Medical Policy

Facet Denervation Treatments (Including Percutaneous, Non-Pulsed Radiofrequency)

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Version Number: 13  
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Product Applicability

<table>
<thead>
<tr>
<th>Well Sense Health Plan</th>
<th>Boston Medical Center HealthNet Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ New Hampshire Medicaid</td>
<td></td>
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<tr>
<td>□ NH Health Protection Program</td>
<td></td>
</tr>
<tr>
<td>□ MassHealth</td>
<td></td>
</tr>
<tr>
<td>□ Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
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<tr>
<td>□ Senior Care Options ◊</td>
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</tr>
</tbody>
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Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers percutaneous, non-pulsed radiofrequency facet denervation of the cervical facet joints or lumbar facet joints for chronic back pain or chronic neck pain to be medically necessary when Plan criteria are met. Plan prior authorization is required for all facet denervation treatments (including percutaneous, non-pulsed radiofrequency facet denervation). It will be determined during the Plan’s prior authorization process if the service is considered medically necessary for the requested indication. See the Plan policy, Medically Necessary (policy number OCA 3.14), for the product-specific definitions of medically necessary treatment. Review the Plan policy, Facet Joint Nerve Injections

Facet Denervation Treatments (Including Percutaneous, Non-Pulsed Radiofrequency)

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2 of 23 (policy number OCA 3.9641), for guidelines for facet joint nerve injections with a local anesthetic agent and/or steroids for pain management.

Various methods of facet denervation may be used for pain management, including radiofrequency (non-pulsed, pulsed, or cooled) denervation, chemical facet neurolysis, laser facet thermal ablation (also known as laser facet neurolysis), and cryodenervation. The Plan considers treatment with pulsed radiofrequency facet denervation/pulsed radiofrequency ablation, cooled radiofrequency facet ablation, laser facet neurolysis (laser facet thermal ablation), and/or cryodenervation to be experimental and investigational for any indication. The Plan considers the treatment with percutaneous, non-pulsed radiofrequency denervation to be experimental and investigational when used for the treatment of thoracic facet joint pain, sacroiliac joint pain, acute back pain, acute neck pain, and/or any other indication not specified in this Plan policy. See the Plan's policy, Experimental and Investigational Treatment (policy number OCA 3.12), for the product-specific definitions of experimental or investigational treatment.

**Description of Item or Service**

The Plan considers percutaneous, non-pulsed radiofrequency facet denervation to be medically necessary when Plan criteria are met (as specified in the Medical Policy Statement and Limitations sections of this policy). The other facet denervation treatments specified below are considered experimental and investigational.

**Chemical Facet Neurolysis:** The use of chemical facet injections with agents such as phenol, alcohol, and/or hypertonic saline has been proposed as an option for pain relief associated with facet disease. There is a lack of published scientific evidence to support the safety and efficacy of this technique. The Plan considers this treatment to be experimental and investigational. See the Plan policy, Facet Joint Nerve Injections (policy number OCA: 3.9641), for Plan medical criteria for injections in the facet joint with a local anesthetic agent and/or steroids for pain management.

**Laser Facet Neurolysis:** Also known as laser facet thermal ablation, laser facet neurolysis is a minimally invasive procedure intended to relieve pain caused by arthritis, damage, or other diseases of the facet joints of the spine. The procedure requires a local anesthetic and sedation and generally takes less than an hour to perform. A small incision is made over the painful facet joint and, under fluoroscopy, a small tube is inserted through which a thin wire is passed to locate the nerve causing the pain. The wire is removed and a small laser device is inserted in its place. The laser is used to debride the joint and deaden the nerve that innervates the joint. There is a lack of published scientific evidence to support the safety and efficacy of this technique. The Plan considers this treatment to be experimental and investigational.

