NO. 91647-R1

NEUROABLATION FOR PAIN MANAGEMENT

Effective date: 03/01/2026 **Last reviewed**: 02/2026

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Policy scope: This policy defines coverage, limitations, and medical necessity criteria for neuroablative procedures intended for pain management, including radiofrequency ablation (conventional), intraosseous basivertebral nerve ablation, pulsed and cooled radiofrequency techniques, and cryoneurolysis.

Related policies:

- Osteoarthritis of the Knee # 91571
- Spine Procedures # 91581

SUMMARY OF CHANGES – R1

Additions:

- New Policy Scope section
- New FDA/Regulatory section
- New Medical/Professional Society Guidelines section
- New Government Regulations section listing applicable CMS NCDs or LCDs

Clarifications:

- Updated background and references

I. MEDICAL NECESSITY CRITERIA

A. Due to insufficient evidence of impact on long-term health outcomes the following procedures are considered experimental/investigational and/or not medically necessary:
    1. Cooled radiofrequency ablation (e.g., Coolief) for all indications.
    2. Pulsed radiofrequency ablation for all indications.
    3. Cryoneurolysis (e.g., iovera) for all indications.

B. Radiofrequency Ablation (RFA) for Back Pain
    1. RFA, defined as conventional non-pulsed radiofrequency devices generating temperatures ranging from 60 °C to 90 °C, targeting pain originating in the cervical, thoracic, or lumbar spinal regions is medically necessary under the following conditions:
        a. Patient's symptoms are not consistent with identifiable pathology including disc herniation, spondylolisthesis, spinal stenosis
        b. Absence of any neurologic deficit.
        c. Back or neck pain predominates over leg pain or arm pain, respectively.
        d. Two diagnostic medial branch nerve blocks, provided under a standard protocol that alternates long- and short-acting anesthetic blocks, produce > 50% symptom relief physiologically consistent with medial nerve branch pathology

    2. RFA is considered experimental/investigational and/or not medically necessary for the following:
        a. RFA of the sacroiliac (SI) joint.
        b. RFA of the sacral nerve.

    3. Intraosseous Basivertebral Radiofrequency Nerve Ablation (e.g., Intracept System) is medically necessary when all the following are met:
        a. Ablation of basivertebral nerves of the L3 through S1 vertebrae; and;
        b. Chronic low back pain of at least six months duration that has not responded to at least six months of conservative care; and
        c. MRI evidence consistent with Type 1 or Type 2 Modic changes; and;
        d. None of the contraindications listed below:
            i. Severe cardiac or pulmonary compromise.
            ii. The targeted ablation zone is less 10 mm away from a sensitive structure not intended to be ablated, including the vertebral foramen (spinal canal).
            iii. Active systemic infection or local infection in the area to be treated.
            iv. Currently pregnant.
            v. Skeletally immature patients (generally < 18 years of age)
            vi. Has implantable pulse generators (e.g., pacemakers, defibrillators) or other electronic implants.

    4. RFA procedure consists of one or more ablations during a single visit.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
None identified	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	None identified
First Coast Service Options, Inc.	None identified
National Government Services, Inc.	None identified
Noridian Healthcare Solutions	None identified
Novitas Solutions, Inc.	None identified
Palmetto GBA	None identified
WPS Insurance Corporation	None identified

III. BACKGROUND

Neuroablative techniques in pain management consist of surgical and nonsurgical procedures to denervate a nerve such as radiofrequency ablation (conventional, cooled, or pulsed), cryosurgery (cryoablation or cryoneurolysis), or chemical ablation. The goal of denervation is to interrupt the pain signals that are sent to the brain from the joints and nerves.

Radiofrequency Ablation
Radiofrequency Ablation (RFA), also referred to as radiofrequency neurotomy or radiofrequency denervation, delivers high-frequency electric current to cause thermal damage with the intent to modulate the transmission of pain signals. For the purposes of this policy, RFA refers to conventional non-pulsed radiofrequency devices which generate temperature ranging from 60 °C to 90 °C to the target nerve. The RFA electrode generates radiofrequency energy that results in friction from the movement of ions generating heat of approximately 80 °C that causes destruction of target nerves. Charring of surrounding tissue at the electrode interface is a key limitation of standard RFA (Kapural and Deering, 2020). The effects of RFA in general are temporary and generally limited since pain signal transmission will return with peripheral nerve regrowth and regeneration (Choi et al., 2016; Gupta et al., 2017). Prior to RFA, a diagnostic block to confirm the source and level pain is conducted to predict the potential level of pain

relief. The block consists of an injection of a local anesthetic near the area of pain. If the diagnostic block provides significant relief, the RFA procedure may move forward.

