Policy Statement

Indications for Therapeutic Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis):

- Positive response to one or two controlled local anesthetic blocks of the facet joint nerves (medial branch blocks), with at least 70% pain relief and/or improved ability to function for a minimal duration at least equal to that of the local anesthetic, but with insufficient sustained relief (less than 2-3 months relief); AND a failure to respond to more active conservative non-operative management for a minimum of 6 weeks in the last 6 months unless the medical reason this treatment cannot be done is clearly documented (Manchikanti, 2013, 2009; Summers, 2013); OR
- Positive response to prior radiofrequency neurolysis procedures with at least 50% pain relief and/or improved ability to function for at least 4 months, and the patient is actively engaged in other forms of appropriate active conservative non-operative treatment (unless pain prevents the patient from participating in conservative therapy*) (Manchikanti, 2013; Qassem, 2017; Sculpo, 2001; Summers, 2013).
- The presence of ALL of the following:
  - Lack of evidence that the primary source of pain being treated is from discogenic pain, sacroiliac joint pain, disc herniation or radiculitis (Manchikanti, 2013, 2009);
  - Pain causing functional disability or an average pain level of ≥ 6 on a scale of 0 to 10 prior to each radiofrequency procedure including radiofrequency procedures done unilaterally on different days (Manchikanti, 2013, 2009; Summers, 2013);
  - Duration of pain of at least 3 months (Manchikanti, 2013; Summers, 2013);
  - Maximum of 3 unilateral facet joint procedures performed on same date of service (AHRQ, 2013).

Frequency:
Limit to 2 facet neurolysis procedures every 12 months, per region (Manchikanti, 2013).

NOTE: Unilateral radiofrequency denervations performed at the same level on the right vs left within 2 weeks of each other would be considered as one procedure toward the total number of radiofrequency procedures allowed per 12 months. Every radiofrequency procedure requires pre-authorization.

Contraindications for Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis):

- History of allergy to local anesthetics or other drugs potentially utilized;
- Lumbosacral radicular pain (dorsal root ganglion);
- Conditions/diagnosis for which procedure is used are other than those listed in Indications;
- Absence of positive diagnostic blocks; OR
- For any nerve other than the medial branch nerve.

Policy Guidelines

Therapeutic Paravertebral Facet Joint Denervation (Radiofrequency Neurolysis) – local anesthetic block followed by the passage of radiofrequency current to generate heat and coagulate the target medial branch nerve.

*Conservative Therapy: (Spine) should include a multimodality approach consisting of a combination of active and inactive components. Inactive components, such as rest, ice, heat, modified activities, medical devices, acupuncture and/or stimulators, medications, injections
(including trigger point), and diathermy can be utilized. Active modalities may consist of physical therapy, a physician supervised home exercise program**, and/or chiropractic care (Summers, 2013; Qassem, 2017).

**Home Exercise Program - (HEP) - the following two elements are required to meet guidelines for completion of conservative therapy:
- Documentation provided of an exercise prescription/plan (Qassem, 2017; Sculpo, 2001);
- Follow up with member with documentation provided regarding completion of HEP, (after suitable 6 week period) or inability to complete HEP due to physical reason - i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute “inability to complete” HEP).

Terminology: Paravertebral Facet Joint Denervation, Radiofrequency Neurolysis, Destruction Paravertebral Facet Joint Nerve, Facet Joint Rhizotomy, Facet Neurolysis, Medial Branch Radiofrequency Neurolysis, Medial Branch Radiofrequency Neurotomy or Radiofrequency Denervation.

Key Primary CPT Codes:
Cervical Thoracic Region
- 64633, +64634

Lumbar Sacral Region
- 64635, +64636

Description

Facet joints (also called zygapophysial joints or z-joints), posterior to the vertebral bodies in the spinal column and connecting the vertebral bodies to each other, are located at the junction of the inferior articular process of a more cephalad vertebra and the superior articular process of a more caudal vertebra. These joints provide stability and enable movement, allowing the spine to bend, twist, and extend in different directions. They also restrict hyperextension and hyperflexion.

