Medicare Medical Policy

Knee: Genicular Nerve Blocks and Nerve Ablation for Knee Pain

MEDICARE MEDICAL POLICY NUMBER: 354

Effective Date: 2/1/2023

Last Review Date: 9/2022

Next Annual Review: 9/2023

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, Providence Plan Partners, and Ayin Health Solutions 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
Conventional (Thermal Non-Pulsed) Radiofrequency Ablation (RFA) and Genicular Nerve Block (diagnostic and therapeutic)	Local Coverage Determination (LCD) for Nerve Blockade for Treatment of Chronic Pain and Neuropathy (L35457) **NOTE:** This LCD states the utility of nerve blocks "in the diagnosis and treatment of non-neuropathic pain and specific syndromes mediated by sympathetic nervous system overactivity has been established." This LCD considers diagnostic and therapeutic nerve blocks, including the use of nerve blocks "to evaluate the patient's response" to pain relief options and "longer-lasting or permanent blockade with the … application of thermal (**not pulsed**) radiofrequency" to be medically necessary. This LCD does not state some types of pain are excluded from coverage and the diagnosis code list in the LCA includes diagnoses codes for knee pain.
Other Ablative Procedures for The Treatment of Knee Pain (e.g., cooled RFA, pulsed RFA, chemical ablation, cryoablation, etc.)	Company medical policy for Knee: Genicular Nerve Blocks and Nerve Ablation for Knee Pain I. These services are considered **not medically necessary** for Medicare based on the Company medical policy. *Services deemed "investigational" are considered not medically necessary for Medicare Plan members. 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

None

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

POLICY GUIDELINES

BACKGROUND

The nerves supplying the knee are called the genicular nerves, comprising the articular branches of the obturator, femoral, saphenous, common peroneal, and tibial nerves. These nerves provide innervation to the capsule of the knee joint, as well as to the intra-articular and extra-articular ligaments. They are thought to contribute to knee-related pain of various etiologies, including but not limited to degenerative joint diseases such as osteoarthritis, chronic pain including knee pain that exists after total knee arthroplasty (TKA) surgery. Nerve ablation procedures proposed to treat knee pain include, but may not be limited to, the following:

- Radiofrequency ablation (RFA) is a minimally invasive treatment proposed to temporarily reduce pain with various causes. This technique is also known as radiofrequency lesioning, radiofrequency nerve ablation (RFNA), radiofrequency neurotomy, denervation, or rhizotomy. Different types include:
    - Conventional RFA
    - Cooled radiofrequency ablation/denervation (also known as C-RFA)
    - Pulsed RFA
- Cryoablation. This may also be known as cryosurgery, cryodenervation, cryogenic neuroablation, cryoneurolysis, or cryoanalgesia.
- Chemical ablation, which may also be referred to as chemical neurolysis, chemical denervation or chemodenervation.
- Genicular nerve blocks (GNB). A GNB generally involves the injection of an anesthetic agent (e.g., lidocaine, bupivacaine) and may be performed to determine suitability for RFA.
    - During the procedure radiofrequency (RF) energy delivers heat to the target nerve thereby creating a lesion that stops pain input to the central nervous system. Prior to planning the RFA procedure, a diagnostic genicular nerve block is conducted to ensure that the patient is a suitable candidate for RFA, usually under fluoroscopic or ultrasonographic guidance.

MEDICARE AND MEDICAL NECESSITY

While the local Medicare contractor – Noridian – has an LCD for nerve blockades used for the treatment of chronic pain or neuropathy, it does not address nerve ablation procedures to treat knee pain, nor does it include all relevant procedure codes (CPT 64454 or 64624).

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, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. *(Medicare Managed Care Manual, Ch. 4, §90.5)*

Following an evidence-based assessment of current peer-reviewed medical literature, the Company may consider certain medical services or technologies to be "investigational." The term "investigational" is not limited to devices or technologies which have not received the appropriate governmental regulatory approval (e.g., U.S. Food and Drug Administration [FDA]), but rather may also mean the procedure, device, or technology does not meet all of the Company's technology assessment criteria, as detailed within the Company policy for *Definition: Experimental/Investigational* (MP5).