For the treatment of chronic back pain originating from sacroiliac joint (SIJ), RFA procedures typically target the areas adjacent to the lumbar L5 dorsal ramus and its branches, as well as the lateral branches of the sacral S1 through S3 dorsal rami (Hayes, 2022). For SIJ denervation, there is a lack of consensus regarding the exact innervation of the joint and the contributions of the various nerves. The anatomy of the SIJ is variable between patients and can even differ from one side to the other within the same person (Roberts et al., 2014). Substantial heterogeneity in RFA treatment characteristics exists across studies (Cheng, 2013; Salman, 2016; Vanaclocha, 2018). The reduction in SIJ pain provided by conventional RFA is likely to last up to 6 months, but it is uncertain whether there is a longer durability of effect. Additionally, it is uncertain whether conventional RFA is associated with change in pain medication use or with improvement in disability/function or QOL.

A systematic review of 25 studies (Matthews et al., 2019) found limited high quality evidence for nonsurgical treatments for Morton's neuroma, a painful compressive neuropathy of the common plantar digital nerve. Corticosteroid injections and manipulation/mobilization have the strongest support, offering modest short term pain relief. Other modalities—alcohol sclerosing injections, radiofrequency ablation, and cryoneurolysis—show promising but very low quality evidence. Overall, conservative care is reasonable first line, but high quality RCTs are still needed to guide treatment selection. The Association of Extremity Nerve Surgeons (2023), does not recommend ablation in the primary treatment of intermetatarsal nerve entrapment (Morton's Neuroma).

Newer types of RFA devices were designed to function at lower temperatures and are less destructive to neuronal tissue. These include pulsed radiofrequency (PRF), which operates at 42 °C, and cooled RFA, which operates at 60 °C. PRF involves short, high-voltage bursts at a frequency of 2 Hertz (Hz) (2 pulses per second) that are separated by rest periods (e.g., 480 msec) that allow tissues to cool down, thereby minimizing tissue damage. The mechanism of action of PRF in pain relief is uncertain, but it may be related to effects of PRF on the electrical fields (Choi et al., 2016; Gupta et al., 2017; Cohen and Soriano, 2018; Kucia et al., 2019). Uncertainty remains surrounding the use of PRF due to the lack of standardization in procedural techniques, and there are currently no established treatment guidelines that recommend the use of PRF for chronic shoulder pain (Kucia et al., 2019; Eckmann et al., 2021). Pudendal neuralgia is a condition characterized by perineal pain resulting from pudendal nerve damage. According to the 2024 European Association of Urology (EAU) Chronic Pelvic Pain Guidelines, pulsed radiofrequency lesioning is an emerging treatment with early evidence suggesting possible benefit. However, current studies include only short-term follow-up, and the guideline emphasizes that additional research is needed before its role in routine management can be established.

Cooled Radiofrequency Ablation (e.g., Coolief)

The cooled RFA (CRFA) technique circulates water internally through the probe that administers the electrical current, which removes heat and keeps the temperature at approximately 60 °C (Gupta et al., 2017; Oladeji and Cook, 2019). CRFA is intended to deliver more energy to target tissues in a larger ablative area (Kapural and Deering, 2020). The Coolief Cooled RF system (Avanos Medical Inc.) is an RFA system designed for the administration of CRFA. The Coolief system consists of a four-foot connecting

cable and tubing, generator, and peristaltic pump unit. A thermocouple in the probe measures the electrode temperature throughout the procedure. A radiopaque marker located at the proximal end can be viewed under fluoroscopy to confirm position. A small current of radiofrequency is transmitted by a radiofrequency generator via an insulated electrode placed within tissue. The friction of charged molecules produces ionic heating that deactivates nerves that send pain signals to the brain. The moving fluid removes heat from where the tip and tissue interface, and large spherical lesions are created (Coolief Cooled RF System).

