1. **Purpose**

   The purpose of this policy is to establish criteria for the medical necessity of radiofrequency joint denervation/ablation procedures (a.k.a. facet neurotomy, facet rhizotomy).

2. **Definitions**

   Radiofrequency joint denervation/ablation (facet neurotomy, facet rhizotomy) refers to the insertion of a radiofrequency probe towards the median branch of the posterior primary rami, which supplies the innervation to the facet joints under fluoroscopic guidance. The radiofrequency electrode is then utilized to create a “continuous” heat lesion by coagulating the nerve supplying the joint with the intention of providing pain relief by denervating the painful facet joint.

3. **Statement of Policy**

   3.1. The determination of medical necessity for the use of radiofrequency joint denervations/ablations (a.k.a. facet neurotomy, facet rhizotomy) is always made on a case-by-case basis.

   3.2. Radiofrequency joint denervations/ablations should be performed using fluoroscopy. Performance of radiofrequency joint denervation/ablations without the use of fluoroscopic guidance is considered not medically necessary.

   3.3. The performance of radiofrequency joint denervations/ablations may be considered medically necessary for a patient who has been diagnosed with facet mediated pain which has been confirmed by provocative testing resulting from disease, injury or surgery who has not responded sufficiently to at least four (4) weeks of conservative therapy (exercise, physical methods including physical therapy, chiropractic care, NSAID's and/or analgesics) and who has undergone a diagnostic medial branch block or facet joint injection which was considered positive. A positive diagnostic response is recorded when greater than 50% pain relief is reported for 80% of the duration of the effect of the local anesthetic used. When intra-articular facet joint injections or medial branch blocks are performed with a local anesthetic and a corticosteroid, a positive response to the procedure is considered when the patient has reported at least a 50% reduction in their pain for at least two (2) weeks. Better treatment outcomes have been reported when 80% pain relief has been reported. When an injection or block is
considered positive, a second (confirmatory) block is not medically necessary to perform a radiofrequency joint denervation/ablation.

3.4. Radiofrequency joint denervations/ablations should only be performed in patients with neck pain or low back pain who do not have a documented and untreated radiculopathy. The performance of radiofrequency joint denervation/ablation in patients who present with documented evidence of radiculopathy that has been untreated may be considered not medically necessary.

3.5. Repeat radiofrequency joint denervation/ablation procedures may be considered medically necessary when there is documented pain relief of at least 50% which has lasted for a minimum of 12 weeks. While repeat radiofrequency joint denervations/ablations may be required, they should not occur at an interval of less than six (6) months from the first procedure. No more than two (2) procedures at the same level(s) should be performed in a 12 month period.

3.6. When performing radiofrequency joint denervations/ablations, no more than three (3) levels should be performed during the same session/procedure. It may be considered medically necessary to perform the procedure at the same level or levels bilaterally during the same session/procedure. The performance of the procedures on more than three (3) levels may be considered not medically necessary.

3.7. Radiofrequency joint denervations/ablation may be considered medically necessary when performed on a patient with previous spinal fusion only when performed at levels above or below the fusion.

3.8. Based on the lack of published, peer-reviewed, scientific literature on the efficacy of “pulsed” radiofrequency ablation for chronic pain syndromes, its use is considered experimental and investigational.

4. References

4.1. Scientific:

The following scientific references were utilized in the formulation of this medical policy. Triad Healthcare, Inc. will continue to review clinical evidence surrounding radiofrequency joint denervations/ablations (a.k.a. facet neurotomy, facet rhizotomy) and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to Triad Healthcare, Inc. so the
information can be reviewed by the Academic Advisory Committee (AAC) and the Medical Quality Improvement Committee (MQIC) to determine if a modification of the policy is in order.


• Nath S, Nath C, Pettersson K. Percutaneous lumbar zygapophysial (Facet) joint neurotomy using radiofrequency current, in the management of chronic low back pain.


4.2. Related Triad Medical Policies:

• TMMP 18 – Medical Necessity
• TMMP 201 – Facet Joint Injections / Medial Branch Blocks

CPT Codes
This policy relates to the use of the following CPT Codes:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description (AMA CPT Guide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>64620</td>
<td>Destruction by neurolytic agent, intercostal nerve</td>
</tr>
<tr>
<td>64633</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT), cervical or thoracic, single facet joint</td>
</tr>
<tr>
<td>64634</td>
<td>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)</td>
</tr>
<tr>
<td>64635</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT), lumbar or sacral, single facet joint</td>
</tr>
<tr>
<td>64636</td>
<td>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)</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes.
Table of Revisions

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/27/2014</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. CPT Codes updated.</td>
</tr>
<tr>
<td>10/11/2013</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. Previous §3.1. reference to Centers for Medicare &amp; Medicaid Services (CMS) removed. §3.3. added “which has been confirmed by provocative testing” resulting from disease…</td>
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<tr>
<td>11/16/2012</td>
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<td>Annual Review. No changes.</td>
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<tr>
<td>07/25/2011</td>
<td>Level 1, 2, 3</td>
<td>§2 added the word continuous into the 2nd sentence. §3 added information for Medicare and Medicaid NCD/LDC. Added §3.7 and 3.8. Added 6 references to the scientific literature section. Added CPT code table.</td>
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<tr>
<td>03/09/2011</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
</tr>
<tr>
<td>03/18/2010</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
</tr>
<tr>
<td>02/18/2009</td>
<td>Level 1, 2, 3</td>
<td>New medical policy.</td>
</tr>
</tbody>
</table>

Triad’s Medical Policies are not recommendations for treatment and providers are expected to exercise their clinical judgment in providing the most appropriate care. Health care providers and patients should not rely on these Medical Policies in making health care decisions. These Medical Policies are guidelines and do not constitute an authorization, certification, explanation of benefits or guarantee of payment. Applications of Triad’s Medical Policies are determined by the enrollee’s benefit documents and contracts and as such individual benefits must be verified. Determinations of medical necessity apply only if the benefit exists and no contract exclusions are applicable. In the event of a conflict, a participant’s benefit plan document shall supersede the information contained in Triad’s Medical Policies.