**Percutaneous Cryodenervation:** Also known as cryoablation or cryoneurolysis, cryodenervation of the facet joint is a minimally invasive method used to treat pain associated with facet disease. Under local anesthesia a slim, luminated, double-walled cryodenervation probe, which is cooled by carbon dioxide, is brought to the location of pain to freeze the nerves and achieve a prolonged but reversible nerve

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conduction block. The published scientific evidence is insufficient to support the efficacy and safety of this procedure for the treatment of chronic pain associated with facet disease. The Plan considers this treatment to be experimental and investigational.

**Percutaneous Radiofrequency Facet Denervation:** Also known as radiofrequency neurolysis, radiofrequency ablation, facet neurotomy, facet rhizotomy, or articular rhizolysis, percutaneous radiofrequency facet denervation is a radiofrequency technique that uses electrodes introduced through the skin (using a local anesthetic and fluoroscopic guidance) to destroy selected nerve fibers to block pain transmission through the neural pathways. Types of radiofrequency facet denervation used to treat chronic neck pain and/or chronic back pain include non-pulsed radiofrequency facet denervation, pulsed radiofrequency facet denervation, and cooled radiofrequency ablation.

1. **Non-Pulsed Radiofrequency Facet Denervation/Conventional Radiofrequency Ablation (RFA):** During conventional RFA an electrode introduced through the skin delivers continuous heat (produced by radio waves) to the medial branch of the ganglion that innervates the targeted facet joint at temperatures of 70-90 degrees Celsius; the intent is to damage specific nerves and interfere with their ability to transmit pain signals. Conventional RF electrodes typically create smaller lesions that do not extend much past the tip. The goal of the treatment is long-term pain relief; however, the nerves regenerate and repeat procedures may be required. The Plan considers this treatment to be medically necessary when Plan criteria are met (as specified in the Medical Policy Statement and Limitations sections of this policy). Non-pulsed radiofrequency facet denervation is also known as conventional radiofrequency ablation.

2. **Pulsed Radiofrequency Facet Denervation/Pulsed Radiofrequency Ablation (RFA):** Pulsed RFA has been proposed as an alternative to conventional RFA, delivering intermittent bursts of heat-generated radiofrequency instead of continuous current. During pulsed radiofrequency, short bursts of high voltage electrical current are used at temperatures that do not exceed 42 degrees Celsius, thereby reducing the risk of destruction to neighboring tissue. This technique is proposed as a possibly safer approach to non-pulsed facet denervation because it does not heat the tissue enough to cause coagulation. Both pulsed RFA and cooled RFA enable larger lesions to be created as a treatment site than those with conventional RFA, which may address the issue of difficulty in locating lateral branch nerves required for conventional RFA. The published scientific evidence is insufficient to support the efficacy and safety of pulsed radiofrequency facet denervation for the treatment of chronic pain associated with facet disease. The Plan considers this treatment to be experimental and investigational for any indication.

3. **Cooled Radiofrequency Ablation (RFA):** Cooled RFA has been proposed as another alternative to conventional RFA. Both pulsed RFA and cooled RFA enable larger lesions to be created as a treatment site than those with conventional RFA, which may address the issue of difficulty in locating lateral branch nerves required for conventional RFA. Cooled RFA uses a cooling probe technology that allows for adjacent tissue to be cooled during the procedure rather than...
charring of tissues. Cooling is regulated by an attached computer. Internally cooled electrodes can create lesions 8 to 10 millimeters (mm) in diameter, with the depth extending distal to the electrode tip. During the cooled RFA procedure, power may be applied for longer periods of up to 150 seconds at 60 degrees Celsius or 75 degrees Celsius. An example of this technology includes but is not limited to the COOLIEF SINERGY Sacroiliac Cooled Radiofrequency System (by Halyard Health/formerly Kimberly-Clark Corp.).