Coolief is cleared for marketing by the U.S. Food and Drug Administration (FDA) for knee pain and is used off-label at all other sites, including the hip. For the treatment of pain associated with knee osteoarthritis, studies generally demonstrated a reduction in pain from baseline up to 6 months, the clinical significance of this reduction was not consistently demonstrated. In addition, the lack of comparison with other minimally invasive techniques limits conclusions that can be drawn. CRFA generally resulted in a statistically significant reduction in pain with 50% to 77% of patients reporting a clinically significant reduction in pain at 6 months in 2 studies and 37% to 74% of patients achieving at least a 50% improvement in pain at 6 months in 4 studies (Davis et al., 2018; McCormick et al., 2018; Davis et al., 2019; Hunter et al., 2019; Kapural et al., 2019). However, proportions of patients achieving a 50% reduction in pain at longer follow-up were reduced substantially (Davis et al., 2019; Hunter et al., 2019). One study evaluated the effect of CRFA prior to total knee arthroplasty (TKA) on post-surgical outcomes. No statistically significant differences were noted in pain reduction, functional outcomes, or medication use in the immediate postoperative phase and at 6 months between patients who underwent CRFA compared with patients who underwent sham prior to TKA.

A prospective randomized comparative trial evaluated cooled lumbar medial branch radiofrequency ablation (C LRFA) versus facet joint steroid injections (FJI) in patients with dual medial branch block–confirmed facet-mediated pain. Thirty-two participants were randomized (C LRFA n=20; FJI n=12) and followed at 1, 3, 6, and 12 months. The primary outcome—≥50% improvement in the numerical pain rating scale (NPRS) at 3 months—was achieved far more often with C LRFA, with responder rates of 70%, 55%, and 45% at 3, 6, and 12 months compared with 25%, 25%, and 17% in the FJI group; the 3-month difference was statistically significant ($P = .014$). Patient Global Impression of Change scores similarly favored C LRFA at 3 and 6 months ($P < .05$). The authors concluded that C LRFA provided superior pain and functional outcomes relative to FJI. The study faced several key limitations, including the absence of participant blinding and a small sample size. Blinding was not possible because C LRFA and FJI had different billing requirements, making blinded procedures financially infeasible. Insurance authorization changes also resulted in frequent FJI denials, contributing to dropout and influencing crossover behavior, as no participants moved from C LRFA to FJI. Because participants were unblinded, some may have viewed C LRFA as the superior option, further reducing interest in FJI. The trial was underpowered, enrolling only 32 of the planned 120 participants out of more than 1,100 screened, after insurer coverage changes halted balanced randomization. Additionally, strict inclusion criteria—requiring dual MBBs with high pain-relief thresholds and excluding mixed pain sources—limit generalizability to patients with clearly dominant facet-mediated pain (McCormick et al., 2023).

In a multicenter randomized comparative effectiveness study of 210 patients with suspected sacroiliac joint (SIJ) pain responsive to diagnostic injections and prognostic lateral branch blocks, cooled radiofrequency ablation (CRFA) was compared with standard medical management (SMM). At 3 months, CRFA produced significantly greater improvements in pain, with mean NRS scores of 3.8 ± 2.4 (mean reduction 2.5 ± 2.5) versus 5.9 ± 1.7 (mean reduction 0.4 ± 1.7) in the SMM group ($p < 0.0001$). Additionally, 52.3% of CRFA patients achieved ≥2-point or ≥30% pain relief compared with 4.3% in SMM ($p < 0.0001$). Disability and quality-of-life outcomes similarly favored CRFA, with greater reductions in Oswestry Disability Index scores (29.7 ± 15.2 vs 41.5 ± 13.6; $p < 0.0001$) and higher EuroQoL-5D values (0.68 ± 0.22 vs 0.47 ± 0.29; $p < 0.0001$). Study limitations included the inability to blind participants, variability in prior treatments among SMM patients, insurance-related barriers that may have influenced expectations, the potential impact of coexisting low back pain generators, and limited generalizability due to the flexible, real-world SMM control arm (Cohen et al., 2024).

