Medicare Medical Policy

Ablative Procedures to Treat Back and Neck Pain

MEDICARE MEDICAL POLICY NUMBER: 13

Effective Date: 1/1/2024

Last Review Date: 11/2023

Next Annual Review: 11/2024

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. 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.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

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

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

Service	Medicare Guidelines
The Following Ablative Back and Neck Procedures • *Intraarticular (IA) Facet Joint Injections* • *Medial Branch Blocks (MBB)* • *Non-pulsed Radiofrequency Ablations (RFA)* • *Facet cyst rupture/aspiration* • *Non-thermal modalities (i.e., pulsed RFA, chemical, low-grade thermal energy [less than 80 degrees Celsius], laser neurolysis, and cryoablation)*	Local Coverage Determination (LCD) for Facet Joint Interventions for Pain Management (L38803)
Destruction by Neurolysis for Sacroiliac Joint Pain (CPT 64640)	Local Coverage Determination (LCD) for Nerve Blockade for Treatment of Chronic Pain and Neuropathy (L35457) **NOTE:** This LCD states diagnostic and therapeutic nerve blocks are considered medically necessary; however, coverage is limited to indications included within the diagnosis code list found in the companion local coverage article (LCA). See "Billing Guidelines" below for additional information.
RFA of the sacroiliac joint (CPT 64625)	LCD: Sacroiliac Joint Injections and Procedures (L39464) *(See Criterion D in the LCD)*
As of January 28, 2024: *Intraosseous basivertebral nerve ablation (e.g., Intracept) (CPT 64628, 64629)*	LCD: Intraosseous Basivertebral Nerve Ablation (L39644)

Prior to January 28, 2024: *Intraosseous basivertebral nerve ablation (e.g., Intracept) (CPT 64628, 64629)*	Company policy for Ablative Procedures to Treat Back and Neck Pain I. This service may be considered **medically necessary** for Medicare when the Company medical policy criteria are met. II. This service is considered **not medically necessary** for Medicare when the Company medical policy criteria are not met. *See Policy Guidelines below.*

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

- Electrical Stimulation and Electromagnetic Therapies, MP333
- Intraoperative Monitoring, MP296

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DOCUMENTATION REQUIREMENTS

In order to review for medical necessity, documentation to support medical necessity **must** be provided. For Medicare Advantage, see the Noridian local coverage article (LCA) A53975 for documentation requirements for spinal fusion procedures.

MEDICARE AND MEDICAL NECESSITY

Only medically reasonable and necessary services or items which treat illness or injury are eligible for Medicare coverage, as outlined in *Title XVIII of the Social Security Act, §1862(a)(1)(A)*.

The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development. In the absence of Medicare coverage policies (e.g., manual, national coverage determination [NCD], local coverage determination [LCD], article [LCA], etc.) which addresses the medical necessity of a given medical service, Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations.

During the MAO review, an evidence-based process must be used. This includes using authoritative evidence, such as studies performed by government agencies (i.e., the FDA), well-designed clinical studies that appeared in peer reviewed journals, and evaluations performed by independent technology assessment groups. *(Medicare Managed Care Manual, Ch. 4, §90.5)* In addition to review of the quality of the body of studies and the consistency of the results, additional consideration may be given to determine if the evidence can be generalized to the Medicare population. Therefore, the Company policy criteria will be applied to intraosseous basivertebral nerve (BVN) ablation until the Noridian LCD is officially in effect.

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.

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

See associated local coverage articles (LCAs) for related billing and coding guidance, as well as additional coverage and non-coverage scenarios and frequency utilization allowances and limitations:

- LCA: Billing and Coding: Facet Joint Interventions for Pain Management (A58405)
- LCA: Billing and Coding: Nerve Blockade for Treatment of Chronic Pain and Neuropathy (A52725)
- LCA: Billing and Coding: Intraosseous Basivertebral Nerve Ablation (A59468)

Facet Joint Interventions

According to the local coverage article (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.

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.

Nerve Blockade

Finally, CPT code 64640, which may be used for destruction by neurolysis for sacroiliac joint pain, is not limited to only the procedures and/or indications addressed in this policy. CPT code 64640 will deny as **not medically necessary** when **not** reported with an ICD-10 code that supports medical necessity for Medicare, as determined by the relevant LCA A52725.

CODES*		
CPT	0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
	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)
	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)
	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)
	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)
	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)
	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 (List separately in addition to code for primary procedure)
	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 or branch
	64999	Unlisted procedure, nervous system
HCPCS	None	

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

None

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Annual review, title change
6/2023	Interim update; Language revision due to Company policy change from "Investigational" to "not medically necessary" (late update to add LCD L39464 for RFA of the SIJ)
1/2024	Annual review; Language revision due to Company criteria change for intraosseous basivertebral nerve ablation (e.g., Intracept procedure); add future Noridian LCD/LCA