Medical Policy Statement

Percutaneous, non-pulsed radiofrequency facet denervation of the cervical facet joints or lumbar facet joints for chronic pain is considered medically necessary when ALL of the following applicable criteria are met and documented in the member’s medical record, as specified below in items 1 through 11:

1. The member has experienced severe and disabling non-radicular back pain or neck pain for at least three (3) months; AND

2. The pain limits the member’s activities of daily living or causes functional disability; AND

3. The pain is suggestive of cervical facet joint origin or lumbar facet joint origin, as evidenced in the medical record by ALL of the following, as specified below in items a through c:

   a. History of primarily non-radicular or axial pain; axial pain is localized at the primary site but can vary in intensity and/or duration of symptoms; AND

   b. Physical examination shows positive provocative signs of facet disease for each spinal level to be treated with findings documented in the medical record; these signs include at least TWO (2) of the following four (4) criteria, as specified below in items (1) through (4):

      (1) Pain with palpation along the paravertebral regions and directly over the transverse processes; AND/OR

      (2) Pain that is increased with hyperextension or rotation of the lumbar spine; AND/OR

      (3) A positive facet loading test for facet joint; AND/OR

      (4) Origin of pain is located at a cervical facet joint or lumbar facet joint; AND

   c. Radiographic imaging that excludes other causes of lumbar pain or cervical pain prior to treatment with diagnostic spinal injections that confirm the presence of facet disease; AND

4. Absence of prior spinal fusion at each the clinically suspected levels; AND

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5. There is no objective physical exam or electrodiagnostic signs of radiculopathy from disc herniation or other spinal pathology in the region being treated as confirmed by ALL of the following, specified below in items a, b, and c:

a. Negative straight leg raise test when the member’s pain is suggestive of lumbar facet joint origin; this test used to diagnosis lumbar (or sacral) nerve root radiculopathy and does not apply to pain suggestive of a cervical facet joint origin; AND

b. No focal motor, sensory, or reflex abnormality; AND

c. When the member has pain that radiates below the knee and has an abnormal straight leg raise test or an abnormal neurological exam, at least ONE (1) of the following additional criteria is required, as specified below in item (1) or item (2):

   (1) No evidence of lumbosacral or cervical radiculopathy on electromyography (EMG)/nerve conduction study (Note: EMG/nerve conduction study is otherwise NOT required to meet Plan criteria); OR

   (2) MRI confirms no nerve root involvement; AND

6. The member’s symptoms have failed to respond to conservative treatment (including physical therapy), as defined below in BOTH item a and item b:

a. Conservative Treatment (Except Physical Therapy):

   The member’s symptoms have failed to respond to at least a three (3)-month course of documented conservative measures, including at least ONE (1) of the following, as specified below in items (1) through (4):

   (1) Activity modification; OR

   (2) Correction of postural abnormalities; OR

   (3) Pharmacotherapies (e.g., anti-inflammatories, analgesics, or muscle relaxants); OR

   (4) The treating physician, and/or treating licensed independent practitioner practicing within the scope of his/her license (i.e., nurse practitioner or physician assistant) has documented the member’s inability to undergo or tolerate the conservative treatment specified above in items (1) through (3), with member-specific information to support this determination; AND
b. Physical Therapy:

ONE (1) of the following criteria is met for physical therapy, as specified below in item (1) for failed clinical response to physical therapy or item (2) when the member is unable to tolerate physical therapy:

(1) Failed Clinical Response to Physical Therapy:

Within the last 24 calendar months of the prior authorization request, the treating physical therapist has documented BOTH of the following conditions in the member’s medical record, as specified below in item (a) and item (b):

(a) The member’s symptoms have failed to respond to six (6) weeks of physical therapy for the member’s condition (i.e., chronic neck pain or chronic back pain), with member-specific information to support this determination;† AND

† Note: The six (6) weeks of physical therapy may also be included as a component of the three (3)-month course of required conservative treatment specified above.

