If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. “Plan documents” include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Illinois may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Paravertebral Facet Injection Procedure Billing & Coding Policy

Policy Number: CPCP036

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: Nov. 14, 2025

Plan Effective Date: Nov. 21, 2025

Description

Facet joint block procedures may be used for pain management for chronic cervical (neck), thoracic (mid-back) and lumbar/sacral (lower-back) pain stemming from the paravertebral facet joints. For purposes of this policy, a facet joint (also called zygapophysial or "Z" joints) joint level refers to the facet joint or the two medial branch (MB) nerves that innervate that facet joint. Imaging guidance is used to assure accurate placement of the needle for the injection.

Reimbursement Information

The Plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

Providers may refer to the Plan's Medical Policy site located on the ***Provider*** tab of the Plan's website to review relevant medical policies about facet joint injection(s) performed under fluoroscopic or computerized tomography (CT).

Documentation Requirements

Documentation must include, but is not limited to:

- Substantiation of the diagnosis
- Care that was rendered on the day of service
- The member's relevant medical history, e.g., prior tried and failed interventions
- Physical examination
- Results of the diagnostic tests and/or procedures.

Billing and Coding

Facet joint interventions (diagnostic and/or therapeutic) must be performed under fluoroscopic or CT guidance.

Image guidance and any injection of contrast are inclusive components of CPT codes 64490-64495. Therefore, providers should not report guidance codes, such as 77001-77003 and 77012, for services in which fluoroscopic or CT guidance is included in the descriptor.

CPT codes 64490-64495 should only be reported once per level, per side, regardless of the number of needle placements that are required.

Examples:

- When an injection is performed on one side of one vertebral level (unilaterally), providers should report the primary injection code (64490 or 64493) with the appropriate modifier RT/LT. If a second level is injected unilaterally, providers should report the add-on code (64491 or 64494), also with the appropriate modifier RT/LT.

- When an injection is performed on both sides of one vertebral level, providers should report the primary injection code (64490 or 64493) with modifier -50. If a second level is injected bilaterally, providers should report the add-on code (64491 or 64494), also with modifier -50.

Bilateral procedures billed with CPT codes 64491, 64492, 64494 or 64495 should only be billed with modifier -50, with the number of services reported as one (1). Appending modifiers RT, LT and -59 to these codes is not appropriate billing and claims will be denied.

The following list may not be all inclusive. Inclusion of a code below does not guarantee reimbursement, nor does it imply that a code is a covered or non-covered service.

CPT Code	Description	Appropriate Usage
64490	INJ PARAVERT F JNT C/T 1 LEV	This code should not be reported more than once per day (primary code).
+ 64491	INJ PARAVERT F JNT C/T 2 LEV	Use in conjunction with 64490 (+add on code).
+ 64492	INJ PARAVERT F JNT C/T 3 LEV	Use in conjunction with 64490, 64491. This code should not be reported more than once per day (+add on code).
64493	INJ PARAVERT F JNT L/S 1 LEV	This code should not be reported more than once per day (primary code).
+ 64494	INJ PARAVERT F JNT L/S 2 LEV	Use in conjunction with 64493 (+add on code).
+ 64495	INJ PARAVERT F JNT L/S 3 LEV	Use in conjunction with 64493, 64494. This code should not be reported more than once per day (+add on code).

Modifier -50 Appropriate Usage

Modifier	Description	Appropriate Usage
50	Bilateral procedure	• Used to report bilateral procedures that are performed during the same service. • The use of modifier 50 is applicable only to services and/or procedures performed on identical anatomical sites, aspects, or organs. • Should only be reported with one line with one unit of service. • Should only be used when the code descriptor does NOT indicate bilateral.

Category III CPT Codes

The following codes may be eligible for reimbursement. Inclusion of one of the codes below does **NOT** guarantee reimbursement. CPT category III codes 0213T-0218T are performed under ultrasound guidance. Therefore, providers should not report ultrasound guidance codes, such as 76942, for services in which ultrasound guidance is included in the descriptor.

CPT Code	Description
0213T	NJX PARAVERT W/US CER/THOR
+ 0214T	NJX PARAVERT W/US CER/THOR
+ 0215T	NJX PARAVERT W/US CER/THOR
0216T	NJX PARAVERT W/US LUMB/SAC
+ 0217T	NJX PARAVERT W/US LUMB/SAC
+ 0218T	NJX PARAVERT W/US LUMB/SAC

Additional Resources

Clinical Payment and Coding Policy
CPCP023 Modifier Reference Policy
CPCP029 Medical Record Documentation

Medical Policy
SUR702.015 Facet Joint Injections

References

Centers for Medicare & Medicaid Services, Local Coverage Determination (LCD): Facet Joint Interventions for Pain Management (L38773). Definitions. Accessed 08/13/2025.

Centers for Medicare & Medicaid Services, Local Coverage Determination (LCD) Article. Billing and Coding: Facet Joint Interventions for Pain Management (A58364). Accessed 08/13/2025.

[1]Carelon, Musculoskeletal Program

[1]*Carelon Medical Benefits Management is an independent company that has contracted with BCBSIL to provide utilization management services for members with coverage through BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors*.

Policy Update History

Approval Date	Description
10/14/2021	New policy
11/2/2021	Revisions to verbiage of new policy
12/22/2022	Annual Review
10/30/2023	Annual Review
11/06/2024	Annual Review
11/14/2025	Annual Review; Grammatical and formatting updates; Language removed in the Description section and above the CPT code table; Additional Resources updated; References updated.