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)*. Thus, services which lack scientific evidence regarding safety and efficacy because they are investigational are "not medically reasonable or necessary" for Medicare Plan members. *(Medicare Claims Processing Manual, Ch. 23, §30 A)*

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 medically necessary diagnosis coding:

- LCA: Billing and Coding: Nerve Blockade for Treatment of Chronic Pain and Neuropathy (A52725)

The code 64640 is not specific to 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 nerve blockade LCA A52725.

The code 0441T is also not specific to the procedures and/or indications addressed in this policy. Category III code 0441T will be considered **not medically necessary** for the therapies addressed in this policy when the request is for any of the ICD-10 diagnosis codes present in the Billing Guidelines

Appendix below. (See also the separate *Radiofrequency Ablation or Cryoablation for Plantar Fasciitis (Medicare Only)* policy for additional non-covered indications).

CODES*		
CPT	0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve
	20999	Unlisted procedure, musculoskeletal system, general
	27599	Unlisted procedure, femur or knee
	64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed
	64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
	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	New Medicare Advantage medical policy

APPENDICES

Diagnosis codes for knee pain may include but are not limited to any of the ICD-10 codes listed below. Additional ICD codes may apply.

Appendix I: Not medically necessary indications for **CPT 0441T**. (See also the separate *Radiofrequency Ablation or Cryoablation for Plantar Fasciitis (Medicare Only)* policy for additional non-covered indications for this code.)

CODE OR RANGE	DESCRIPTION
M0516	Rheumatoid lung disease with rheumatoid arthritis of knee
M05161	Rheumatoid lung disease with rheumatoid arthritis of right knee
M05162	Rheumatoid lung disease with rheumatoid arthritis of left knee
M05169	Rheumatoid lung disease with rheumatoid arthritis of unspecified knee
M0526	Rheumatoid vasculitis with rheumatoid arthritis of knee
M05261	Rheumatoid vasculitis with rheumatoid arthritis of right knee
M05262	Rheumatoid vasculitis with rheumatoid arthritis of left knee
M05269	Rheumatoid vasculitis with rheumatoid arthritis of unspecified knee
M0536	Rheumatoid heart disease with rheumatoid arthritis of knee
M05361	Rheumatoid heart disease with rheumatoid arthritis of right knee
M05362	Rheumatoid heart disease with rheumatoid arthritis of left knee
M05369	Rheumatoid heart disease with rheumatoid arthritis of unspecified knee
M0546	Rheumatoid myopathy with rheumatoid arthritis of knee
M05461	Rheumatoid myopathy with rheumatoid arthritis of right knee
M05462	Rheumatoid myopathy with rheumatoid arthritis of left knee
M05469	Rheumatoid myopathy with rheumatoid arthritis of unspecified knee
M0556	Rheumatoid polyneuropathy with rheumatoid arthritis of knee
M05561	Rheumatoid polyneuropathy with rheumatoid arthritis of right knee
M05562	Rheumatoid polyneuropathy with rheumatoid arthritis of left knee
M05569	Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified knee
M0566	Rheumatoid arthritis of knee with involvement of other organs and systems
M05661	Rheumatoid arthritis of right knee with involvement of other organs and systems
M05662	Rheumatoid arthritis of left knee with involvement of other organs and systems
M05669	Rheumatoid arthritis of unspecified knee with involvement of other organs and systems
M0576	Rheumatoid arthritis with rheumatoid factor of knee without organ or systems involvement
M05761	Rheumatoid arthritis with rheumatoid factor of right knee without organ or systems involvement
M05762	Rheumatoid arthritis with rheumatoid factor of left knee without organ or systems involvement
M05769	Rheumatoid arthritis with rheumatoid factor of unspecified knee without organ or systems involvement
M0586	Other rheumatoid arthritis with rheumatoid factor of knee
M05861	Other rheumatoid arthritis with rheumatoid factor of right knee
M05862	Other rheumatoid arthritis with rheumatoid factor of left knee
M05869	Other rheumatoid arthritis with rheumatoid factor of unspecified knee
M0606	Rheumatoid arthritis without rheumatoid factor, knee
M06061	Rheumatoid arthritis without rheumatoid factor, right knee
M06062	Rheumatoid arthritis without rheumatoid factor, left knee
M06069	Rheumatoid arthritis without rheumatoid factor, unspecified knee
M06261	Rheumatoid bursitis, right knee
M06262	Rheumatoid bursitis, left knee