(b) No reduction in associated pain or only a minor reduction in pain with physical therapy, with member-specific information to support this determination; OR

(2) Inability to Tolerate Physical Therapy:

The treating physical therapist, treating physician, and/or treating licensed independent practitioner practicing within the scope of his/her license (i.e., nurse practitioner or physician assistant) has documented in the member’s medical record within the last 24 calendar months the member’s inability to physically tolerate physical therapy for this condition (including documentation of the member’s pain levels, member’s functional limitations due to the pain, member’s physical exam findings, and provider’s description of why the member was unable to tolerate physical therapy); AND

7. Diagnostic facet joint injections (either intraarticular facet injection/facet block or facet medial branch block per injection site) before percutaneous, non-pulsed radiofrequency facet denervation meet ONE (1) of the following applicable criteria, as specified below in item a or item b:
a. Required before the initial treatment and treatment intervals greater than 12 calendar months at the same affected site:

A trial of fluoroscopic-guided diagnostic facet joint injections with local anesthetic has been conducted before the initial treatment with percutaneous, non-pulsed radiofrequency facet denervation at an affected site or when it has been greater than 12 calendar months since the last radiofrequency treatment at the same affected site, and BOTH of the following criteria are met as specified below in items (1) and (2).

(1) Facet joint injection (either intraarticular facet injection/facet block or facet medial branch block per injection site) has been successful in reducing greater than 70% of the member’s pain (with each facet joint injection complying with Plan medical criteria specified in Plan policy, Facet Joint Nerve Injections, policy number OCA: 3.9641); AND

(2) The spinal section to be treated with radiofrequency has had a diagnostic facet joint injection within 12 calendar months of the treatment date; OR

b. Not required for repeat treatment within 12 calendar months at the same affected site:

A diagnostic facet block is not required for repeat radiofrequency at a previously treated site if it has been less than 12 calendar months since the last radiofrequency treatment; AND

8. Member will be treated with percutaneous, non-pulsed radiofrequency denervation for cervical facet joint pain or lumbar facet joint pain (and not thoracic facet joint pain or sacroiliac joint pain); AND

9. The treatment frequency, number of levels, and clinical results for percutaneous, non-pulsed radiofrequency facet denervation comply with ALL of the following guidelines, as specified below in items a, b, and c:

a. The treating provider must identify the level(s) that will be treated and may not exceed the following applicable criteria, as specified below in item (1), item (2), or item (3):

(1) With each bilateral treatment, no greater than two (2) levels bilaterally per treatment session per region (i.e., cervical region or lumbar region) for the initial treatment or repeat treatment; OR

(2) With each unilateral treatment, no greater than two (2) levels unilaterally per treatment session per region (i.e., cervical region or lumbar region) for the initial treatment or repeat treatment; OR
(3) With each session that includes both bilateral and unilateral treatment per region (i.e., cervical region or lumbar region), the criteria specified above in items (1) and (2) must be met for the initial treatment or repeat treatment; AND

b. Repeat non-pulsed, facet denervation procedures will be at intervals that meet BOTH of the following criteria, as specified below in items (1) and (2):

(1) The time period since the last treatment session is six (6) calendar months or longer for the same anatomic site (which is defined as the same side and the same spinal level); AND

(2) Frequency of treatment does not exceed a maximum of two (2) times (i.e., 2 treatment sessions) per a 12-month period, with the 12-month time frame beginning on the date of the first treatment; AND

c. The procedure had BOTH of the following results for the member with past non-pulsed radiofrequency treatment, as specified below in item (1) and item (2):

(1) Greater than 50% relief is obtained for at least 12 weeks following the previous treatment (including after the first non-pulsed radiofrequency treatment); AND

(2) Ability to perform previously painful movement without deterioration of the pain relief; AND

10. Treatment is provided as part of a comprehensive pain management program, and the pain management program includes ALL of the following components, as specified below in items a through d:

a. An individualized treatment plan has been developed for the member by a treating provider; AND

b. As part of the treatment plan, the treating provider reviews previous and current services and documents in the medical record a physical exam (when appropriate); AND

c. The treating provider evaluates results of treatment and documents the member’s pain condition, duration of clinical response, and functional improvement in activities, including at least ONE (1) of the following criteria, as specified in items (1) through (5):

