Back: Ablative Procedures to Treat Back and Neck Pain
(All Lines of Business Except Medicare)

Effective Date: 1/1/2020

Technology Assessment Committee Approved Date: 11/04; 7/05; 6/10; 1/15
Medical Policy Committee Approved Date: 1/06; 7/06; 5/08; 5/11; 8/11; 12/11; 8/12; 11/12; 7/13; 6/14; 7/15; 2/16; 10/16; 12/16; 10/17; 12/17; 2/18; 3/19

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:

All lines of business, except Medicare

BENEFIT APPLICATION

Medicaid Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY CRITERIA

Note: The Coverage Limitations and Requirements* noted below may be considered in addition to the following medical policy criteria for all medical necessity determinations.

Non-Pulsed Radiofrequency Ablation (RFA) for Facet Pain

Covered Indications

1. Initial non-pulsed radiofrequency ablation of the cervical (C1-T1) or lumbar spine from the L1-2 facet joint (T12 and L1 medial branches) to the L5-S1 facet joint (L4 and L5 medial branches)
may be considered medically necessary and covered for the treatment of facet pain when all the following criteria are met:

A. Pre-procedural documentation must include a complete initial evaluation with history and an appropriately focused musculoskeletal and neurological physical examination. There should be a summary of the pertinent diagnostic tests or procedures justifying the presence of facet joint pain; and

B. Patients must have symptoms consistent with facet disease that have not responded to three (3) months of conservative care (e.g., NSAIDS, acetaminophen, physical therapy); and

C. Recent radiographic imaging must prove there is no non-facet pathology (e.g., significant stenosis, fracture, tumor, infection, significant deformity or instability) that might explain the source of the patient’s pain; and

D. Clinical documentation must implicate that the facet joint is the source of pain; and

E. Two positive diagnostic facet joint injections/medial branch blocks* on different days with local anesthetic (no steroids or other drugs) that demonstrate ≥ 80% relief of the primary index pain and duration of relief is consistent with the agent employed. Pain diaries may be requested to ensure this criterion is met.

*Note: Even though either procedure can be used to diagnose facet joint pain, a medial branch block is generally considered more appropriate.

II. Repeat non-pulsed radiofrequency ablation of cervical or lumbar spine facet joint pain, previously treated in the initial procedure, may be considered medically necessary and covered when both of the following criteria (A. and B.) are met:

A. Criteria I. above is met; and

B. There is documentation the patient experienced ≥ 50% improvement of pain for at least 12 weeks after the initial ablation; and

C. The repeat procedure is performed at a minimum of six months following the initial ablation procedure.

Note: Repeat diagnostic blocks are not required when performing a repeat radiofrequency joint denervation/ablation at the same spinal level(s) as a prior successful ablation procedure.

Non-Covered Indications

III. Non-pulsed radiofrequency ablation for the treatment of facet pain is considered not medically necessary and is not covered when the above criteria I. or II. are not met, including, but not limited to:

A. Radiofrequency ablation of the thoracic spine.
B. Radiofrequency ablation at the level of a prior fusion.

Non-Pulsed Radiofrequency Ablation for Non-Facet Pain

Non-Covered Indications

IV. Non-pulsed radiofrequency ablation for the treatment of non-facet-related back and/or neck pain is considered investigational and not covered for all indications, including, but not limited to pain related to:

A. The dorsal root ganglion.
B. The ganglion impar (impar of Walther).
C. The intraosseous basivertebral nerve.
D. The sacrum or sacroiliac joint.
E. Thoracic spine.

All Other Ablative Procedures

V. Other ablative procedures (e.g., pulsed RFA, cooled RFA, cryoablation, chemical ablation) are considered investigational and not covered for the treatment of all types of back and neck pain.

*Coverage Limitations and Requirements for Non-Pulsed RFA for Facet Pain (Criteria I. and II.)

1. A maximum of five (5) facet joint injection sessions inclusive of medial branch blocks, intraarticular injections, facet cyst rupture and RF ablations may be performed per rolling 12-month year in the cervical spine and five (5) in the lumbar spine.
2. For each covered spinal region (cervical or lumbar), no more than two (2) thermal RF sessions will be reimbursed in any calendar rolling 12 month year, involving no more than four (4) joints per session, e.g., two (2) bilateral levels or four (4) unilateral levels.
3. Neither conscious sedation nor Monitored Anesthesia Care (MAC) is routinely necessary for intra-articular facet joint injections or medial branch blocks and are not routinely reimbursable. Individual consideration may be given for payment in rare unique circumstances if the medical necessity of sedation is unequivocal and clearly documented.
4. Pre-procedural documentation must include a complete initial evaluation including history and an appropriately focused musculoskeletal and neurological physical examination. There should be a summary of pertinent diagnostic tests or procedures justifying the presence of facet joint pain and the absence of pain from other sources.
5. Facet joint interventions (diagnostic and/or therapeutic) must be performed under fluoroscopic or computed tomographic (CT) guidance. Facet joint interventions performed under ultrasound guidance will not be reimbursed.
6. A hard (plain radiograph with conventional film or specialized paper) or digital copy image or images which adequately document the needle position and contrast medium flow (excluding RF ablations and those cases in which using contrast is contra-indicated, such as patients with documented contrast allergies), must be retained and submitted if requested.

