REIMBURSEMENT POLICY STATEMENT
GEORGIA MEDICAID

Policy Name		Policy Number	Effective Date
Facet Joint Interventions		PY-1162	12/01/2020-05/31/2022
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CareSource and its affiliates 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.

CareSource 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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. Documentation, including dates of service, for conservative therapies are not required for PA, but must be available upon request.

II. Medial Branch Nerve Block Injections
   A. Up to two medial branch nerve block injections in the cervical/thoracic or lumbar regions are considered medically necessary.
      1. Only three (3) spinal levels (unilateral or bilateral) may be treated at the same time (maximum amount of six injections per rolling 12 months);
      2. A response of at least 50% pain relief must be achieved before the second injection is performed; and
      3. Injections should be at least two (2) weeks apart.
      4. Maximum number of benefit limits in this policy are based on medial necessity.
      5. The member must meet the medically necessary criteria in the corresponding Facet Joint Interventions medical policy, before a diagnostic injection is performed.

III. 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.
   B. A maximum of four (4) radiofrequency facet ablations per rolling twelve (12) months (two left and two right per spinal region: cervical, thoracic or lumbar).
   C. Repeat Radiofrequency Facet Ablation in the same spinal region and side is considered medically necessary when ALL of the criteria in the corresponding Facet Joint Interventions medical policy 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.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.**

F. Related Policies/Rules

Facet Joint Interventions Medical Policy

G. Review/Revision History

	DATE	ACTION
Date Issued	05/13/2020	This policy replaces the Facet Medial Branch Nerve Block and Radiofrequency Facet Ablation policies.
Date Revised	07/22/2020 11/11/2020	Revisions: Medial Branch Nerve Block injection clinical criteria; requirement of one "successful" RFA session. Revision: RFA language revised around benefit limit for clarity. (This revision does not require a network notification or a change of the Effective Date).
Date Effective	12/01/2020	
Date Archived	05/31/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

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

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