



Radiofrequency Neurotomy

LOB(s): <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> Medicaid	State(s): <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other: <input checked="" type="checkbox"/> Oregon <input type="checkbox"/> Washington
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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 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. 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)
- C. Reduction of pain after local anesthetic block
- D. Member has documentation of pain duration for at least 6 months with no indication of resolving
- 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:

1. NSAIDS and or steroid injections
2. Physical therapy / Chiropractic treatment
3. Prescription strength analgesics
4. Home exercise program

OR

5. Documentation of contraindication(s) for conservative care

- E.** MRI demonstrated Modic type 1 (MC1) or Modic type 2 (MC2) 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 Oregon Health Plan (OHP) Prioritized List of Health Services.

Medicare

PacificSource Medicare follows Local Coverage Determination (LCD) L39644 for Intraosseous Basivertebral Nerve Ablation (Intrasept 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 block/injection
 - **Note:** pudendal nerve blocks for obstetrics and other operative procedures are not considered to be experimental, investigational, or unproven.
- Pulsed Radiofrequency (PRF) Neurotomy
- Sacroiliac (SI) joint pain

PacificSource considers Intraosseous Radiofrequency Nerve Ablation System (Intracapt 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.

- 64430 Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve
- 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

CPT® codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

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>

Bonwich, J. B. (March 29, 2022). Persistent groin pain following hernia repair and post-herniorrhaphy neuralgia. UpToDate. http://www.uptodate.com/contents/persistent-groin-pain-following-hernia-repair-and-post-herniorrhaphy-neuralgia?source=search_result&search=Persistent+groin+pain&selectedTitle=1%7E150

Comin, J., Obaid, H., Lammers, G., Moore, J., Wotherspoon, M., & Connell, D. (2013). Radiofrequency denervation of the inguinal ligament for the treatment of 'Sportsman's Hernia': a pilot study. *British journal of sports medicine*, 47(6), 380–386. <http://www.ncbi.nlm.nih.gov/pubmed/22952407>

Conger, A., Burnham, T., Clark, T., Teramoto, M., & McCormick, Z. (August 2, 2022). The Effectiveness of Intraosseous Basivertebral Nerve Radiofrequency Ablation for the Treatment of Vertebrogenic Low Back Pain: An Updated Systematic Review with Single-Arm Meta-analysis. *Academic.oup.com*. https://academic.oup.com/painmedicine/article/23/Supplement_2/S50/6646819#

Datta, S., Lee, M., Falco, F. J., Bryce, D. A., & Hayek, S. M. (2009). Systematic assessment of diagnostic accuracy and therapeutic utility of lumbar facet joint interventions. *Pain physician*, 12(2), 437–460. <http://www.painphysicianjournal.com/current/pdf?article=MTlwMQ%3D%3D&journal=48>

Fischgrund, J. S., Rhyne, A., Franke, J., Sasso, R., Kitchel, S., Bae, H., Yeung, C., Truumees, E., Schaufele, M., Yuan, P., Vajkoczy, P., Depalma, M., Anderson, D. G., Thibodeau, L., & Meyer, B. (2019, April 1). Intraosseous Basivertebral Nerve Ablation for the treatment of chronic low back pain: 2-year results from a prospective randomized double-blind sham-controlled Multicenter Study. *International Journal of Spine Surgery*. <https://www.ijssurgery.com/content/13/2/110>

Hakeem, A., & Shanmugam, V. (2011). Current trends in the diagnosis and management of post-herniorrhaphy chronic groin pain. *World journal of gastrointestinal surgery*, 3(6), 73–81.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3135872/pdf/WJGS-3-73.pdf>

Hayes Knowledge Center. (July 6, 2021). Health Technology Assessment, Annual Review: Pulsed Radiofrequency Application To The Dorsal Root Ganglion for Treatment Of Lumbosacral Radicular Pain.

Hayes Knowledge Center. (February 17, 2023). Medial Branch Nerve Block Injections for The Treatment of Chronic Nonmalignant Spinal Pain of Facet Joint Origin.

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>

Kim, H. S., Wu, P. H., & Jang, I. T. (2020). Lumbar Degenerative Disease Part 1: Anatomy and Pathophysiology of Intervertebral Discogenic Pain and Radiofrequency Ablation of Basivertebral and Sinuvertebral Nerve Treatment for Chronic Discogenic Back Pain: A Prospective Case Series and Review of Literature. *International journal of molecular sciences*, 21(4), 1483.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7073116/>

Mayo Clinic. (January 26, 2022). Patient Care & Health Information: *Trigeminal Neuralgia*.

<https://www.mayoclinic.org/diseases-conditions/trigeminal-neuralgia/symptoms-causes/syc-20353344>

MCG 27th edition. Facet Neurotomy ACG: A-0218 (AC)

NASS. (October 26, 2021). Prospective, randomized, Multicenter Study of intraosseous Basivertebral nerve ablation ... NASS North American Spine Society. [https://www.nassopenaccess.org/article/S2666-5484\(21\)00041-X/fulltext](https://www.nassopenaccess.org/article/S2666-5484(21)00041-X/fulltext)

Obermann M. (2019). Recent advances in understanding/managing trigeminal neuralgia.

F1000Research, 8, F1000 Faculty Rev-505. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6480942/>

Appendix

Policy Number:

Effective: 1/1/2021

Next review: 8/1/2024

Policy type: Enterprise

Author(s):

Depts: Health Services

Applicable regulation(s):

Commercial OPs: 4/2024

Government OPs: 4/2024

