Instructions for use
The following coverage policy applies to health benefit plans administered by Cigna. Coverage policies are intended to provide guidance in interpreting certain standard Cigna benefit plans and are used by medical directors and other health care professionals in making medical necessity and other coverage determinations. Please note the terms of a customer’s particular benefit plan document may differ significantly from the standard benefit plans upon which these coverage policies are based. For example, a customer’s benefit plan document may contain a specific exclusion related to a topic addressed in a coverage policy.

In the event of a conflict, a customer’s benefit plan document always supersedes the information in the coverage policy. In the absence of federal or state coverage mandates, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of:
1. The terms of the applicable benefit plan document in effect on the date of service
2. Any applicable laws and regulations
3. Any relevant collateral source materials including coverage policies
4. The specific facts of the particular situation

Coverage policies relate exclusively to the administration of health benefit plans. Coverage policies are not recommendations for treatment and should never be used as treatment guidelines.

This evidence-based medical coverage policy has been developed by eviCore, Inc. Some information in this coverage policy may not apply to all benefit plans administered by Cigna.

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CMM-208~Radiofrequency Joint Ablations/Denervations

CMM-208.1 Definitions

Radiofrequency joint denervation/ablation (i.e., 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.

CMM-208.2 General Guidelines

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.

CMM-208.3 Indications and Non-Indications

✓ A radiofrequency joint denervation/ablation is considered medically necessary for facet mediated pain resulting from disease, injury or surgery and confirmed by provocative testing when both of the following criteria are met:
  o Failure of at least three (3) months of conservative therapy (e.g., exercise, physical methods including physical therapy, chiropractic care, NSAID’s and/or analgesics)
  o Positive diagnostic medial branch block or facet joint injection using either a local anesthetic or a local anesthetic combined with corticosteroid as evidenced by either of the following:
    ▪ A beneficial clinical response to an intra-articular facet injection or medial branch block performed with a local anesthetic with greater than 50% pain relief reported for 80% of the duration of the effect of the local anesthetic used
    ▪ A beneficial clinical response to an intra-articular facet joint injection or medial branch block performed with a local anesthetic and a corticosteroid with at least a 50% reduction in pain for at least two (2) weeks.

✓ When an injection or block is considered positive, a second (confirmatory) block is not medically necessary to perform a radiofrequency joint denervation/ablation.
A radiofrequency joint denervation/ablation should only be performed for neck pain or low back pain in the absence of an untreated radiculopathy. The performance of a radiofrequency joint denervation/ablation in an individual with an untreated radiculopathy is considered not medically necessary.

A repeat radiofrequency joint denervation/ablation is 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.

When performing radiofrequency joint denervations/ablations, no more than three (3) levels should be performed during the same session/procedure. It is 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 is considered not medically necessary.

A radiofrequency joint denervation/ablation is considered medically necessary when performed on an individual with previous spinal fusion only when performed at levels above or below the fusion.

Based on the lack of published peer-reviewed scientific literature on the efficacy of these methods of ablation, the following procedures are considered experimental, investigational, or unproven:

- Pulsed radiofrequency ablation for chronic pain syndromes
- Endoscopic radiofrequency denervation/endoscopic dorsal ramus rhizotomy
- Cryoablation/cryoneurolysis/cryodenervation
- Chemical ablation (e.g., alcohol, phenol, glycerol)
- Laser ablation
- Ablation by any method for sacroiliac (SI) joint pain
- Cooled radiofrequency ablation
**CMM-208.4 Procedure (CPT®) Codes**

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code’s inclusion on this list does not necessarily indicate prior authorization is required.

<table>
<thead>
<tr>
<th>CPT®</th>
<th>Code Description/Definition</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>
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</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the health plan and is based on the individual’s policy or benefit entitlement structure as well as claims processing rules.

**CMM-208.5 References**


