# *Medicare Medical Policy*

# Ablative Procedures to Treat Back and Neck Pain

**MEDICARE MEDICAL POLICY NUMBER:** 13

**Effective Date:** 12/1/2025

**Last Review Date:** 11/2025

**Next Annual Review:** 11/2026


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**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 |
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| ***The Following Facet-related Ablative Back and Neck Procedures***<br><br>• *Intraarticular (IA) Facet Joint Injections*<br>• *Medial Branch Blocks (MBB)*<br>• *Non-pulsed Radiofrequency Ablations (RFA)*<br>• *Ablative procedures of the occipital nerve (conventional or non-thermal, including cryoablation)*<br>• *Facet cyst rupture/aspiration*<br>• *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): Facet Joint Interventions for Pain Management (~~L38803~~) ***(As of 4/16/2026, use LCD L38801)***<br>• Local Coverage Article (LCA): Billing and Coding: Facet Joint Interventions for Pain Management (~~A58405~~) ***(As of 4/16/2026, use LCA A58403)***<br><br>**NOTE:**<br>1. Prior to applying coverage criteria in the LCD, take note of all limitations and non-covered services/indications found in the LCD.<br>2. In addition, coverage is limited to indications included within the diagnosis code list found in the above companion LCA.<br>3. The Policy Guidelines section below provides more information around the use of this LCD and LCA for ablative procedures of occipital nerves. According to the LCD, when clinical and/or imaging findings point to a "**diagnosis other than** facet joint syndrome," then facet joint intervention procedures are considered "not reasonable and necessary." |
| *Destruction by Neurolysis for Sacroiliac Joint Pain (CPT 64640)* | LCD: Nerve Blockade for Treatment of Chronic Pain and Neuropathy (~~L35457~~) ***(As of 3/5/2026, use LCD L35456; as of 11/1/2026, see the "Note" below regarding the new LCA for Billing and Coding: Peripheral Nerve Injections and Procedures for Chronic Pain, A60300)***<br><br>**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 |

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| | article (LCA). See "Billing Guidelines" below for additional information. **For services on/after 11/1/2026:** The LCA A60300 states, "The following CPT® codes are non-covered for pain management: 64430*, 64632*, 64420, 64421, 64620, 64450, **64640,** 64999, 0440T, 0441T and 0442T." Therefore, CPT code 64640 for any pain management indication, including but not limited to destruction by neurolysis for sacroiliac joint pain, may be considered **not medically necessary** as of 11/1/2026. |
| *RFA of the sacroiliac joint (CPT 64625)* | LCD: Sacroiliac Joint Injections and Procedures (~~L39464~~) ***(As of 3/5/2026, use LCD L39462)*** *(See Criterion D in the LCD)* |
| *Intraosseous basivertebral nerve ablation (e.g., Intracept) (CPT 64628, 64629)* | LCD: Intraosseous Basivertebral Nerve Ablation (~~L39644~~) ***(As of 3/5/2026, use LCD L39642)*** |
| **Medicare Coverage Criteria:** "MA organizations may create publicly accessible internal coverage criteria… when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs." *(§ 422.101(b)(6) – see Policy Guidelines below*)<br>• **Medicare Coverage Manuals:** Medicare does not have criteria for **non-facet** joint interventions in a coverage manual.<br>• **National Coverage Determination (NCD):** Medicare does not have an NCD for **non-facet** joint interventions.<br>• **Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):** As of the most recent policy review, no Medicare Administrative Contractors (MACs) have LCDs for **non-facet joint interventions**.<br>• **Noridian J-F Local Coverage Determination (LCD)/Local Coverage Article (LCA):** As of the most recent policy review, no Medicare Administrative Contractors (MACs) have LCDs for **non-facet** joint interventions. While the Noridian F-F LCD ~~L38803~~ *(as of 4/16/26, LCD L38801)* cites the American Society of Anesthesiologists (ASA) Task Force as stating, "Conventional or thermal radiofrequency ablation of the dorsal root ganglion should not be routinely used for the treatment of lumbar radicular pain," the LCD is specific to facet joint interventions or pain management only, and thus, does **not** provide fully established coverage criteria for radiofrequency ablation of the dorsal root ganglion.<br>• Therefore, in the absence of **fully established** Medicare coverage criteria in a manual, NCD, LCD, or other regulatory guidance for the health plan's service area, Company criteria below are applied for medical necessity decision-making. In this case, Medicare coverage criteria are considered "not fully established" as defined under CFR § 422.101(6)(i)(B) as the available Medicare coverage policies provide flexibility for coverage decisions beyond the NCD and LCD.<br>• ***NOTE:*** *The summary of evidence, as well as the list of citations/references used in the development of the Company's internal coverage criteria, are publicly available and can be found using the Company medical policy link below [CFR § 422.101(6)(ii)(A) and (B)].* | |
| *Non-Facet-Related Interventions for Back and/or Neck Pain Not Otherwise Addressed*<br><br>*Examples Include:*<br>• *RFA of the dorsal root ganglion* | Company medical policy for Ablative Procedures to Treat Back and Neck Pain<br><br>I. These services are considered **not medically necessary** for Medicare based on the Company medical policy. *See Policy Guidelines below.* |