(1) Increased social activities; OR

(2) Decreased need for pain medication; OR

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(3) Performing activities of daily living; OR

(4) Returning to work; OR

(5) Sleeping; AND

d. The treating provider coordinates a medically necessary service or treatment (as defined in the Plan’s Medically Necessary policy, policy number OCA: 3.14) to maximize physical functioning for the member, while complying with the Plan’s prior authorization guidelines; AND

11. The member is 21 years of age or older on the date of service.

Limitations

1. Contraindications to percutaneous, non-pulsed radiofrequency facet denervation include at least ONE (1) of the following, as specified below in items a though e:

   a. Definitive clinical and/or imaging findings; OR

   b. Neurologic abnormalities caused by cauda equine syndrome, sepsis, or lesions of the spinal cord such as myelopathies, demyelination, or spinal cord injuries; OR

   c. Proven specific causes of low back pain, including discogenic pain, herniation, grade 3-4 spondylolisthesis, spondylosis, spinal stenosis, clinical radiculopathy, radiculitis, multiple sclerosis, coagulation disorders, pregnancy, malignancy, infection, and trauma; OR

   d. Allergy to local anesthetics and/or steroids used with facet injections to confirm the presence of facet disease; OR

   e. Lack of response to diagnostic nerve blocks

2. Any ONE (1) of the following indications for percutaneous, non-pulsed radiofrequency is considered experimental and investigational, as specified below in items a through g:

   a. Percutaneous, non-pulsed radiofrequency facet denervation procedures in areas other than facet joints; OR

   b. Percutaneous, non-pulsed radiofrequency denervation for sacroiliac joint pain; OR
c. Percutaneous, non-pulsed radiofrequency facet denervation for the treatment of thoracic facet joint pain; OR

d. Percutaneous, non-pulsed radiofrequency facet denervation treatment for the management of other chronic pain syndromes such as trigeminal neuralgia or post-laminectomy syndrome; OR

e. When the member has exceeded the maximum allowable number of percutaneous, non-pulsed radiofrequency treatments specified in this Plan policy; OR

f. Percutaneous, non-pulsed radiofrequency treatment without guided imaging (i.e., blinded); OR

g. Percutaneous, non-pulsed radiofrequency treatment for a member less than 21 years old.

3. Pulsed radiofrequency facet denervation/pulsed radiofrequency ablation, cooled radiofrequency ablation, chemical facet neurolysis, laser facet neurolysis, and/or percutaneous cryodenervation for any indication are considered experimental and investigational.


**Definitions**

**Denervation:** Interruption of the nerve connection to an organ or area of the body to temporarily or permanently block nerve pathways to relieve pain or spasticity by using heat, cutting, or a chemical.

**Facet Joint:** Also known as paravertebral facet joints, zygapophysial joints, or Z-joints, facet joints are pairs of small are joints that are situated between the interlocking bones at each vertebral level of the spine, allowing the spine to flex while maintaining its stability. Facet joints are named for the vertebrae they connect and the side of the spine where they are found. There are two facet joints at every level of the vertebral column, except at the top level of the cervical spine. Facet joints are encased with facet joint capsules which contain synovial fluid that protects and lubricates the joints. When functioning correctly, facet joints move freely controlling the movement of the spine. Facet joint pain may arise directly from the facet joint either from inflammation or nerve impingement (which must be ruled out with diagnostic testing). When facet joints become worn or torn, the cartilage may become thin or disappear and there may be a reaction of the bone of the joint underneath, producing overgrowth of bone spurs and an enlargement of the joints. The facet joints are thought to be a common source of chronic neck pain and/or chronic back pain. For lumbar facet joints, the symptoms often include low back pain, radiating pain down the back of the buttocks and upper thighs, and increased pain while standing or bending backward. For cervical facet joints, the
symptoms include neck pain, radiating pain across the neck and shoulders, and worsening symptoms with turning the head from side to side or looking up.

