Priority Health	BILLING POLICY No. 142
FACET JOINT INTERVENTIONS FOR PAIN MANAGEMENT	
Date of origin: Sept 2025	**Review dates: August 2026**

POLICY OVERVIEW

This policy provides guidelines for billing, coding, and documentation, ensuring claims are processed according to contractual agreements and industry standards.
Facet joint interventions are minimally invasive; image-guided procedures used to diagnose and treat chronic neck or low back pain arising from the facet joints. These procedures, which include medial branch blocks, intra-articular facet injections, radiofrequency ablation (RFA), and facet cyst aspiration/rupture, help identify the source of pain and provide targeted pain relief. They are typically considered after conservative treatments such as medications, physical therapy, and activity modification have failed and are often incorporated into a comprehensive pain management plan to improve function and quality of life.

DEFINITIONS

A facet joint injection—also known as a *facet block*—is a therapeutic procedure used to treat acute spinal pain, defined as pain lasting up to 4 weeks from onset. The injection involves placing a local anesthetic and sometimes a corticosteroid either:

- Directly into the facet joint capsule (*intraarticular injection*), or
- Along the medial branch nerves that supply the facet joints.

Purpose:
To reduce inflammation and interrupt pain signals originating from the facet joints.

MEDICAL POLICY

Moderate Sedation for Interventional Pain Management #91632

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Billing details

Each spinal level contains two facet joints—one on the right side and one on the left—referred to as bilateral facet joints. During a facet joint procedure, treatment may target one side (unilateral) or both sides (bilateral) at a given spinal level. These procedures may include:

- A diagnostic nerve block
- A therapeutic intraarticular facet joint injection
- A medial branch block injection
- Or medial branch radiofrequency ablation (neurotomy)

All of these can be performed within a single session. Importantly, even if both sides are treated, bilateral intervention is still classified as a single-level procedure.

64491 or 64494 describes a second level which should be reported in addition to the primary procedure.

64492 or 64495 describes a third and additional level and should be listed in addition to the code for the primary and second level procedure. This cannot be reported more than once per day. 64492 should be reported in conjunction with 64490/64491, and 64495 should be reported in conjunction with 64493/64494. Per CMS guidelines, codes 64492 and 64495 will only be covered upon appeal if sufficient documentation of medical necessity is present.

CPT codes 64633, 64634, 64635, and 64636 should be billed per facet joint, not per individual nerve. While each facet joint receives input from two nerves, only one unit of the appropriate code may be reported for each joint that is denervated, regardless of how many nerves are treated during the procedure.

Imaging guidance is included in codes 64633-64636 – do not report imaging separately.

For services performed in the ASC, physicians must continue to use modifier 50. Only the ASC facility itself must report the applicable procedure code on 2 separate lines, with 1 unit each, and append the RT and LT modifiers to each line.

Coding specifics

CPT	DESCRIPTION
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure
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, single facet joint

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information

11 – office
22 – outpatient hospital
24 – ambulatory surgical center

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

• 50: bilateral procedure: unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50
• KX: requirements specified in the medical policy have been met
• LT: left side (used to identify procedures performed on the left side of the body)
• RT: right side (used to identify procedures performed on the right side of the body)
59 (XU, XE, XS) - distinctly separate service

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.
• The medical record must accurately describe the services rendered and support the CPT/HCPCS code reported on the claim.
• The medical record procedural detail should clearly detail indications for performing the service, describe medical necessity for the services, detail the anatomical site or location including laterality when applicable, and any pre and/or post services associated with the procedure
• The medical record should detail the name and units of any drug or medication supplied or injected. The associated NDC should also be detailed.
• At a minimum, the medical record should include the following:
    o Assessment as it related to the chief complaint or conditions reported by the member
    o Appropriate or relevant medical history
    o Any pertinent tests and/or procedural details
    o Post procedural plan should be outlined
    o Signature and date that meet valid signature requirements.

Reimbursement specifics

Per the American Society of Anesthesiologists, use of Moderate or Deep Sedation, General Anesthesia, and Monitored Anesthesia Care (MAC) is not considered medically reasonable and necessary during facet injections See Moderate Sedation for Interventional Pain Management #91632

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

LCD L38841 Facet Joint Interventions for Pain Management

Billing and Coding: Facet Joint Interventions for Pain Management

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
8/17/2026	Policy overview has been added. Also, removed language under the reimbursement section as well as medical necessity information under billing details and put CPT codes in table format. Also, denial language has been removed.