# Radiofrequency Neurotomy

| LOB(s): | State(s): |
|---|---|
| ☒ *Commercial*<br>☒ *Medicare* | ☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:* |
| ☒ *Medicaid* | ☒ *Oregon* ☐ *Washington* |

## Enterprise Policy

*PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.*

*Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.*

## Background

Radiofrequency neurotomy (RFN) is an outpatient procedure used to help relieve chronic lumbar, thoracic, or cervical spinal pain by creating a heat lesion on certain nerves to stop the nerve from sending pain signals to the brain. The procedure is also called radiofrequency facet denervation, radiofrequency ablation, or radiofrequency rhizotomy. Radiofrequency neurotomy is not curative and may need to be repeated for symptom relief.

Prior to RFN, diagnostic medial branch block injections (MBB, also called facet joint injections) are done to diagnose the source of pain. Medial branch nerves transmit pain signals from the facet joints to the brain. Medial Branch Block are completed prior to radiofrequency neurotomy to confirm appropriate treatment levels.

## Criteria

### Commercial

**I. Radiofrequency Neurotomy of the Spine**

PacificSource considers radiofrequency neurotomy of the spine medically necessary when **ALL** of the following criteria is met:

**A.** Patient is diagnosed with spondylosis or facet joint syndrome of the lumbar, thoracic, or cervical spine

**B.** Pain duration for at least 6 months with no indication of resolving

**C.** Other causes of generalized back pain have been ruled out

**D.** Documented failure of six consecutive months of physician-directed conservative care, during current episodes of pain, including NSAIDS plus **ONE** of the following:

**1.** Physical therapy

**2.** Chiropractic treatment

**3.** Prescription strength analgesics or steroids injections

**4.** Home exercise program

**OR**

**5.** Documentation of contraindication(s) for conservative care

**E.** **Two** positive temporary medial branch block diagnostic tests are required within 6 months of the requested radiofrequency neurotomy, evidenced by an 80% or greater reduction in pain on **BOTH** initial and secondary diagnostic blocks of the facet nerve.

**1.** If the first diagnostic test is less than 80% a second test is considered not medically necessary

**F.** For each covered spinal region only two radiofrequency neurotomy procedures (or dates of service) will be reimbursed in any rolling 12-month year. Each procedure is limited to four levels total per procedure (i.e., 2 bilateral or 4 unilateral levels or joint spaces per procedure).

**Example:** Right L1-L2 = 1 level (joint space)

Bilateral L1-L2 = 2 levels (joint space)

Bilateral L1-L2, L3-L4 = 4 levels (joint spaces)

## II. Repeat Radiofrequency Neurotomy Procedures

PacificSource considers repeat radiofrequency neurotomy procedures medically necessary when **ALL** of the following criteria is met:

**A.** At least 6 months since the previous RFA treatment at the same level

**B.** Repeat radiofrequency neurotomy is at the same spinal level(s) at previous procedure

**C.** Prior successful neurotomy (50% or more reduction in pain for a minimum of 3 months post procedure)

## III. Radiofrequency Neurotomy of Ilioinguinal Nerve

PacificSource considers radiofrequency neurotomy therapy of the ilioinguinal nerve medically necessary when the **ALL** of following criteria is met:

**A.** Member has moderate to severe pain following an inguinal hernia repair

**B.** Member has documentation of pain duration for at least 6 months with no indication of resolving

**C.** Other causes of pain have been ruled out via imaging studies. (CT and MRI are used primarily to exclude non-neuropathic hernia-related pathologies or other non-hernia-related disease in the differential diagnosis)

**D.** Reduction of pain after local anesthetic block

**E.** Documented failure of 6 consecutive months of physician-directed conservative care, during current episodes of pain, including **ONE** of the following:

**1.** Physical therapy

**2.** Chiropractic treatment

**3.** Home exercise program

**OR**

**4.** Documentation of contraindication(s) for conservative care

**F.** Documented failure of six consecutive months of physician-directed pharmaceutical management, during current episodes of pain, including NSAIDS plus **TWO** of the following:

**1.** Topical treatments (e.g., capsaicin, lidocaine)

**2.** Opioids

**3.** Steroids injections

**4.** Antidepressants

**5.** Anti-epileptic

**OR**

**6.** Documentation of contraindication(s) for conservative care

## IV. Intra-Osseous Basivertebral Nerve Ablation

**Prior Authorization is required**

PacificSource considers Intra-Osseous Basivertebral Nerve Ablation (e.g., INTRACEPT® Intraosseous Nerve Ablation System) medically necessary when the **ALL** of following criteria is met:

**A.** Requested procedure is between L3-S1

**B.** Pain duration for at least 6 months with no indication of resolving

**C.** Other causes of generalized back pain have been ruled out

**D.** Documented failure of six consecutive months of physician-directed conservative care, during current episodes of pain, including **ALL** of the following:

a. NSAIDS and or steroid injections

b. Physical therapy / Chiropractic treatment

c. Prescription strength analgesics

d. Home exercise program

**OR**

e. Documentation of contraindication(s) for conservative care

**E.** MRI demonstrated Modic type 1 (MC1) or Modic type 2 (MC2) changes in at least one vertebral endplate, at 1 or more levels from L3 to S1 (e.g., endplate changes, inflammation, edema, disruption, and/or fissuring)