**Facet Joint Innervation:** Facet joints have a nerve supply from two levels, one branch arises from the nerve root/medial branch at that facet joint level and the second from the facet joint level above. For example, when considering the L4–L5 facet joint, innervation is supplied by the medial branches originating from the L3 and L4 nerves. The dorsal primary ramus (major terminal branch of all 31 pairs of mixed spinal nerves) loops posteriorly and splits into a lateral branch, intermediate branch, and a medial branch. It is this medial branch of the dorsal primary ramus that supplies the sensation for the facet joints. (Note: The L5 medical branch cannot be anesthetized, so the targeted nerve is the L5 dorsal ramus for the diagnosis or treatment of facet pain.) Practitioners should take care when referring to a segment to identify if the provider is referring to the joint or to the nerves that innervate that joint.

**Facet Loading Test:** A physical exam and analysis of a patient's symptoms used by a physician/provider to help identify the facets that will be subjected to diagnostic blocks. Clinical findings such as tenderness to palpation over the facet joint and the cutaneous distribution of pain help identify the facet joint to be injected. For cervical facet joints, there are distinctive segmental pain patterns, with some overlap between these patterns and those for cervical discogenic pain. If the patient has marked tenderness to palpation of a particular facet joint or if pain increases with motion or loading of the joint, trial blockade of the joint may be considered. Acute sinovitis may present as posterior focal discrete pain, easily identifiable by palpation and axial loading, and referral pattern. Facet injections (either intraarticular facet injections/facet blocks or facet medial branch blocks) can play a role in precisely localizing the source of pain.

**Facet Medial Branch Block:** A type of facet injection where a strong local anesthetic is injected on or near the medial branch nerves that supply the targeted facet joint(s) to temporarily interrupt the pain signal being carried from a specific facet joint. If pain is relieved with treatment according to established guidelines, a diagnosis of facet joint(s) pain may be made. No steroid is administered with a medical branch block.

**Facet Medial Branch Nerves:** Small nerves that carry pain signals from the facet joints in the spine to the brain.

**Neurolysis:** Destruction of nervous tissue to temporarily or permanently block nerve pathways to relieve pain or spasticity.

**Radiculopathy:** A condition in which one (1) or more nerve roots are compressed, which adversely affects their function and causes them to not work properly. A radiculopathy can manifest with some or all of the following symptoms and signs: radiating extremity pain in a dermatomal distribution, focal motor level weakness, focal sensory level numbness, difficulty controlling specific muscles, and/or reflex abnormalities. When a radiculopathy exists, the problem occurs at or near the nerve root;

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however, pain or other symptoms often radiate to the part of the body served by that nerve. For example, a nerve root impingement in the neck can produce pain and weakness in the forearm. Likewise, a compressed nerve in the lower back or lumbar-sacral spine can be manifested with symptoms in the foot. Radiculopathy may also present in an extremity through a process called referred pain, where pain is felt in the affected extremity, as opposed to the spine.

**Straight Leg Raise Test:** The classical straight leg raise test is performed with the patient lying supine with the legs fully extended. In the patient with lower back pain, the leg with pain is the one being evaluated. The examiner places one hand under the ankle of the affected leg and the other hand on the knee, and then lifts the ankle and flexes the hip/thigh relative to the pelvis. The nerve roots are not brought to tension and stretched by the straight leg raise until 35 to 70 degrees of angulation have been reached at the hip/thigh. The test is considered positive if pain is reproduced or increased in the lower back or leg. Since the straight leg raise is not completely sensitive or specific to radiculopathy, further testing must be pursued to define the nature of the irritation if the straight leg raise is ever positive.

