



REIMBURSEMENT POLICY STATEMENT GEORGIA MEDICAID

Policy Name		Policy Number	Effective Date
Radiofrequency Facet Ablation		PY-1082	06/01/2020
Policy Type			
Medical	Administrative	Pharmacy	REIMBURSEMENT

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. Subject

Radiofrequency Facet Ablation

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Nearly 84% of adults experience back pain during their lifetime. Long term outcomes are largely favorable for most patients, but a small percentage of patient's symptoms are categorized as chronic. Chronic pain is defined by the International Association for the Study of Pain as: "pain that persists beyond normal tissue healing time, which is assumed to be three months".

Interventional procedures for management of acute and chronic pain are part of a comprehensive pain management care plan that incorporates conservative treatment in a multimodality approach. Multidisciplinary treatments include promoting patient self-management and aim to reduce the impact of pain on a patient's daily life, even if the pain cannot be relieved completely. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by physicians qualified to deliver these health services.

C. Definitions

- Radiofrequency Facet Ablation: is performed using percutaneous introduction of an electrode under fluoroscopic guidance to thermocoagulate medial branches of the dorsal spinal nerves.

D. Policy

I. Radiofrequency Facet Ablation

- A. A prior authorization (PA) is required for each radiofrequency facet joint degeneration /ablation for pain management.
- B. For each spinal region (cervical/thoracic or lumbar) two (2) radiofrequency facet ablations per rolling 12 months, involving no more than four (4) joints per session, e.g., two (2) bilateral levels or four (4) unilateral levels.
- C. A repeat RFA in the same spine region requires documented pain relief of at least 50% for a minimum of 6 months after the initial RFA.
- D. Repeat RFA cannot be performed for at least six (6) months following the initial RFA
- E. Radiofrequency facet ablation should be performed with imaging guidance.
 1. Coverage for image guidance and any injection of contrast are inclusive components and are not reimbursed separately.



E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting Georgia Medicaid approved HCPCS and CPT codes along with appropriate modifiers. Please refer to the individual Georgia Medicaid fee schedule for appropriate codes.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.**

Radiofrequency Facet Ablation	Description
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)

F. Related Policies/Rules

Radiofrequency Facet Ablation MM-0216

G. Review/Revision History

	DATE	ACTION
Date Issued	12/11/2019	
Date Revised	N/A	
Date Effective	06/01/2020	
Date Archived		

H. References

1. Georgia Department of Community Health Fee Schedules. Retrieved November 8, 2019

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

GA-P-0881

12/11/2019

DCH Approved 03/02/2020