Facet Joint Denervation Will Require Prior Review
Effective April 1, 2012

Key Messages

- Effective April 1, 2012, facet joint denervation will require prior review/certification by BCBSNC. An updated medical policy is available at bcbsnc.com.

- Effective January 1, 2012, the new CPT codes are:
  - 64633 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); cervical or thoracic, single facet joint
  - 64634 – Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); cervical or thoracic, each additional facet joint (list separately in addition to code for primary procedure)
  - 64635 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); lumbar or sacral, single facet joint
  - 64636 - Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); lumbar or sacral, each additional facet joint (list separately in addition to code for primary procedure)

- CPT codes 64622, 64623, 64626, and 64627 were deleted as of December 31, 2011.

FAQs

1. What is facet joint denervation?
Facet joint denervation is a form of treatment for chronic neck or back pain that involves the destruction of the small nerves (near the facet joints) of the spine that transmit pain sensation from those joints to the brain. When the nerves are interrupted or destroyed, pain sensations from those joints are usually decreased.

2. Why is BCBSNC requiring prior review/certification for facet joint denervation?
The prior review process will allow the member and provider to know when this service is covered and when it is not covered.

3. When is facet joint denervation covered by BCBSNC?
Coverage is only provided for radiofrequency facet joint denervation of the cervical and lumbar spine when the criteria and guidelines are met.
4. When is facet joint denervation not covered by BCBSNC?
It is not covered for other methods of denervation, including: pulsed radiofrequency, laser, cryodenervation and chemical (e.g., phenol) denervation. Only the radiofrequency method is covered (when criteria of the policy are met). Also, facet joint denervation is not covered for the treatment of nerves in the thoracic spine, sacral spine, or sacroiliac joints. It is only covered for cervical (below C2 level) and lumbar nerves.

5. Are there any other treatments that could be used in place of facet joint denervation?
Radiofrequency facet joint denervation may be medically necessary when all criteria and guidelines are met. Shared decision-making is recommended for consideration of alternative treatments such that the patient and his or her physician discuss the risks and benefits of any treatment option. We would expect the physician to consider the best medical evidence and individual patient preferences in determining, along with the patient, what treatment approach would be preferred in any given case.

6. What criteria must be met in order for facet joint denervation to be approved for coverage?
Updated criteria for coverage are outlined in the medical policy for facet joint denervation, available online for providers January 1, 2012. This revised policy will be effective April 1, 2012. Among the criteria are the following:
- History, physical and imaging must support the diagnosis of pain that originates from the facet joints.
- The pain must have failed to respond to three months of other conservative therapy.
- A diagnostic trial of two successful medial branch nerve blocks under fluoroscopic guidance must have been completed.
- If there was a prior successful treatment, then at least six months must have elapsed prior to subsequent treatment at same levels and same side of spine.

7. Which BCBSNC members are affected by this new prior review/certification requirement?
This new prior review/certification requirement applies to all members in our commercial lines of business (group underwritten, group ASO, and individual), as well as State Health Plan members.

8. Which lines of business are not affected by this new prior review/certification requirement?
The new prior review requirement does not apply to the Federal Employee Program or our Medicare programs. These programs may have their own prior review/certification requirements. Please check with these programs to see if there are any additional requirements.

9. How will a provider initiate the prior review/certification process?
Providers should contact 1-800-672-7897 for prior review/certification, or consult the Provider Blue Book for further instructions regarding the prior review/certification process.
10. **What documentation does the member’s doctor need to provide to BCBSNC?**
The provider should submit the member’s complete history, the physical examination, and radiographic or imaging evaluations. The records must also address the medical necessity criteria as outlined in the medical policy. Refer to the [medical policy](#) for specific coverage criteria.

11. **What if the member has previously received this service and needs a repeat treatment?**
Repeat treatments also require prior review/certification. Repeat treatments may be authorized if all of the following apply:
   - The criteria and guidelines of the medical policy were previously met
   - Six months has elapsed since the previous treatment
   - Trial blocks with documented improvement were administered prior to the previous treatment
   - The denervation is planned for the same level(s) and side of the spine