



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**General Guidelines****Indications****Non-Indications****Procedure (CPT®) Codes****References**

Definitions

- **Axial:** Relating to or situated in the central part of the body, in the head and trunk as distinguished from the limbs, e.g., axial skeleton.
- **Cervical Facet Pain:** Pain located in the cervical spine, which may be characterized by chronic headaches, restricted motion, and axial neck pain, which may radiate sub-occipitally to the shoulders or mid-back.
- **Facet Joint Pain:** A set of concurrent signs or symptoms to describe the facet joint as the pain generator. The typical clinical signs or symptoms may include local paraspinal tenderness; pain that is brought about or increased on hyperextension, rotation, and lateral bending; low back stiffness; absence of neurologic deficit; absence of root tension signs (non- radiating below the knee, absence of paresthesia).
- **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 L5 – S1.
 - ◆ **Note:** The following articulations are not facet joints:
 - Atlanto-occipital articulation (located between occiput – atlas [C1])
 - The atlanto-axial articulation (atlas [C1] and the axis [C2])
 - Below L5 – S1 (sacrum)
- **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.
- **Positive Response (to a diagnostic facet joint injection/medial branch block):** at least 80% relief of facet mediated pain for at least the expected minimum duration of the effect of the local anesthetic used.
- **Radiofrequency Joint Denervation/Ablation (RFA)** (i.e., facet neurotomy, facet rhizotomy): Traditional or standard RFA involves the insertion of a radiofrequency probe (under fluoroscopic guidance) towards the medial branch of the posterior primary rami, which supplies the innervation to the facet joints. 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.
 - ◆ **Note:** The radiofrequency joint denervation/ablation applies directly to the facet joint(s) denervated/ablated and not to the number of nerves denervated/ablated that innervate the facet joint(s).
- **Region:** describes the segments of the spine as follows:
 - ◆ Cervical/Thoracic region= C1-C7/T1-T12
 - ◆ Lumbar/Sacral region= L1-L5/S1-S5
- **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 on a single date of service.

General Guidelines

Application of Guideline

- In regards to radiofrequency joint denervation/ablation, this guideline only applies to radiofrequency joint denervation/ablation for facet mediated pain and not for other indications/conditions that are not in scope of management for this guideline (i.e. third occipital nerve [TON] ablation for cervicogenic headaches).
 - ◆ Radiofrequency joint denervation/ablation should only be performed for axial cervical, thoracic, or lumbar pain in the absence of an untreated radiculopathy.
- In regards to peripheral nerve destruction, this guideline is applicable to requests for codes listed in the **Procedure Codes** section **and** only for conditions specifically addressed in this guideline. Use of these CPT codes for any other indication or condition is not in scope for this guideline.
- The determination of medical necessity for the performance of radiofrequency joint denervations/ablations is always made on a case-by-case basis.

Image Guidance

- Radiofrequency joint denervation/ablation should be performed with CT or fluoroscopic guidance

Frequency & Number of Procedures

- Only one invasive modality or procedure will be performed on the same date of service (e.g., facet joint injection, medial branch block, epidural steroid injection, and sacroiliac joint injection)
- When criteria are met, no more than two (2) radiofrequency joint denervation/ablation procedures at the same level(s) are permitted during a rolling 12 month period of time.
 - ◆ **Note:** At least six (6) months is required between radiofrequency joint denervation/ablation procedures.

Levels

- Radiofrequency joint denervations/ablations are permitted on no more than three (3) contiguous facet joint levels (whether unilateral or bilateral), 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 criteria are met, radiofrequency joint denervations/ablations are only permitted from levels C2-3 to L5-S1.
 - ◆ **Note:** The radiofrequency joint denervation/ablation applies directly to the facet joint(s) denervated/ablated and not to the number of nerves that innervate the facet joint(s).

- Radiofrequency joint denervations/ablations are only permitted when performed at a unfused posterior spinal motion segment(s). The following is the ONLY exception allowed:
 - ◆ **Note:** Exception allowed for patients with clinically suspected pseudarthrosis at the posteriorly-fused spinal motion segment(s).

Indications

Initial Radiofrequency Joint Denervation/Ablation

- A radiofrequency joint denervation/ablation is considered **medically necessary** for facet mediated axial cervical, thoracic, or lumbar pain resulting from disease, injury, or surgery when **ALL** of the following are met:
 - ◆ 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)
 - **Note:** If conservative treatment is contraindicated, the reason(s) for the contraindication(s) is/are required to be documented in the medical record
 - ◆ There has been a documented positive response with two (2) sequential diagnostic facet joint injections/medial branch blocks at the same level(s)
 - Positive response is 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.
 - ◆ 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)
 - ◆ The spinal motion segment(s) is not posteriorly fused at the requested level(s)
 - **Note:** Exception allowed for patients with clinically suspected pseudarthrosis at the posteriorly-fused spinal motion segment(s).
- 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:
 - ◆ The procedure is performed at a minimum of six (6) months following the prior denervation/ablation
 - ◆ There is documented pain relief of at least 50% which has lasted for a minimum of 12 weeks
- **Note:** 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.

Non-Indications

Not Medically Necessary

- Radiofrequency joint denervations/ablations performed without meeting the requirements listed in the **Definitions**, the **General Guidelines**, and the **Indications** sections are considered **not medically necessary**.

Experimental, Investigational, or Unproven (EIU)

Techniques for Denervation/Ablications of Facet Joints or Peripheral Nerves

- Denervation/ablications of facet joints or peripheral nerves using **ANY** of the following techniques is considered **experimental, investigational, 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

- Peripheral nerve destruction using cryoablation or laser, electrical, chemical or radiofrequency ablation is considered **experimental, investigational, 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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