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| • *RFA of the ganglion impar (impar of Walther).*<br>• *Other non-facet joint ablative procedures (e.g., pulsed RFA, cooled RFA, cryoablation, chemical ablation) not addressed* | |

**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~~ (A53972) for documentation requirements for spinal fusion procedures.

**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.

**ABLATIVE PROCEDURES OF THE OCCIPITAL NERVE**

Each facet has a dual nerve supply, with the exception at the C2–C3 zygapophysial joint, which has a singular nerve supply from the third occipital nerve (the superficial medial branch of C3 dorsal ramus). While this makes the occipital nerve unique, it is still a facet nerve and thus, subject to the terms of the facet joint intervention LCD and LCA. Several common indications for occipital nerve ablation are **not** included as covered indications or diagnoses by the Noridian LCD and LCA. This includes, but is not necessarily limited to, occipital neuralgia (M54.81) and headaches (e.g., cluster, migraine, etc.).

In addition, LCD L38803 *(as of 4/16/26, LCD L38801)* states, "Several alternatives to percutaneous radiofrequency denervation have been proposed, including pulsed radiofrequency, cryoablation, laser ablation, and chemical ablation, in which a neurolytic substance (e.g., alcohol, phenol, glycerol) is injected into the affected nerve root. An alternative method of denervation using an endoscopic approach (i.e., endoscopic dorsal ramus rhizotomy) has also been proposed. There is insufficient evidence in the published medical literature to determine the safety and efficacy of these emerging alternative modalities or approaches compared to thermal radiofrequency denervation for the treatment of spinal pain." Therefore, cryoablation of the occipital nerve, or other spinal levels, would also be considered **not medically necessary** based on the LCD L38803 *(as of 4/16/26, LCD L38801)*.

## *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~~) ***(As of 4/16/2026, see LCA A58403)***
- LCA: Billing and Coding: Nerve Blockade for Treatment of Chronic Pain and Neuropathy (A52725) ***(As of 11/1/2026, see LCA for Nerve Blockade for Treatment of Chronic Pain and Neuropathy A60300)***
- LCA: Billing and Coding: Intraosseous Basivertebral Nerve Ablation (~~A59468~~) ***(As of 3/5/2026, see LCA A59466)***

### Facet Joint Interventions

According to the local coverage article (LCA) A58405 (or A58403, as of 4/16/2026), 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, or L38801 as of 4/16/2026).

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~~ ***(As of 3/5/2026, see LCA A56034; For services on/after 11/1/2026:*** *The LCA A60300 states, "The following CPT® codes are non-covered for pain management: 64430*, 64632*, 64420, 64421, 64620, 64450,* ***64640,*** *64999, 0440T, 0441T and 0442T." Therefore, CPT code 64640 for any pain management indication, including but not limited to destruction by neurolysis for sacroiliac joint pain, may be considered* ***not medically necessary*** *as of 11/1/2026)*.

| **CODES*** | | |
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| **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) |

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| | 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 |
| 4/2024 | Interim update; Clarified criteria used for occipital nerve ablative procedures |
| 12/2024 | Annual review; add notation of non-coverage from the Noridian LCD (10/3/2025: Replaced A53975 with A53972 due to Noridian JF consolidation with JE LCD policies) |
| 12/2025 | Interim update (Sept. UM Committee review); add non-Facet joint interventions to policy scope - Annual review (Nov. UM Committee review), no additional changes (3/6/2026: Replaced multiple LCDs and LCAs due to Noridian JF consolidation with JE LCD policies) (4/27/2026: Replaced LCD L38803 and companion LCA due to Noridian JF consolidation with JE LCD policies) (11/1/2026: Replaced LCD L35456/A52725 with L40265/A60300) |