# Radiofrequency Neurotomy

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

## Enterprise Policy

*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 determination 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 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 help diagnose the source of pain. Medial branch nerves transmit pain signals from the facet joints to the brain. One to two MBB injections should be done prior to radiofrequency neurotomy to confirm appropriate treatment levels.

## Criteria

**Prior authorization is required.**

### Commercial

**Radiofrequency Neurotomy of the Spine:**

PacificSource considers radiofrequency neurotomy medically necessary when ALL of the following criteria are met:

- Patient is diagnosed with spondylosis or facet joint syndrome of the cervical or lumbar area
- Other causes of generalized back pain have been ruled out
- Pain duration for at least 6 months with no indication of resolving

- Pain has not responded to conservative measures over 3-6 months (e.g. NSAIDS, manipulation, PT, HEP, and local analgesic/steroid injections)
- Diagnostic, temporary block(s) with local anesthetic of the facet nerve (medial branch block (MBB) done within 6 months of the requested MBB has resulted in 80% or greater reduction in pain or meets the following results:
    - If first MBB results in 80% or greater reduction in pain, a second MBB is not required and clinician may approve request if other criteria met.
    - If first MBB results in 50-79% reduction in pain, a second MBB is required.
    - If second MBB results in 50% or greater reduction in pain, clinician may approve request if other criteria met
    - If second MBB results in less than 50% pain reduction, Medical Director Review is required.
- For each covered spinal region (cervical or lumbar) only 2 radiofrequency neurotomy procedures (or dates of service) will be reimbursed in any rolling 12 month year. Each procedure is limited to 4 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)
- No Contraindications exist such as the following:
    - Patient is unwilling or unable to consent or cooperate
    - Evidence of untreated infection
    - Medically or psychiatrically unstable
    - Indeterminate results of diagnostic nerve block
    - Bleeding diathesis or using anticoagulants that pose bleeding risk
    - Inadequate pain relief or relief lasting less than 6 months from prior RF neurotomy

**Repeat Radiofrequency Neurotomy Procedures:**

Repeat radiofrequency neurotomy procedures are considered medically necessary when ALL of the following criteria are met:

- At least 6 months have elapsed since the previous RFA treatment
- The patient obtained 50% or greater pain relief following the previous treatment.

**Radiofrequency Neurotomy of Ilioinguinal Nerve:**

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

- Member has moderate to severe pain following a hernia repair.

- 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)

- Member has recurrent pain with a positive response to local anesthetic block which is documented

- Member has documentation of pain duration for at least 6 months with no indication of resolving

- Member has failed to respond to 6 months of conservative management (e.g., chiropractic therapy/physical therapy and a home exercise program).

- The member must have failed a pharmaceutical trial of at least 3 from the following categories, unless contraindicated
    - Pharmacotherapy (including topical treatments such as capsaicin and lidocaine, opioids, nonsteroidal anti-inflammatory/opioid medications, antidepressants and anti-epileptic (anticonvulsant) drugs) after a 6 month trial.

**Trigeminal Neuralgia:**

PacificSource considers radiofrequency neurotomy for the treatment of trigeminal neuralgia medically necessary when All of the following indications are met:

- Secondary causes of Trigeminal Neuralgia such as multiple sclerosis or a tumor have been ruled out
- Pain has not responded to conservative measures over 3-6 months (e.g., medications such as anticonvulsants, antispasmodic agents, and NSAIDs, manipulation, PT, HEP and local analgesic/steroid injections.

### Medicaid

Radiofrequency Neurotomy is not a covered benefit per Guideline Notes 37 and 173 of the OHP Prioritized List of Health Services.

### Medicare

PacificSource Medicare follows Local Coverage Determination (LCD) L34993 for Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy.

## Experimental / Investigational / Unproven

Radiofrequency Neurotomy is considered investigational/experimental for the following conditions:

- Cervicogenic Headache
- Genicular nerve ablation
- Pulsed Radiofrequency (PRF) Neurotomy
- SI joint pain
- Thoracic region pain

## Coding Information

61790 Creation, Lesion, Stereotactic, Percutaneous, Neurolytic Agent; Gasserian Ganglion

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.

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 nerve (used for S1, S2, S3 lateral branches during RFA)

64681 Destruction by neurolytic agent, with or without radiographic monitoring: superior hypogastric plexus.

77003 Fluoroscopic guidance for injection.

## Related Policies

New and Emerging Technology_ Coverage Status

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## Appendix

**Policy Number:**

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**Policy type:** Enterprise

**Author(s):**

**Depts:** Health Services

**Applicable regulation(s):** [Applicable Regulation(s)]

**Commercial Ops:** 6/2021

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