


MEDICAL POLICY	Back: Facet Joint Interventions for Pain Management (Medicare Only)
Effective Date: 4/1/2022  4/1/2022	Medical Policy Number: 13 Medical Policy Committee Approved Date: 2/16; 10/16; 10/17; 12/18; 11/19; 6/2020; 2/2021; 2/2022
Medical Officer _____ Date _____	

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

Medicare only

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
Facet Joint Interventions	<ul style="list-style-type: none"> For services on/after 04/25/2021: Local Coverage Determination (LCD): Facet Joint Interventions for Pain Management (L38803) For services prior to 04/25/2021: LCD: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L34995)

In the absence of a Medicare coverage policy or guidance (e.g., manual, national coverage determination [NCD], local coverage determination [LCD] article [LCA], etc.), Medicare guidelines allow a Medicare Advantage Organization (MAO) to make coverage determinations, applying an objective, evidence-based process, based on authoritative evidence. (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5) Therefore, the commercial medical policy, **Back: Radiofrequency Ablation for Persistent Facet Pain (All Lines of Business Except Medicare)**, applies to the following services:

- Radiofrequency ablation (RFA) of the sacroiliac joint (CPT 64625)

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POLICY GUIDELINES

Thermal and Non-Thermal Radiofrequency ablation (RFA)

Radiofrequency ablation (RFA) is a minimally invasive procedure performed with imaging guidance (fluoroscopy or CT) and involves using energy in the radiofrequency range to cause necrosis of specific nerves, preventing the neural transmission of pain.

- Conventional radiofrequency ablation (non- pulsed or continuous) applies **thermal** energy of typically 80 to 85 degrees Celsius. The terms radiofrequency ablation and radiofrequency neurotomy are used interchangeably. Both terms refer to a procedure that destroys the functionality of the nerve using radiofrequency energy.
- **Non-thermal** methods of denervation include chemical (chemodenervation), low-grade thermal energy (less than 80 degrees Celsius), pulsed RFA, laser neurolysis, and cryoablation.

BILLING GUIDELINES

See related LCAs for additional coding and billing guidance:

- Services **on/after** April 25, 2021: LCA: Billing and Coding: Facet Joint Interventions for Pain Management ([A58405](#))
- Services **prior to** April 25, 2021: See LCA: Billing and Coding: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy ([A57728](#))

According to LCA A58405, CPT codes 64492 and 64495, as well as Category III codes 0213T-0218T, are all non-covered services for Medicare; however, CPT codes 64492 and 64495 may be reviewed on appeal with sufficient documentation to support medical necessity (see “Limitation” #6 in LCD L38803).

Also according to this LCA, limited Medicare coverage was established for CPT codes 64490, 64491, 64493, 64494, 64633, 64634, 64635, and 64636.

Finally, non-thermal facet joint denervation (including chemical, low grade thermal energy (<80 degrees Celsius or any other form of pulsed radiofrequency) should not be reported with CPT codes 64633, 64634, 64635 or 64636. These services should be reported with CPT code 64999. Code 64999 is non-covered when used to report non-thermal facet joint denervation.

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CPT/HCPCS CODES

Medicare Only	
Prior Authorization Required	
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)
No Prior Authorization Required	
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
Not Covered	
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level

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0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level (List separately in addition to code for primary procedure)
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level (List separately in addition to code for primary procedure)
0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)

Unlisted Codes	
All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed relative to services addressed in this policy then prior-authorization is required and may be non-covered.	
64999	Unlisted procedure, nervous system

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

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MEDICAL POLICY CROSS REFERENCES

Back: Ablative Procedures to Treat Back and Neck Pain (All Lines of Business Except Medicare), MP21