7. Intraarticular facet block will not be reimbursed as a diagnostic test unless medial branch blocks cannot be performed due to specific documented anatomic restrictions.

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**BILLING GUIDELINES**

**Facet Pain**

- For paravertebral facet destruction by neurolysis of the T12-L1 joint, or nerves innervating that joint use CPT 64633.
- Image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64633-64636. Image guidance and localization are required for the performance of paravertebral facet joint nerve destruction by neurolytic agent described by 64633-64636.
- Do not report 64633-64636 in conjunction with 77003, 77012.

**Sacroiliac Joint Pain**

The CPT code 64640, which is appropriate for destruction by neurolysis for sacroiliac joint pain, is not specific to the procedures and/or indications addressed in this policy. Code 64640 will be considered investigational for the therapies addressed in this policy when the request is for any of the following ICD-10 diagnosis codes:

<table>
<thead>
<tr>
<th>Code or Code Range</th>
<th>Description</th>
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<tbody>
<tr>
<td>G57.00 - G57.03</td>
<td>Lesion of sciatic nerve</td>
</tr>
<tr>
<td>M25.751 - M25.759</td>
<td>Osteophyte, hip</td>
</tr>
<tr>
<td>M43.08</td>
<td>Spondylolisthesis, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M43.18</td>
<td>Spondylolisthesis, sacral and sacrococcygeal region</td>
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<tr>
<td>M43.28</td>
<td>Fusion of spine, sacral and sacrococcygeal region</td>
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<tr>
<td>M46.1</td>
<td>Sacroiliitis, not elsewhere specified</td>
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<tr>
<td>M46.98</td>
<td>Unspecified inflammatory spondylopathy, sacral and sacrococcygeal region</td>
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<td>M47.28</td>
<td>Other spondylosis with radiculopathy, sacral and sacrococcygeal region</td>
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<tr>
<td>M47.818</td>
<td>Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M47.898</td>
<td>Other spondylosis, sacral and sacrococcygeal region</td>
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</table>
### MEDICAL POLICY

**Back: Ablative Procedures to Treat Back and Neck Pain**
*(All Lines of Business Except Medicare)*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>M48.08</td>
<td>Spinal stenosis, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M48.8X8</td>
<td>Other specified spondylopathies, sacral and sacrococcygeal region</td>
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<td>M51.17</td>
<td>Intervertebral disc disorders with radiculopathy, lumbosacral region</td>
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<td>M53.2X8</td>
<td>Spinal instabilities, sacral and sacrococcygeal region</td>
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<td>M53.3</td>
<td>Sacrococcygeal disorders, not elsewhere classified</td>
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<td>M53.88</td>
<td>Other specified dorsopathies, sacral and sacrococcygeal region</td>
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<td>M54.14 - M54.17</td>
<td>Radiculopathy, thoracic or lumbosacral region</td>
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<td>M54.30 - M54.5</td>
<td>Sciatica and lumbago</td>
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<td>M72.9</td>
<td>Neuralgia and neuritis, unspecified</td>
</tr>
<tr>
<td>M76.00 - M76.22</td>
<td>Enthesopathies, hip</td>
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### CPT/HCPCS CODES

#### All Lines of Business except Medicare

**Prior Authorization Required**

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<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>
</tr>
<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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<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>
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<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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**No PA Required**

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<td>Destruction by neurolytic agent; other peripheral nerve or branch</td>
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**Not Covered**

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<th>Description</th>
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</thead>
<tbody>
<tr>
<td>64625</td>
<td>Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)</td>
</tr>
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<td>C9752</td>
<td>Destruction of intraosseous basivertebral nerve, first two vertebral bodies, including imaging guidance (e.g., fluoroscopy), lumbar/sacrum</td>
</tr>
<tr>
<td>C9753</td>
<td>Destruction of intraosseous basivertebral nerve, each additional vertebral body, including imaging guidance (e.g., fluoroscopy), lumbar/sacrum (list separately in addition to code for primary procedure)</td>
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</table>