In a multicenter randomized study of 210 patients with injection-confirmed SIJ pain who responded to prognostic lateral branch blocks, participants were assigned to cooled radiofrequency ablation (CRFA) or standard medical management (SMM), with 12-month follow-up and an option for SMM participants to cross over to CRFA at 3 months. At 12 months, CRFA produced sustained improvement, with mean pain scores decreasing from 6.4 ± 1.4 to 3.5 ± 2.6 in the randomized cohort and 6.1 ± 1.5 to 3.4 ± 2.5 in the crossover group. Responder rates (≥2-point or ≥30% pain reduction with PGIC ≥ 5) were 57.4% and 55.6%, respectively. Quality-of-life and functional outcomes improved meaningfully, with EuroQoL-5D-5L increases of +0.22 and +0.21, and Oswestry Disability Index reductions of 12.4% and 13.7%, and no serious CRFA-related adverse events. Overall, the findings support durable, clinically meaningful benefit of CRFA in refractory SIJ pain. Limitations included lack of participant blinding, prior treatment failures within the SMM group, absence of a control arm beyond 3 months, and potential confounding from coexisting low back pain generators. Additional factors—such as less specific block criteria, variability in SIJ pain sources, remote COVID-19 era follow-up, and long symptom duration—may have influenced non-response. (Cohen et al., 2025).

The Intracept® Intraosseous Nerve Ablation System

The Intracept® Intraosseous Nerve Ablation System (Relievant Medsystems) uses radiofrequency ablation to interrupt the nerve pathway of the basivertebral nerves (BVN) of the L3 through S1 vertebrae, leading to relief of associated pain. Under fluoroscopic guidance, a cannula is advanced through the pedicle. The cannula is utilized to create a channel to the trunk of the basivertebral nerve. Then a radiofrequency probe is inserted into the curved path and placed at the basivertebral nerve. Finally, a radiofrequency generator is utilized to ablate the basivertebral nerve. The Intracept System is intended for the relief of chronic low back pain of at least six months duration that has not responded to at least six months of conservative nonsurgical care, and is also accompanied by features consistent with Type 1 such as inflammation, edema, vertebral endplate changes, disruption and fissuring of the endplate, vascularized fibrous tissues within the adjacent marrow, hypointensive signals, or Type 2 Modic changes to the vertebral body marrow including replacement of normal bone marrow by fat, and hyperintensive signals on an MRI. Evidence in the peer-reviewed literature include two randomized control trials, and retrospective and prospective case series evaluating the Intracept system for treatment of chronic low back pain. Fischgrund (2018; 2019)

compared Intracept treatment to sham treatment and Khalil (2019) compared it to usual care. Fischgrund et al (2018) published a double-blind, a sham-controlled RCT evaluating the safety and efficacy of the Intracept system and RF ablation of the BVN for the treatment of chronic low back pain. A total of 225 participants with chronic (≥ 6 months) isolated lumbar pain who had not responded to at least 6 months of non-operative management were randomized to either a sham (n=78) or treatment (n=147) intervention. In the active treatment group, the RF probe was activated and the temperature at the tip was maintained at 85°C for 15 minutes. The duration of the session in the sham group was the same but the RF treatment was only simulated. Study participants had a minimum ODI of 30 points (on 100 point scale) and a minimum VAS of 4 cm (10 cm scale). The primary efficacy endpoint was the comparative change in ODI from baseline to 3 months. Both intention-to-treat (ITT) and per protocol (PP) analysis were pre-planned. At 3 months, in the ITT analysis, there was no statistically significant difference between groups in the primary outcome, mean ODI. ODI improved a mean of 19.0 points in the treatment group and 15.4 points in the sham group, p=0.107. However, there was a difference between groups in the 3-month PP analysis: the mean ODI in the treatment arm improved 20.5 points and 15.2 points in the sham arm, p=0.019. In the 12-month PP analysis, the difference between the treatment and sham groups in mean ODI was no longer statistically significant (22.6 points versus 25.3 points, p=0.153). PP analyses of pain severity (assessed by VAS) found no significant difference between groups in VAS improvement at 3 months (p=0.083) but significantly greater improvement in the treatment compared with the control group at 6 and 12 months. Fischgrund et al (2019) reported 24-month results from the above RCT. In this group, the mean improvement in ODI, which was 20.8 points at 3 months, was 23.4 points at 23 months. Data were not available on ODI outcomes at 24 months in the sham-treated group as unblinding occurred after 12 months and most individuals crossed over to treatment with the Intracept system. Fischgrund et al (2020) reported on 5-year treatment arm results. Mean ODI score improved from 42.81 to 16.86 at 5-year follow-up, a reduction of 25.95 points (p < 0.001). 66% of patients reported a > 50% reduction in pain, 47% reported a > 75% reduction in pain, and 34% of patients reported complete pain resolution.

