Medical Policy: Radiofrequency Ablation for Spinal Pain

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
MG.MM.ME.39	2/14/2025	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

Definition

Radiofrequency ablation (RFA) (aka facet neurotomy, facet rhizotomy or articular rhizolysis) is a percutaneous treatment using radiowave-induced heat to create a lesion in a spinal sensory nerve. The goal of RFA is to relieve pain by interrupting the transmission of pain signals from the sensory nerve to the brain.

Guideline

Members with moderate to severe cervical, thoracic or lumbar spinal pain are eligible for coverage of radiofrequency ablation (RFA) when the following criteria are met.

Supportive documentation that must be presented to the Plan includes the medical record on history, physical and radiographic evaluations.

1. Pain is secondary to facet joint origin, as evidenced by the absence of nerve root compression and radicular pain[1]
2. Neuroradiologic studies do not confirm any disc herniation infection or tumor
3. Pain is refractory for a 6-month period and has failed to respond to 3 months of conservative management (e.g., nonsteroidal anti-inflammatory/opioid medications, chiropractic therapy/physical therapy and a home exercise program)

[1] Facet pain may occur in association with radiculopathy and in the presence of herniated disc.

4. Demonstration of symptom relief secondary to a trial of 2 controlled diagnostic medial branch blocks provided under a standard alternating protocol of alternating short and long-acting anesthetic blocks. No IV sedation or opioids should be used during this

Intracept Intraosseous Basivertebral Nerve Ablation System Criteria for Chronic low back pain (CLBP) (Commercial and Medicare)

1. Skeletal maturity
2. CLBP for at least 6 months
3. Failure to respond to 3 months of conservative management (e.g., nonsteroidal anti-inflammatory/opioid medications, chiropractic therapy/physical therapy and a home exercise program)
4. Vertebrogenic back pain as evidenced by Type 1 or Type 2 Modic changes on MRI — endplate hypo-intensity (Type 1) or hyperintensity (Type 2) on T1 images plus hyperintensity on T2 imag es (Type 1) involving in the endplates between L3 and S1

Limitations/Exclusions

1. Members should have no history of spinal fusion surgery in the vertebral level being treated.
2. Use of thermal RFA to destroy any other spinal structure other than the medial branch nerve is considered investigational and hence not covered
3. Denervation procedures of the sacroiliac joint are considered experimental/investigational
4. Non-thermal RF modalities for medial branch ablation including chemical, low-grade thermal, or pulsed radiofrequency ablation (CPT 64625) are not covered
5. As results may be transient, a repeat RFA is considered medically necessary when a prior treatment has been successful as follows:
    - Maximum of 2 times over a 12-month period per side and level (i.e., no more than 2 procedures per year)
    - Achievement of ≥ 50% pain reduction in conjunction with functional improvement
6. The following treatment protocols are not considered to be medically necessary:
    - > 1 treatment per level per side within a 6-month period
    - > 2 treatments per year
    - Long-term, repeated or maintenance. (Requests for treatment beyond the 1st year will be medical-director-reviewed)

    Note: RFA performed to the medial branch nerves for a maximum of 3 facet levels, or denervation of 5 spinal medial branches unilaterally, U*will*U *be allowed on a single visit.*
7. The following procedures are not considered medically necessary, as they are investigational:
    - Automated percutaneous lumbar discectomy (APLD)/automated percutaneous nucleotomy.
    - Coblation® Nucleoplasty™, disc nucleoplasty, decompression nucleoplasty plasma disc decompression

- Cryoneurolysis
- Devices for anular repair (e.g., Inclose™ Surgical Mesh System, Xclose™ Tissue Repair System).
- Endoscopic epidural adhesiolysis
- Epiduroscopy, epidural myeloscopy, epidural spinal endoscopy
- Intervertebral disc biacuplasty
- Intraosseous basivertebral nerve radiofrequency ablation (Intracept System) (covered Commercial and Medicare only)
- Laser ablation
- Laser discectomy (percutaneous or laparoscopic), laser-assisted disc decompression (LADD), laser disc decompression
- Percutaneous epidural adhesiolysis, percutaneous epidural lysis of adhesions
- Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), intradiscal radiofrequency.
- Thermomodulation, percutaneous radiofrequency thermomodulation, Intradiscal electrothermal annuloplasty (IDET)/ percutaneous intradiscal radiofrequency thermocoagulation)/ SpineCATH™
- Pulsed radiofrequency
- Racz procedure (covered Medicare only, 62263 and 62264)
- Radiofrequency thermocoagulation for chronic coccydynia

Procedure Codes

62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days (Medicare Only)
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day (Medicare Only)
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral (Commercial and Medicare only)
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) (Commercial and Medicare Only)
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)

Diagnosis Codes

M12.88	Other specific arthropathies, not elsewhere classified, other specified site
M47.11	Other spondylosis with myelopathy, occipito-atlanto-axial region
M47.12	Other spondylosis with myelopathy, cervical region
M47.13	Other spondylosis with myelopathy, cervicothoracic region
M47.14	Other spondylosis with myelopathy, thoracic region
M47.15	Other spondylosis with myelopathy, thoracolumbar region
M47.16	Other spondylosis with myelopathy, lumbar region
M47,811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M53.81	Other specified dorsopathies, occipito-atlanto-axial region
M53.82	Other specified dorsopathies, cervical region
M53.83	Other specified dorsopathies, cervicothoracic region
M53.85	Other specified dorsopathies, thoracolumbar region
M54.2	Cervicalgia
M54.40	Lumbago with sciatica, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.5	Low back pain
M54.6	Pain in thoracic spine
M54.81	Occipital neuralgia
M62.830	Muscle spasm of back
M71.30	Other bursal cyst, unspecified site
M71.38	Other bursal cyst, other site

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Specialty-matched clinical peer review.

Revision History

Company(ies)	DATE	REVISION
ConnectiCare	Feb. 14, 2025	Transferred policy content to individual company branded template
ConnectiCare EmblemHealth	Jan. 12, 2024	Added Intracept Commercial coverage Added Intracept criteria applicable to Commercial and Medicare
ConnectiCare EmblemHealth	Aug. 12, 2022	Added radiofrequency thermocoagulation for chronic coccydynia to Limitations/Exclusions as investigational
ConnectiCare	May 13, 2022	ConnectiCare adopts clinical criteria of its parent corporation EmblemHealth
EmblemHealth	Apr. 18, 2022	Added Medicare coverage for intraosseous basivertebral nerve radiofrequency ablation eff. 01/01/2022
EmblemHealth	Dec. 10, 2021	Added “infection or tumor” to indication: Neuroradiologic studies do not confirm any disc herniation infection or tumor Clarified repeat RFA language Added intraosseous basivertebral nerve radiofrequency ablation (Intracept System) as investigational
EmblemHealth	Mar. 8, 2019	Added coverage for thoracic pain
EmblemHealth	Oct. 12, 2018	Noted that facet pain may occur in association with radiculopathy and in the presence of herniated disc
EmblemHealth	Nov. 13, 2015	Thoracic pain indication removed
EmblemHealth	Jul. 14, 2017	Added Interna® Dermal Regeneration FENIX™ Continence Restoration System as investigational