**Applicable Coding**

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Because the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

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### CPT Codes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description: Codes Covered When Medically Necessary</th>
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<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>
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<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>
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<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>
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### Clinical Background Information

Disorders of the facet joints often contribute to chronic neck pain and/or chronic back pain. By blocking the nerve to a cervical facet joint (for chronic neck pain) or a lumbar facet joint (for chronic back pain), the pain impulses can be interrupted. Generally, facet nerve blocks are performed as part of a work-up for chronic back pain or chronic neck pain. Confirmation that the facet joint is the source of pain is obtained if the block is successful in pain relief. A trial of facet nerve block injections is important prior to attempts at radiofrequency facet denervation procedures. Percutaneous, non-pulsed radiofrequency facet denervation is used to block cervical or lumbar pain transmission through the neural pathways. There is insufficient scientific evidence to determine the safety, effectiveness, and/or impact on health outcomes or patient management of percutaneous radiofrequency facet denervation for the treatment of thoracic back pain or sacroiliac joint pain.

Percutaneous, non-pulsed radiofrequency facet denervation procedures involve the selective destruction of sensory nerve fibers by heat produced by radio waves through an electrode. The objectives of treatment are to eliminate pain and reduce the likelihood of pain recurrence without adjacent motor dysfunction or other complications. Radiofrequency systems include a generator and electrodes for nerve stimulation and thermocoagulation. Typically the procedure is done in an outpatient setting. A local anesthetic is injected into the region prior to the procedure and light sedation may be used. The patient is placed in a prone position, and needles are introduced and positioned at the target area using fluoroscopic or computed tomography (CT) guidance. Continuous (non-pulsed) radiofrequency energy is targeted to the nerves using an electrode for 40 to 90 seconds at a temperature of 70-90 degrees Celsius. After the electrode is withdrawn, a small sterile dressing is applied to the site. The patient may ambulate immediately and is discharged the same day. Analgesics and anti-inflammatory medications are prescribed to ease discomfort from the denervation procedure. Side effects are rare and are usually mild and transient. The most common complications are discomfort at the operative site, transient burning pain, slight sensory loss, numbness, ataxia, infection, and local hypersensitivity. Outcomes are determined in terms of subjective ratings of pain.

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relief, percentage change in pain, or changes in pain scores on a visual analog scale or a numerical rating scale.

At the time of the Plan’s most recent policy review, no clinical guidelines were found from the Centers for Medicare & Medicaid Services (CMS) for facet denervation (including percutaneous, non-pulsed radiofrequency). Determine if applicable CMS criteria are in effect for these services in a national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request for a Senior Care Options member.

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17 of 23


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<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulatory Approval: N/A</td>
<td>08/12/07 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>MPCTAC, QIC, and Utilization Management Committee (UMC)</td>
</tr>
</tbody>
</table>

*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13
*Effective Date for Senior Care Options Product(s): 01/01/16

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Facet Denervation Treatments (Including Percutaneous, Non-Pulsed Radiofrequency)