Cryoneurolysis

The iovera° system is used to perform cryoneurolysis or cryoanalgesia, in which peripheral nerves are temporarily ablated using extreme cold administered by closed-end microneedles. The iovera° treatment does not include the injection of substances or opioids or other drugs. Cryoneurolysis is distinct and not equivalent to cryoablation, also known as cryoneuroablation, which functions with cooler temperatures (≤ –140°C) and completely destroys surrounding tissues. A randomized, double-blind, sham-controlled, multicenter trial with a 6-month follow-up in patients with mild-to-moderate knee osteoarthritis (OA) found statistically significant reduction in pain and improvement in function with iovera° over sham treatment was observed up to 90 days follow-up, depending on the scale used, with no benefit at 120 and 180 days (Radnovich, 2017). The change from baseline was clinically significant for iovera° treated patients for described measures of pain and function at all follow-up time points. For the sham group, pain and function was not clinically significant up to 150 days follow-up; however, at 180 days, there was a clinically significant reduction for both pain measures, suggesting a potential placebo effect. No studies compared iovera° with active treatment, and none evaluated potential clinical benefits of repeat administration. Currently, no relevant guidance specifically addresses the use of the iovera° system for treatment of osteoarthritis of the knee.

A 2024 systematic review and meta-analysis (Antunes Júnior et al.) evaluated seven RCTs (437 patients) assessing radiofrequency (RF) and cryoneurolysis (CN) for knee osteoarthritis pain. Both modalities produced significant pain reduction at 4, 12, and 24 weeks, with CN showing the most consistent and durable benefit (e.g., –2.25 Visual Analog Scale (VAS) at 4 weeks; –1.28 at 24 weeks). Functional outcomes utilizing the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) also improved, though patient perception and quality-of-life measures showed no consistent advantage over comparators. Despite encouraging results—particularly for CN—the evidence is limited by protocol variability, inconsistent techniques, and lack of long-term data. Ablation appears to be a minimally invasive option for patients who fail conservative therapy, but standardized treatment methods and additional high-quality research are needed.

Another systematic review (Almeida et al.) of 25 randomized trials (2,049 patients) evaluated minimally invasive genicular nerve–targeted treatments for knee osteoarthritis, including radiofrequency ablation (RFA), genicular nerve block, and cryoneurolysis. Overall evidence quality was low to very low. RFA showed only modest short-term pain reduction at 4–12 weeks, with no sustained benefit and no improvement in function. Evidence for nerve blocks and cryoneurolysis was very limited and uncertain, showing minimal or inconsistent effects. Across studies, no increase in serious adverse events was observed. Given the limited and lowcertainty evidence, routine use of these interventions for knee OA is not supported at this time.

A systematic review and meta-analysis (Goodwin et al.) of six studies evaluated the effectiveness of preoperative cryoneurolysis as an adjunct for pain management in patients undergoing total knee arthroplasty (TKA). Across all included studies, cryoneurolysis demonstrated a large and clinically meaningful reduction in peri and postoperative pain, with a pooled effect size of d = 1.47 (95% CI, 1.08–1.85). Pain improvement typically lasted 6–12 weeks postoperatively. Evidence also indicated favorable patient-centered benefits, including improved mobility, faster return to routine activities, and higher overall satisfaction. While short-term results are consistently positive, data on long-term durability and optimal timing of treatment remain limited. Additional well-designed studies are needed to determine standardized protocols and confirm long-term safety and efficacy.

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
American Academy of Orthopaedic Surgeons (AAOS)	oak3cpg.pdf
Society of Interventional Radiology Research Consensus Panel	Percutaneous Management of Osteoarthritis in the Knee: Proceedings from the Society of Interventional Radiology Research Consensus Panel - Journal of Vascular and Interventional Radiology
American Society of Pain and Neuroscience (ASPN)	JPR_A_464393 1601..1638

