



Radiofrequency Ablation for Spinal Pain

Last Review Date: October 13, 2017

Number: MG.MM.ME.39aC2

Medical Guideline Disclaimer

Property of EmblemHealth. All rights reserved. The treating physician or primary care provider must submit to EmblemHealth the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, EmblemHealth will not be able to properly review the request for prior authorization. The clinical review criteria expressed below reflects how EmblemHealth determines whether certain services or supplies are medically necessary. EmblemHealth 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). EmblemHealth expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program 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 EmblemHealth, as some programs exclude coverage for services or supplies that EmblemHealth considers medically necessary. If there is a discrepancy between this guideline and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and web site links are accurate at time of publication. EmblemHealth Services Company LLC, ("EmblemHealth") has adopted the herein policy in providing management, administrative and other services to HIP Health Plan of New York, HIP Insurance Company of New York, Group Health Incorporated and GHI HMO Select, related to health benefit plans offered by these entities. All of the aforementioned entities are affiliated companies under common control of EmblemHealth Inc.

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.

Related Medical Guideline

[Pain Management](#)

Guideline

Members with moderate to severe cervical 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. Low back (lumbar) or neck (cervical) pain is secondary to facet joint origin, as evidenced by the absence of nerve root compression and radicular pain.
2. Neuroradiologic studies do not confirm any disc herniation
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).
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.
5. No history of spinal fusion surgery in the vertebral level being treated.

Limitations/Exclusions

1. Emblem considers RFA in the thoracic spine to be experimental/investigational due to a lack of evidence supporting use of the procedure.
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 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:
 - \geq 6-month treatment lapse per level per side.
 - Achievement of \geq 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, will 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 annular repair (e.g., Inclose[™] Surgical Mesh System, Xclose[™] Tissue Repair System).
 - Endoscopic epidural adhesiolysis.
 - Epiduroscopy, epidural myeloscopy, epidural spinal endoscopy.
 - Intervertebral disc biacuplasty.
 - 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.

Revision History

November 13, 2015 — thoracic pain indication removed

Applicable Procedure Codes

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)

Applicable ICD-10 Diagnosis Codes

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
M54.81	Occipital neuralgia

References

- Carragee, E., Persistent Low Back Pain, *The New England Journal of Medicine*, Volume 352, No. 18, May 5, 2005.
- Chou, Roger. Subacute and chronic low back pain: Nonsurgical interventional treatment. In *UpToDate, Atlas*, Steve J (Ed), Waltham, MA, 2010.
- Diwan, A., and S. Khan, Chronic low back pain: issues and management, part I, *Orthopedic Clinics of North America*, Vol. 34, No. ix, 2003.
- Doleys, D., and B. Dinoff, Psychological aspects of interventional therapy, *Anesthesiology Clinics of North America*, Vol. 21, 767-783, 2003.
- Hayes Inc. Hayes Medical Technology Directory. Ablation for Chronic Low Back Pain. Lansdale, PA: Hayes, Inc.; August 2009.
- Hayes Inc. Hayes Medical Technology Directory. Radiofrequency Ablation for Cervical and Thoracic Back Pain. Lansdale, PA: Hayes, Inc.; October 2009.
- Helm S, Hayek SM, Benyamin R, Manchikanti L. Systematic review of the effectiveness of thermal annular procedures in treating discogenic low back pain. *Pain Physician* 2009; 12(1): 207-232
- Hooten, M., et al., Radiofrequency Neurotomy for Low Back Pain: Evidence-Based Procedural Guidelines, *Pain Medicine*, Vol. 6, No. 2, 2005.

J. Gossner : Radiofrequency denervation of the facet joints in chronic low back pain- a short review. *The Internet Journal of Radiology*. 2010 Volume 12 Number 1.

Lord S.M., et al. Percutaneous Radio-Frequency Neurotomy for Chronic Cervical Zygapophyseal-Joint Pain. *The New England Journal of Medicine* Vol. 335 No. 23, 1721-1726, December 5, 1996.

Mikeladze, G., et al., Pulsed radiofrequency application in treatment of chronic zygapophyseal joint pain, *The Spine Journal*, Vol. 3, Issue 5, September 2003.

Niemisto L, Kalso E, Malmivaara A, et al. Radiofrequency denervation for neck and back pain. A systemic review of randomized controlled trials (Cochrane Review) in: *The Cochrane Library*, Issue 1, 2003. Oxford: Update Software. Date of most recent substantive amendment: 5 April 2002.

Specialty-matched clinical peer review.

Spinal Pain: Evidence-Based Practice Guidelines, *Pain Physicians*, Vol. 8, No.1, 1-47, 2005.

Staats, P., Interventional pain management, *Anesthesiology Clinics of North America*, Vol. 21, Issue 4, Xiii-xiv, December 2003.

U.S. Department of Health and Human Services, National Center for Health Statistics, *Health, United States, 2005 With Chartbook on Trends in the Health of Americans*, 2005.