Radiofrequency Ablation for Spinal Pain

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 Health Insurance Plan of Greater New York and Group Health Incorporated, 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

Endoscopic and Percutaneous Lysis of Epidural Adhesions (RACZ Procedure) — Medicare

Pain Management

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.*
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.

* Facet pain may occur in association with radiculopathy and in the presence of herniated disc.
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 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:
   - ≥ 6-month treatment lapse per level per side.
   - 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, 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 anular 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 (covered for Medicare members only).
Radiofrequency Ablation for Spinal Pain
Last review: Mar. 8, 2019
Page 3 of 5

Revision History

<table>
<thead>
<tr>
<th>Date</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar. 8, 2019</td>
<td>Added coverage for thoracic pain</td>
</tr>
<tr>
<td>Oct. 12, 2018</td>
<td>Noted that facet pain may occur in association with radiculopathy and in the presence of herniated disc</td>
</tr>
<tr>
<td>Nov. 13, 2015</td>
<td>Thoracic pain indication removed</td>
</tr>
</tbody>
</table>

Applicable Procedure Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64633</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint</td>
</tr>
<tr>
<td>64634</td>
<td>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)</td>
</tr>
<tr>
<td>64635</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint</td>
</tr>
<tr>
<td>64636</td>
<td>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)</td>
</tr>
</tbody>
</table>

Applicable ICD-10 Diagnosis Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M12.88</td>
<td>Other specific arthropathies, not elsewhere classified, other specified site</td>
</tr>
<tr>
<td>M47.11</td>
<td>Other spondylosis with myelopathy, occipito-atlanto-axial region</td>
</tr>
<tr>
<td>M47.12</td>
<td>Other spondylosis with myelopathy, cervical region</td>
</tr>
<tr>
<td>M47.13</td>
<td>Other spondylosis with myelopathy, cervicothoracic region</td>
</tr>
<tr>
<td>M47.14</td>
<td>Other spondylosis with myelopathy, thoracic region</td>
</tr>
<tr>
<td>M47.15</td>
<td>Other spondylosis with myelopathy, thoracolumbar region</td>
</tr>
<tr>
<td>M47.16</td>
<td>Other spondylosis with myelopathy, lumbar region</td>
</tr>
<tr>
<td>M47.811</td>
<td>Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region</td>
</tr>
<tr>
<td>M47.812</td>
<td>Spondylosis without myelopathy or radiculopathy, cervical region</td>
</tr>
<tr>
<td>M47.813</td>
<td>Spondylosis without myelopathy or radiculopathy, cervicothoracic region</td>
</tr>
<tr>
<td>M47.814</td>
<td>Spondylosis without myelopathy or radiculopathy, thoracic region</td>
</tr>
<tr>
<td>M47.815</td>
<td>Spondylosis without myelopathy or radiculopathy, thoracolumbar region</td>
</tr>
<tr>
<td>M47.816</td>
<td>Spondylosis without myelopathy or radiculopathy, lumbar region</td>
</tr>
<tr>
<td>M47.817</td>
<td>Spondylosis without myelopathy or radiculopathy, lumbosacral region</td>
</tr>
<tr>
<td>M47.818</td>
<td>Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M53.0</td>
<td>Cervicocranial syndrome</td>
</tr>
<tr>
<td>M53.1</td>
<td>Cervicobrachial syndrome</td>
</tr>
</tbody>
</table>
Radiofrequency Ablation for Spinal Pain
Last review: Mar. 8, 2019
Page 4 of 5

References

Specialty-matched clinical peer review.

