health Fee Schedules. Retrieved on April 15, 2020 from www.mmis.georgia.gov

**The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.**

GA-MED-P-131362 Date Issued 05/13/2020 DCH Approved 06/09/2020