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>06/10/08</td>
<td>Updated clinical criteria to clarify that the procedure is medically appropriate for patients with facet joint pain and included criteria for additional facet denervation procedures. These changes are effective 11/01/08.</td>
<td>11/01/08 Version 2</td>
<td>06/10/08: MPCTAC 06/24/08: UMC 08/13/08: QIC</td>
</tr>
<tr>
<td>06/23/09</td>
<td>Changed policy name, replaced the criteria for radiological findings negative for disc herniation and nerve root compression with: negative physical signs of radiculopathy or radicular pain, including negative straight leg raising or root tension signs, normal neurological examination, absence of signs of radiculopathy on any electrodiagnostic examinations; updated references. The effective date of changes is 10/01/09.</td>
<td>10/01/09 Version 3</td>
<td>06/23/09: MPCTAC 06/23/09: UMC 07/22/09: QIC</td>
</tr>
<tr>
<td>06/01/10</td>
<td>Updated references. No changes to criteria.</td>
<td>Version 4</td>
<td>06/30/10: MPCTAC 07/28/10: QIC</td>
</tr>
<tr>
<td>06/01/11</td>
<td>Updated references, updated clinical criteria to clarify that the absence of prior spinal fusion and radiculopathy must be at the clinically suspect levels, changed the criteria to allow repeat treatments every six months to a maximum of two times per year per side per level. Updated the limitations section to include that pulsed radiofrequency, chemical neurolysis and laser facet neurolysis are considered experimental and investigational.</td>
<td>Version 5</td>
<td>06/29/11: MPCTAC 07/27/11: QIC</td>
</tr>
<tr>
<td>07/01/12</td>
<td>References updated and language</td>
<td>Version 6</td>
<td>06/20/12: MPCTAC</td>
</tr>
<tr>
<td>Policy Revisions History</td>
<td></td>
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<tr>
<td>added as an introductory paragraph in Applicable Coding section. Updated clinical criteria. Added definitions for radiculopathy and straight leg raise test. Added symptoms of axial pain and signs of facet disease. Added symptoms of axial pain and signs of facet disease. Added definition of a comprehensive pain management program and referenced the Plan’s Medically Necessary policy.</td>
<td>07/18/12: MPCTAC 08/22/12: QIC</td>
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<tr>
<td>08/13/12</td>
<td>08/13/12: MPCTAC 09/06/12: QIC</td>
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<td></td>
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<tr>
<td>02/01/13</td>
<td>02/20/13: MPCTAC 03/21/13: QIC</td>
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<td></td>
</tr>
<tr>
<td>Updated language in Summary section. Reformatted and added clinical criteria in the Medical Policy Statement section (formerly named the Clinical Guideline Statement), updated references. Changed name of policy category from “Clinical Coverage Guidelines” to “Medical Policy.” Revised policy title: added “percutaneous” to identify the type of radiofrequency denervation and added “chronic neck pain.”</td>
<td>02/01/13 (as specified above) for the Well Sense Health Plan product; these policy revisions were approved by MPCTAC on 02/20/13 and QIC on 03/21/13 for applicable Plan products.</td>
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</tr>
<tr>
<td>08/14/13 and 08/15/13</td>
<td>08/14/13: MPCTAC (electronic vote) 08/15/13: QIC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review for effective date 07/01/14. Changed policy title from Percutaneous Radiofrequency Facet Denervation for Chronic Back Pain and Chronic Neck Pain to Facet Denervation (Including Percutaneous, Non-Pulsed Radiofrequency). Revised Summary, Description of Item or Service, Definitions, Clinical Background Information, and References sections. Revised criteria in the Medical Policy</td>
<td>07/01/14: MPCTAC 04/16/14: QIC</td>
<td></td>
<td></td>
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<tr>
<td>03/01/14</td>
<td>03/19/14: MPCTAC</td>
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</tbody>
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### Policy Revisions History

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Effective Date</th>
<th>Reviewing Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/01/15</td>
<td>Revised criteria in the Medical Policy Statement section. Updated references. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available.</td>
<td>06/01/15</td>
<td>02/27/15: MPCTAC (electronic vote) 03/11/15: QIC</td>
</tr>
<tr>
<td>11/25/15</td>
<td>Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.</td>
<td>01/01/16</td>
<td>11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC</td>
</tr>
<tr>
<td>02/01/16</td>
<td>Review for effective date 06/01/16. Updated criteria in the Medical Policy Statement section. Updated Summary, Description of Item or Service, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.</td>
<td>06/01/16</td>
<td>02/17/16: MPCTAC 03/09/16: QIC</td>
</tr>
</tbody>
</table>

### Last Review Date

02/01/16

### Next Review Date

02/01/17

### Authorizing Entity

QIC

### Other Applicable Policies

- Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12
- Medical Policy - *Facet Joint Nerve Injections*, policy number OCA 3.9641
- Medical Policy - *Medically Necessary*, policy number OCA 3.14
- Medical Policy - *Sacroiliac Joint Injections*, policy number OCA: 3.9642

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22 of 23
Reference to Applicable Laws and Regulations


Disclaimer Information: +

Medical Policies are the Plan’s guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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