North American Spine Society (NASS)	Diagnosis and Treatment of Low Back Pain - Clinical Guideline
Agency for Healthcare Research and Quality	Comparative Effectiveness Review No. 247 Interventional Treatments for Acute and Chronic Pain: Systematic Review
American Society of Interventional Pain Physicians (ASIPP)	REF1MA1.pdf
American Academy of Pain Medicine (AAPM) and American Society of Regional Anesthesia & Pain Medicine (ASRA-PM)	Consensus practice guidelines on sacroiliac joint complex pain from a multispecialty, international working group | Pain Medicine | Oxford Academic
Association of Extremity Nerve Surgeons	AENS CPG - 2.0 - FINAL.pdf
European Association of Urology 2024	EAU-Guidelines-on-Chronic-Pelvic-Pain-2024.pdf

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Notice date
iovera° system (Pacira BioSciences)	K133453 K211334 K220656 K243677	03/24/2014 09/10/2021 05/20/2022 12/26/2024
cryoICE® CRYO2 / CRYO3 (AtriCure)	K180138 K200697	02/15/2018 12/23/2020
cryoICE® cryoSPHERE / cryoSPHERE+ (AtiCure)	K182565 K200697 K243157	11/09/2018 12/23/2020 10/28/2024
cryoICE® cryoXT (AtriCure)	K250371	04/10/2025
AtriCure cryoFORM® / cryoICE® CRYO2 Cryoablation Probe	K152337	03/22/2016
AtriCure cryoSPHERE+™, cryoSPHERE MAX™ Cryoablation Probes	K233170	10/26/2023
Coolief* Cooled Radiofrequency Kit (Halyard Health Inc.)	K163236	12/16/2016

Coolief* Cooled RF Probe (Halyard Health Inc.)	K163461	04/13/2017
Coolief* Radiofrequency Generator (CRG) System (Avanos Medical Inc.)	K192491	02/21/2020
Coolief Cooled Radiofrequency Kit Advanced (Avanos Medical Inc.)	K203066	12/22/2020
COOLIEF* Radiofrequency Generator (Avanos Medical Inc.)	K242057	08/14/2024
Electrothermal 20S Spine System (Smith & Nephew Inc.)	K033981	02/25/2004
G4 Radiofrequency Generator, Model RFG-4 (Cosman Medical Inc.)	K082051	10/16/2008
NeuroTherm NT 100 RF Lesioning System (NeuroTherm Inc.)	K052878	01/23/2006
NT 2000 Lesioning Generator (NeuroTherm Inc.)	K111576	09/20/2011
Intracept System (Relievant Medsystems Inc.	K190504	05/03/2019
PainBlocker Cryoneuroablation System (Epimed International Inc.)	K854334	04/30/1986

VI. CODING

ICD-10 Codes that may support medical necessity

G89.21-G89.29	Chronic pain, not elsewhere classified
G89.3	Neoplasm related pain (acute) (chronic)
G89.4	Chronic pain syndrome
M54.03-M54.09	Panniculitis affecting regions of neck and back
M54.5-M54.9	Other back pain
M62.830	Muscle spasm of back
R52	Pain, unspecified

CPT/HCPCS Codes

64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure.
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
64640	Destruction by neurolytic agent; other peripheral nerve or branch
C9808	Nerve cryoablation probe (e.g., cryoice, cryosphere, cryosphere max, cryoice cryosphere, cryoice cryo2), including probe and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
C9809	Cryoablation needle (e.g., iovera system), including needle/tip and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)
0440T	Ablation, percutaneous, cryoablation, including image guidance; upper extremity distal/peripheral nerve
0441T	Ablation, percutaneous, cryoablation, including image guidance; lower extremity distal/peripheral nerve
0442T	Ablation, percutaneous, cryoablation, including image guidance; nerve plexus or truncal nerve (e.g. Brachial plexus, pudendal nerve)

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, services and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service or procedure is medically necessary. For more information, refer to the Priority Health Provider Manual.

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

RFA procedures are limited to two per year. RFA procedures beyond two per year require medical review.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the member's specific benefits. Group-specific policy will supersede this policy when applicable.

- **HMO/EPO**: This policy applies to insured HMO/EPO plans.
- **POS**: This policy applies to insured POS plans.
- **PPO**: This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.
- **ASO**: For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.
- **INDIVIDUAL**: For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.

- **MEDICARE**: Coverage is determined by the Centers for Medicare and Medicaid Services (CMS); if a coverage determination has not been adopted by CMS, this policy applies.
- **MEDICAID/HEALTHY MICHIGAN PLAN**: For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

General and Clinical Practice Guidelines

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