**F.** Statement from a primary care physician, neurologist, physiatrist, psychiatrist, psychologist, or other licensed behavioral and/or medical health care provider attesting to the absence of untreated, underlying mental health conditions/issues (e.g., depression, drug, alcohol abuse) as a major contributor to chronic back pain

**V. Trigeminal Neuralgia:**

PacificSource considers radiofrequency neurotomy for the treatment of trigeminal neuralgia medically necessary when **ALL** of the following indications is met:

**A.** Secondary causes of Trigeminal Neuralgia have been ruled out (e.g., multiple sclerosis, tumor)

**B.** Member has failed conservative measures over 3-6 months (e.g., pharmaceutical trial, physical therapy, chiropractic therapy)

### Medicaid

PacificSource Community Solutions follows Guideline Note 173 of the Health Evidence Review Commission (HERC) Prioritized List of Health Services for coverage of Radiofrequency Neurotomy and considers there to be insufficient evidence of the benefit of the treatment.

PacificSource Community Solutions (PCS) follows the general coverage requirements, limitations, and exclusions outlined in OARs 410-141-3820 and 410-141-3825 for adult members 21 years and older.

PacificSource Community Solutions (PCS) follows EPSDT coverage requirements in OAR 410-151-0002 for members under the age of 21. Coverage of radiofrequency neurotomy treatment is determined through case-by-case reviews for EPSDT Medical Necessity and EPSDT Medical Appropriateness defined in OAR 410-151-0001. The coverage guidance for radiofrequency neurotomy in Guideline Note 173 of the Prioritized List may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review.

### Medicare

PacificSource Medicare follows Local Coverage Determination (LCD) L39644 for Intraosseous Basivertebral Nerve Ablation (Intracept procedure)

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow internal policy for determination of coverage and medical necessity.

## Experimental/Investigational/Unproven

PacificSource considers Radiofrequency Neurotomy to be experimental, investigational, or unproven for the following conditions:

- Cervicogenic Headache
- Cluneal nerve pain
- Genicular nerve pain

- Peripheral nerve pain innervating hip (Femoral and Obturator nerves)
- Plantar nerve pain (Mortons neuroma)
- Pudendal nerve destruction
- Pulsed Radiofrequency (PRF) Neurotomy
- Sacroiliac (SI) joint pain

PacificSource considers Intraosseous Radiofrequency Nerve Ablation System (Intracept Procedure (Intra-Osseous Basivertebral Nerve Ablation (BNA)) ablation to be experimental, investigational, or unproven for all *other* indications.

PacificSource considers Radiofrequency Ablation "Coolief" Cooled RF (Cooled radiofrequency denervation) to be experimental, investigational, or unproven.

## Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

64600 Destruction, Neurolytic, Trigeminal Nerve; Supraorbital/Infraorbital/Mental/Inferior Alveolar-

64605 Destruction, Neurolytic, Trigeminal Nerve; 2nd & 3rd Division

64610 Destruction, Neurolytic, Trigeminal Nerve; 2nd & 3rd Division W/Radiologic Monitoring

64624 Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed-

64625 Destruction by neurolytic agent, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography) nerves

64628 Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral

64629 Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral

64630 Destruction, Neurolytic; Pudendal Nerve

64632 Destruction by Neurolytic Agent; Plantar Common Digital Nerve (Morton's neuroma)

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)

64640 Destruction by neurolytic agent; other peripheral nerves

64999 Unlisted Proc, Nervous System



## Related Policies

New and Emerging Technology - Coverage Status

## References

American Society of Anesthesiologists Task Force on Chronic Pain Management, & American Society of Regional Anesthesia and Pain Medicine (2010). Practice guidelines for chronic pain management: an updated report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine. Anesthesiology, 112(4), 810–833. http://anesthesiology.pubs.asahq.org/article.aspx?articleid=1932775#67949989

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Hayes Knowledge Center. (December 2, 2021). Health Technology Assessment: Percutaneous Radiofrequency Ablation for Cervical and Thoracic Spinal Indications.

Kennedy, D. (April 23, 2019). Radiofrequency Ablation (RFA) for Facet and Sacroiliac Joint Pain. https://www.spine-health.com/treatment/injections/radiofrequency-ablation-rfa-facet-and-sacroiliac-joint-pain

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The Health Evidence Review Commission (HERC) Prioritized List of Health Services https://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx

## Appendix

**Policy Number:**

**Effective:** 1/1/2021 **Next review:** 9/1/2025

**Policy type:** Enterprise

**Author(s):**

**Depts:** Health Services

**Applicable regulation(s):** OARs 410-141-3820, 410-141-3825, 410-151-0001, 410-151-0002

**Commercial OPs:** 10/2024

**Government OPs:** 10/2024