**Unlisted Codes**
All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then prior-authorization is required.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>27299</td>
<td>Unlisted procedure, pelvis or hip joint</td>
</tr>
<tr>
<td>64999</td>
<td>Unlisted procedure, nervous system</td>
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**DESCRIPTION**

Radiofrequency ablation (also known as RFA, RF lesioning, RF nerve ablation, RF neurotomy, RF denervation, RF coagulation or thermocoagulation, or RF rhizotomy), is a minimally invasive (percutaneous) technique used to destroy nerves using heat generated by radiofrequency emissions. It is typically used to treat persistent back and neck pain generated by diseased facets. However, it has also been proposed as a treatment to temporarily reduce other back and neck pain of non-facet origin, including the sacrum and the sacroiliac joint. It has also been proposed as a treatment of back and neck pain by targeting structures other than the facet joint and the medial branch, including the dorsal root ganglion and the intraosseous basivertebral nerve.

**Conventional (Non-Pulsed) Radiofrequency Ablation**

The conventional form of RFA is referred to as non-pulsed, or continuous RFA. During non-pulsed RFA, a constant application of radiofrequency energy delivers heat to the target nerve thereby creating a lesion that stops pain input to the central nervous system. Prior to planning the procedure, a diagnostic nerve block is conducted to ensure that the patient is a suitable candidate for RFA. The procedure is performed in an outpatient setting, typically by a pain specialist. It is usually performed under fluoroscopic guidance to facilitate localization of the target nerves. After local anesthetic has been injected, an RF cannula is inserted and advanced until it makes contact with bone. Stimulation is performed at 50 hertz to identify the location of each target nerve. Anesthetic may be applied to the target nerve to relieve pain during RFA. During conventional RFA, the RF probe is advanced through the cannula and the temperature of the tip is typically increased to 70°C to 80°C for 90 to 120 seconds. One lesion is created at each of the target nerves.¹

**Pulsed Radiofrequency Ablation**

Pulsed RFA (P-RFA) is another proposed alternative to conventional RFA. P-RFA involves the application of heat applied in short bursts instead of a continuous flow, allowing the tissue to cool between applications and a resulting tissue temperature of approximately 42°C or lower. Lower tissue temperatures and short bursts of application are thought to reduce the risk of destruction to nearby tissue. Examples of devices used for this procedure include, but may not be limited to, the Stryker MultiGen™ 2 RF Generator System (when used on the pulsed mode).
**Cooled Radiofrequency Ablation**

Cooled radiofrequency ablation/denervation (also known as C-RFA) is a variation on conventional RFA that is also being researched. C-RFA maintains the tissue temperature immediately adjacent to the electrode at 60°C while the target nerve is heated to approximately 75°C. This purportedly allows for treatment of a large tissue area without the risk of adjacent tissue damage. Examples of devices used for this procedure include, but may not be limited to, the Coolief Cooled RF Probe.

**Chemical Ablation**

Chemical ablation may also be referred to as chemical neurolysis, chemical denervation or chemodenervation, and involves the injection of neurolytic agents (e.g., phenol, alcohol, glycerol, saline, and sodium morrhuate). This proposed treatment option for chronic pain generally results in a permanent destruction of the nerve.

**REVIEW OF EVIDENCE**

A review of the ECRI, Hayes, Cochrane, and PubMed databases was conducted regarding the use of ablative therapies as potential treatments for chronic back and neck pain of various etiologies. Below is a summary of the available evidence identified through January of 2019.

Because of the subjective nature of outcome measures like pain, randomized clinical trials (RCTs) are needed to determine whether outcomes are truly improved with the use of ablative procedures as opposed to placebo effect. Ideally, trials should be sufficiently powered to avoid spurious results, include homogenous patient populations, longer follow up periods, and report objective outcome measures such as imaging in addition to standardized methods of measuring subjective outcomes like pain severity and functional impairment. Therefore, the evidence review below has primarily focused on RCTs and systematic reviews that have included RCTs.

Despite the limited availability of high-quality evidence for the use of RFA for the treatment of persistent facet pain of the cervical and lumbar regions, RFA has evolved in to a standard of care for treatment for these specific areas of the spine. Therefore, the evidence review below does not include conventional RFA for either the cervical or lumbar regions to treat facet pain.

**Non-Pulsed Radiofrequency Ablation (RFA) for Facet Pain**

**Miscellaneous Non-Covered Indications for Facet Pain**

There are no radiological findings conclusive for the diagnosis of lumbar facet syndrome. Studies have not been able to show correlation between facet joint pain and degenerative changes noted in radiographs.²
No studies were identified which examined the use of RFA at the level of a previous spinal fusion and in many of the available studies identified, these patients were excluded. Therefore, the safety and efficacy regarding the use of RFA to treat facet pain after fusion, has not been determined.

