



CLINICAL GUIDELINES

CMM-208: Ablations/Denervations of Facet Joints and Peripheral Nerves

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Clinical guidelines for medical necessity review of Comprehensive Musculoskeletal Management Services.

CMM-208: Ablations/Denervations of Facet Joints and Peripheral Nerves

Definitions

- **Facet (zygapophyseal) joints:** paired, diarthrodial synovial joints located between the superior and inferior articular pillars in the posterior spinal column, innervated by medial branch nerves, from C2 -3 to L 5 – S1. The articulations between occiput – atlas (C1) and the atlas (C1) and the axis (C2) and below L5 – S1 (sacrum) are not facet joints.
- **Facet Level:** the zygapophyseal joint or the two medial branch (MB) nerves that innervate that zygapophyseal joint. Each level has a pair of facet joints: one on the right side and one of the left side of the spine.
- **Radiofrequency joint denervation/ablation** (i.e., facet neurotomy, facet rhizotomy): 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).
- **Session:** a time period, which includes all procedures (i.e., medial branch block (MBB), intra-articular (IA) facet joint injection, and radiofrequency ablation (RFA)) performed during one day.

General Guidelines

This guideline only applies to radiofrequency joint denervation/ablation for facet mediated pain and not for other indications that are not in scope of management (i.e. third occipital nerve (TON) ablation for cervicogenic headaches).

- The determination of medical necessity for the performance of radiofrequency joint denervations/ablations is always made on a case-by-case basis.
- Only one invasive modality or procedure will be performed on the same date of service.
- Radiofrequency joint denervations/ablations of no more than three (3) contiguous facet levels, whether unilateral or bilateral, should be performed during the same session. If performed bilaterally during the same session, a total of up to six (6) radiofrequency joint denervations/ablations at contiguous facet levels may be performed during that session.
- 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.

Indications

Initial Radiofrequency Joint Denervation/ Ablation

- 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)
 - ◆ Pain has persisted for at least 3 months
 - ◆ In the past 3 months, pain has persisted despite at least four (4) weeks of conservative therapy (e.g., exercise, physical therapy, chiropractic care, or medications to include nonsteroidal anti-inflammatory drugs [NSAID's] or analgesics) unless contraindicated and the reason(s) for the contraindication(s) is/are documented in the medical record
 - ◆ Two (2) positive diagnostic facet joint injections/medial branch blocks as evidenced by at least 80% relief of facet mediated pain for at least the expected minimum duration of the effect of the local anesthetic used.
- For an individual with a prior spinal fusion, radiofrequency joint denervation/ablation performed at an unfused spinal segment located either above or below the fused spinal segment is considered **medically necessary** when the above criteria are met.

Repeat Radiofrequency Joint Denervation/ Ablation

- 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 (6) months following the prior denervation/ablation

Non-Indications

Not Medically Necessary

- 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 (2) procedures at the same level(s) during a 12 month period of time
 - ◆ In the absence of two (2) sequential positive diagnostic facet joint injections/medial branch blocks at the same level(s) for an initial radiofrequency treatment

- ◆ For a repeat radiofrequency treatment, in the absence of at least 50% relief of facet mediated pain for 12 weeks and/or a timeframe of less than at least six (6) months following a previous radiofrequency treatment at the same level(s)
- ◆ 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 (with the exception of patients with clinically suspected pseudarthrosis)
- ◆ When performed on more than three (3) contiguous spinal joint levels during the same session/procedure
- ◆ When performed to treat pain arising from above C2-3 and below L5-S1 spinal levels
- ◆ On the same day of service when performing other injections (e.g., facet joint injection, medial branch block, epidural steroid injection, and sacroiliac joint injection)
- ◆ Ablation of the atlanto-occipital articulation and/or atlanto-axial articulation
- ◆ Clinical findings and imaging studies suggest 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; or, pain related to spinal instrumentation)

Experimental, Investigational, and/or Unproven (EIU)

- Denervation/ablations of facet joints or peripheral nerves using **ANY** of the following techniques is considered **experimental, investigational, and/or unproven (EIU)**:
 - ◆ Pulsed radiofrequency ablation
 - ◆ Endoscopic radiofrequency denervation/endoscopic dorsal ramus rhizotomy
 - ◆ Cryoablation/cryoneurolysis/cryodenervation
 - ◆ Chemical ablation (e.g., alcohol, phenol, glycerol)
 - ◆ Laser ablation
 - ◆ Cooled radiofrequency ablation
 - ◆ Basivertebral nerve radiofrequency ablation
- Peripheral nerve destruction using cryoablation or laser, electrical, chemical or radiofrequency ablation is considered **experimental, investigational, and/or unproven (EIU)** for treatment of **ANY** of the following conditions:
 - ◆ Chronic pain syndromes
 - ◆ Foot/heel pain
 - ◆ Hip pain
 - ◆ Knee pain
 - ◆ Sacroiliac (SI) joint pain
 - For SI joint ablation refer to **CMM-203: Sacroiliac Joint Procedures**
 - ◆ Shoulder pain

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
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
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)
64632	Destruction by neurolytic agent, plantar common digital nerve
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
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.	

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