

# Cigna Medical Coverage Policies – Musculoskeletal Radiofrequency Joint Ablation/Denervation

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## 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**

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## CMM-208.1: Definitions

- **Radiofrequency joint denervation/ablation** (i.e., facet neurotomy, facet rhizotomy) refers to the insertion of a radiofrequency probe towards the medial 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. The injection/block applies directly to the facet joint(s) blocked/ablated and not to the number of nerves blocked/ablated that innervate the facet joint(s).

## CMM-208.2: General Guidelines

- The determination of medical necessity for the performance of radiofrequency joint denervations/ablation is always made on a case-by-case basis.
- When performing radiofrequency joint denervations/ablations, it may be necessary to perform the procedure at the same level(s) bilaterally; however, no more than three (3) levels should be performed during the same session/procedure.
- When performing a repeat radiofrequency joint denervation/ablation at the same spinal level(s) as a prior successful denervation/ablation procedure, further diagnostic facet joint injections/medial branch blocks at that spinal level(s) are not necessary.

## CMM-208.3: Indications

- A radiofrequency joint denervation/ablation is considered **medically necessary** for facet mediated pain resulting from disease, injury, or surgery when **ALL** of the following are met:
  - ◆ Clinical findings and imaging studies suggest no other obvious cause of the pain (e.g., central spinal stenosis with neurogenic claudication/myelopathy, foraminal stenosis or disc herniation with concordant radicular pain/radiculopathy, infection, tumor, fracture, pseudoarthrosis, pain related to spinal instrumentation).
  - ◆ Failure of at least three (3) months of conservative therapy (e.g., exercise, physical methods including physical therapy, chiropractic care, nonsteroidal anti-inflammatory drugs [NSAID’s] and/or analgesics)
  - ◆ Two positive diagnostic facet joint injections/medial branch blocks as evidenced by at least 80% relief of pain for at least the expected minimum duration of the local anesthetic used.
- For individuals with a prior spinal fusion, radiofrequency joint denervation/ablation is considered **medically necessary** when the above criteria are met and the procedure is performed at an unfused spinal segment located either above or below the posterior fused spinal segment.
- A repeat radiofrequency joint denervation/ablation when **BOTH** of the following criteria are met:

- ◆ There is documented pain relief of at least 50% which has lasted for a minimum of 12 weeks
- ◆ The procedure is performed at a minimum of six months following the prior denervation/ablation

### **CMM 208.4: Non-Indications**

- Performance of a radiofrequency joint denervation/ablation for **ANY** of the following indications is considered **not medically necessary**:
  - ◆ When performed without the use of fluoroscopic guidance
  - ◆ Performing more than two procedures at the same level(s) during a 12 month period of time
  - ◆ In the absence of two sequential positive diagnostic facet joint injections/medial branch
  - ◆ When performed for neck pain or low back pain in the presence of an untreated radiculopathy.
  - ◆ When performed at a posteriorly fused spinal motion segment
  - ◆ When performed on more than three (3) spinal levels during the same session/procedure
  - ◆ When performed to treat pain arising from above C2-3 and below L5-S1 spinal levels
- Performance of radiofrequency joint denervation/ablations for **ANY** of the following indications is 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-208.5: 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.	
CPT®	Code Description/Definition
<b>64633</b>	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT), cervical or thoracic, single facet joint
<b>64634</b>	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)
<b>64635</b>	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT), lumbar or sacral, single facet joint
<b>64636</b>	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)
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-208.6: References

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