I. Policy: Facet or Sacroiliac Joint Denervation

II. Purpose/Objective:
To provide a policy of coverage regarding Facet or Sacroiliac Joint Denervation

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION: Radiofrequency (RF) facet and/or sacroiliac joint denervation is a percutaneous procedure in which sensory afferent nerve fibers are selectively destroyed by heat produced by radio waves delivered through an electrode. The objective is to eliminate pain, reduce the likelihood of recurrence, and prolong the time to recurrence by selectively destroying pain fibers without inducing excessive sensory loss, motor dysfunction, or other complications. Pulsed radiofrequency (PRF, also known as cold RA) consists of short bursts of electrical current of high voltage in the radiofrequency range but without heating the tissue enough to cause coagulation. This allows the tissue to cool between bursts, resulting in considerably lower maximum temperatures, compared with the continuous mode, and reduces the risk of neighboring tissue destruction. Neurolytic facet and/or sacroiliac joint denervation involves the application of chemical and physical agents including but not limited to alcohol, phenol, glycerol, aminoglycocides, and hypertonic saline, to selectively destroy painful nociceptive pathways.

INDICATIONS: Requires Prior Authorization by a Plan Medical Director or Designee
The Plan considers facet joint denervation by radiofrequency energy or neurolytic agent (alcohol, phenol) medically necessary for members with intractable cervical or lumbar pain when ALL of the following criteria are met:

1. Organic etiology of pain based on history and physical exam, leading to a diagnosis of any of the following:
   a. Spinal enthesopathy
   b. Cervical spondylosis without myelopathy
   c. Thoracic spondylosis without myelopathy
   d. Lumbosacral spondylosis without myelopathy (Facet Arthropathy)
   e. Spondylosis with myelopathy, lumbar region
   f. Spondylosis of unspecified site without mention of myelopathy
   g. Cervical degenerative disc disease
   h. Thoracic degenerative disc disease
   i. Lumbar degenerative disc disease
   j. Intervertebral cervical disc disorder with myelopathy
   k. Intervertebral thoracic disc disorder with myelopathy
   l. Intervertebral lumbar disc disorder with myelopathy
   m. Postlaminectomy syndrome, cervical region
   n. Postlaminectomy syndrome, thoracic region
   o. Postlaminectomy syndrome, lumbar region
   p. Spinal stenosis, unspecified region other than cervical
   q. Spinal stenosis, of thoracic region
   r. Spinal stenosis of lumbar region
   s. Spinal stenosis, other region other than cervical
   t. Facet syndrome
   u. Acquired spondylolisthesis
   v. Spondyloysis, congenital
   w. Congenital spondylolisthesis

   and

2. Trial of facet joint injections has been successful in reducing pain level by at least 50% or greater; and
3. There is no history of prior posterior spinal fusion in the same area that is to undergo radiofrequency treatment

The Plan considers sacroiliac joint denervation by radiofrequency energy or neurolytic agent (alcohol, phenol) medically necessary for members with intractable SI joint pain when ALL of the following criteria are met:

1. Trial of SI joint injections has been successful in reducing pain level by at least 50% or greater; and
2. There is no history of prior spinal fusion in the same area that is to undergo radiofrequency treatment

LIMITATIONS:
If the patient has had prior facet and/or SI joint denervation, the procedure may be repeated once at the same level if at least 6 months has elapsed since the initial treatment and if the patient has at least 50% or greater reduction in pain level.

EXCLUSIONS:
The Plan does NOT provide coverage for facet and/or SI joint denervation by radiofrequency energy or neurolytic agent as a treatment for chronic cervical or lumbar pain when the above criteria are not met because it is considered experimental, investigational or unproven. There is insufficient evidence in the peer-reviewed published medical
literature to establish the effectiveness of this test on health outcomes when compared to established tests or technologies.

The Plan does **NOT** provide coverage for pulsed radiofrequency facet and/or SI joint denervation as a treatment for any indication because it is considered **experimental, investigational or unproven**. There is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established tests or technologies.

**Associated Key Words:** Joint Neurolysis, Joint Lesioning, Joint Neurotomy, Rhizotomy, Articular Rhizolyisis, Radiaodfrequency Thermoablation, Radiofrequency Ablation, Radiofrequency Thermoneurolysis, Radiofrequency Neurolysis)

**Note:** A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

**CODING ASSOCIATED WITH:** Facet or Sacroiliac Joint Denervation

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

- **64633** Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
- **64634** each additional facet joint
- **64635** Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
- **64636** each additional facet joint
- **64640** Destruction by neurolytic agent, other peripheral nerve or branch
- **77003** Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint), including neurolytic agent destruction
- **77012** Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation

**REFERENCES:**

- Hayes, INC. Radiofrequency ablation of cervical and thoracic back pain. Hayes Directory (online). Current as of10/26/09


This policy will be revised as necessary and reviewed no less than annually.

Devised: 12/11/09

Revised: 12/11; 8/14 (criteria change, limitations); 2/15 (criteria change, limitations); 6/16 (add SI joint)

Reviewed: 12/10, 12/12, 12/13, 1/16, 1/17, 1/18, 1/19