Related Policies
- N/A

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status
- N/A
Rationale

Facet joints are clinically important spinal pain generators in patients with chronic spinal pain. Pain mediated by the facet joints may be caused by repetitive stress and/or cumulative low-level trauma resulting in osteoarthritis and inflammation. In patients with chronic low back pain, facet joints have been implicated as a cause of the pain in 15% to 45% of patients. They are considered as the cause of chronic spinal pain in 48% of patients with thoracic pain and 54% to 67% of patients with chronic neck pain. Facet joints may refer pain to adjacent structures, making the underlying diagnosis difficult as referred pain may assume a pseudoradicular pattern. Lumbar facet joints may refer pain to the back, buttocks, and proximal lower extremities while cervical facet joints may refer pain to the head, neck and shoulders.

Imaging findings are of little value in determining the source and location of ‘facet joint syndrome’, a term originally used by Ghormley and referring to back pain caused by pathology at the facet joints. Imaging studies may detect changes in facet joint architecture, but correlation between radiologic findings and symptoms is unreliable. Although clinical signs are also unsuitable for diagnosing facet joint-mediated pain, they may be of value in selecting patients for controlled local anesthetic blocks of either the medial branches or the facet joint itself. This is an established tool in diagnosing facet joint syndrome.

Facet joints are known to be a source of pain with definitive innervations. Interventions used in the treatment of patients with a confirmed diagnosis of facet joint pain include: medial branch nerve blocks in the lumbar, cervical and thoracic spine; and radiofrequency neurolysis (see additional terminology). The medial branch of the primary dorsal rami of the spinal nerves has been shown to be the primary innervations of facet joints. Substance P, a physiologically potent neuropeptide considered to play a role in the nociceptive transmission of nerve impulses, is found in the nerves within the facet joint.

Radiofrequency neurolysis is a minimally invasive treatment for cervical, thoracic and lumbar facet joint pain. It involves using energy in the radiofrequency range to cause necrosis of specific nerves (medial branches of the dorsal rami), preventing the neural transmission of pain. The objective of radiofrequency neurolysis is to both provide relief of pain and reduce the likelihood of recurrence.

Members of the American Society of Anesthesiologists (ASA) and the American Society of Regional Anesthesia and Pain Medicine (ASRA) have agreed that conventional or thermal radiofrequency ablation of the medial branch nerves to the facet joint should be performed for neck or low back pain. Radiofrequency neurolysis has been employed for over 30 years to treat facet joint pain. Prior to performing this procedure, shared decision-making between patient and physician must occur, and patient must understand the procedure and its potential risks and results.

Initial Clinical Reviewers (ICRs) and Physician Clinical Reviewers (PCRs) must be able to apply criteria based on individual needs and based on an assessment of the local delivery system.

References


**Documentation for Clinical Review**

**Please provide the following documentation (if/when requested):**

- History and physical and/or consultation notes including:
  - Diagnostic facet joint block (medial branch block) results
  - Prior conservative treatment(s) including duration and patient response(s)
  - Treatment plan
- Prior procedure(s) and dates
- Diagnostic radiological reports

**Post Service**

- Procedure report

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.
The following services may be considered medically necessary in certain instances and investigational in others. Services may be considered medically necessary when policy criteria are met. Services may be considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

<table>
<thead>
<tr>
<th>Type</th>
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<th>Description</th>
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<tbody>
<tr>
<td>CPT®</td>
<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>
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| HCPCS | None |
| ICD-10 Procedure | None |

**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
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<tbody>
<tr>
<td>01/01/2017</td>
<td>Adoption of National Imaging Associates (NIA) Clinical Guidelines</td>
<td>Medical Policy Committee</td>
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<tr>
<td>07/01/2018</td>
<td>NIA Clinical Guideline update</td>
<td>Administrative Review</td>
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**Definitions of Decision Determinations**

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.
**Prior Authorization Requirements (as applicable to your plan)**

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.