M06269	Rheumatoid bursitis, unspecified knee
M0686	Other specified rheumatoid arthritis, knee
M06861	Other specified rheumatoid arthritis, right knee
M06862	Other specified rheumatoid arthritis, left knee
M06869	Other specified rheumatoid arthritis, unspecified knee
M0806	Unspecified juvenile rheumatoid arthritis, knee
M08061	Unspecified juvenile rheumatoid arthritis, right knee
M08062	Unspecified juvenile rheumatoid arthritis, left knee
M08069	Unspecified juvenile rheumatoid arthritis, unspecified knee
M0826	Juvenile rheumatoid arthritis with systemic onset, knee
M08261	Juvenile rheumatoid arthritis with systemic onset, right knee
M08262	Juvenile rheumatoid arthritis with systemic onset, left knee
M08269	Juvenile rheumatoid arthritis with systemic onset, unspecified knee
M0846	Pauciarticular juvenile rheumatoid arthritis, knee
M08461	Pauciarticular juvenile rheumatoid arthritis, right knee
M08462	Pauciarticular juvenile rheumatoid arthritis, left knee
M08469	Pauciarticular juvenile rheumatoid arthritis, unspecified knee
M08.861-M08.869	Other juvenile arthritis, knee
M08.961-M08.969	Juvenile arthritis, unspecified, knee
M12.561-M12.569	Traumatic arthropathy, knee
M12.861-M12.869	Other specific arthropathies, not elsewhere classified, knee
M13.161-M13.169	Monoarthritis, not elsewhere classified, knee
M13.861-M13.869	Other specified arthritis, knee
M174	Other bilateral secondary osteoarthritis of knee
M175	Other unilateral secondary osteoarthritis of knee
M172	Bilateral post-traumatic osteoarthritis of knee
M1710	Unilateral primary osteoarthritis, unspecified knee
M1711	Unilateral primary osteoarthritis, right knee
M1712	Unilateral primary osteoarthritis, left knee
M1730	Unilateral post-traumatic osteoarthritis, unspecified knee
M1731	Unilateral post-traumatic osteoarthritis, right knee
M1732	Unilateral post-traumatic osteoarthritis, left knee
M17.0-M17.9	Osteoarthritis of knee
M21.061-M21.069	Valgus deformity, not elsewhere classified, knee
M21.161-M21.169	Varus deformity, not elsewhere classified, knee
M21.261-M21.269	Flexion deformity, knee
M22.00-M22.92	Disorder of patella
M23.000-M23.92	Internal derangement of knee
M24.361-M24.369	Pathological dislocation of knee, not elsewhere classified
M24.461-M24.469	Recurrent dislocation, knee
M24.561-M24.569	Contracture, knee
M24.661-M24.669	Ankylosis, knee
M25.361-M25.369	Other instability, knee
M25.561-M25.569	Pain in knee
M25.661-M25.669	Stiffness of knee, not elsewhere classified
M25.761-M25.769	Osteophyte, knee
M25.861-M25.869	Other specified joint disorders, knee
M66.0	Rupture of popliteal cyst
M67.361-M67.369	Transient synovitis, knee
M67.461-M67.469	Ganglion, knee
M67.50-M67.52	Plica syndrome

M67.861-M67.869	Other specified disorders of synovium and tendon, knee
M70.40-M70.42	Prepatellar bursitis
M70.50-M70.52	Other bursitis of knee
M71161	Other infective bursitis, right knee
M71162	Other infective bursitis, left knee
M71169	Other infective bursitis, unspecified knee
M71561	Other bursitis, not elsewhere classified, right knee
M71562	Other bursitis, not elsewhere classified, left knee
M71569	Other bursitis, not elsewhere classified, unspecified knee
M71.20-M71.22	Synovial cyst of popliteal space
M92.40-M92.42	Juvenile osteochondrosis of patella
M92.50-M92.52	Juvenile osteochondrosis of tibia and fibula
M94.261-M94.269	Chondromalacia, knee
S80.00XA-S80.02XS	Contusion of knee
S83.101A-S83.196S	Subluxation and dislocation of knee
S83.401A-S83.92XS	Sprain of knee
S87.00XA-S87.02XS	Crushing injury of knee
T84.84XA-T84.84XS	Pain due to internal orthopedic prosthetic devices, implants and grafts
Z96.651-Z96.659	Presence of artificial knee joint