In 2013, Joo et al., compared the use of repeat RFA (n=20) to alcohol ablation (AA) (n=20) in patients with recurrent thoracolumbar facet pain after an initial successful RFA. At the 24-month follow-up only one RFA patient compared to 17 AA patients were without facet joint pain. Authors concluded AA in medial branch block neurotomy provided superior long-term pain relief compared to repeat RFA. This study is limited by small sample size, which limit conclusions regarding the use of repeat RFA compared to AA. No RCTs were identified regarding the safety and efficacy of initial RFA as a treatment of facet disease of the thoracic spine.

**Non-Pulsed Radiofrequency Ablation (RFA) for Non-Facet Pain**

**Ablation/Denervation of the Dorsal Root Ganglion (DRG)**

**Systematic Reviews**

In 2011, Chua et al. published the results of a systematic review that evaluated pulsed RFA (P-RFA) of spinal structures, including two small RCTs where treatment was directed at the DRG. These two RCT are discussed in detail below. Although both of the RCTs included reported a dissipation of the beneficial effects of RFA at 6-8 months, authors considered the evidence for P-RFA of the dorsal root ganglion “compelling” for treatment of cervical radicular pain, but found the evidence for PRF for lumbosacral pain to be of low methodological quality.

In 2013, Pope et al. published a review that included four studies for conventional (non-pulsed) radiofrequency, and 10 for P-RFA of the DRG for chronic radicular pain. Regarding conventional RFA, the reviewers stated that “although prospective observational and retrospective studies have yielded consistent support for DRG treatment in the cervical, thoracic, lumbar, and sacral regions, controlled studies are less compelling, complicated by the challenge of the lurking deafferentation pain potential. Patient selection is vague. Larger, sham-controlled, prospective studies are required to elucidate the place of conventional RFA treatment of the DRG for treatment of chronic pain.”

Regarding pulsed RFA, the reviewers stated that there was a paucity of RCTs (only one of the 10 studies included was randomized). Although results were “intriguing”, further larger powered, prospective, randomized, sham-controlled studies were needed. The reviewers concluded that “despite a robust understanding of the DRG and its importance in acute nociception, as well as the development and maintenance of chronic pain, relatively poor evidence exists regarding current therapeutic strategies. More prospective studies are required to better qualify the role of the DRG in chronic pain care.”

In 2015, Maas et al. published the results of a Cochrane review that assessed the effectiveness of RF denervation procedures for the treatment of patients with chronic low back pain (CLBP) due to various etiologies, including three RCTs for lumbar radicular pain. The review concluded that the effectiveness...
of RFA on low pain back pain arising from the DRG was inconclusive. These three RCTs were heterogeneous in terms of:

- Diagnostic method: Three separate diagnostic blocks versus, low-volume segmental nerve block versus clinical features plus CT/MRI imaging findings.
- Treatment: Two studies used conventional RFA and one study used pulsed RFA.
- Comparator group: Two studies used placebo, and the other study used P-RFA plus cryodenervation for comparison.

In 2017, Facchini et al. published a review of pulsed RFA in the treatment of pain associated with different spinal conditions. Four RCTs on P-RFA treatment for cervical radicular pain were included. One study reported significantly better outcome at 3 months compared with sham. The other three studies concluded that P-RFA administered to a DRG might be as effective as transforaminal epidural steroid injection in terms of attenuating lumbar radicular pain caused by disc herniation. Three RCTs and seven observational studies evaluating P-RFA in managing disc herniation and radiculitis were included in the review. Although all studies reported good pain results, different comparator groups were used (placebo, corticosteroids, P-RFA + conventional RFA). In addition, the reviewers felt that the major issues concerning those studies were the lack of standardization of P-RFA parameters, enrolment criteria and heterogeneity in results reporting. There was also concern regarding the invasiveness of the treatment intradiscally.

In 2018, Kwak et al. published a systematic review of the effectiveness of P-RFA treatment on cervical radicular pain, including 4 studies, only one of which was an RCT. The single RCT was published by Lee et al. in 2016 and is summarized below. The other included studies consisted of two small prospective case series (n= 15 and 21) and one small retrospective case series (n=22). All included studies suffer from small sample size and lack of long-term follow-up and all but one study suffer from poor study design and lack of a comparator group. The review not only included heterogeneous studies in terms of study design, but also reported significant heterogeneity between studies with regard to outcomes at multiple follow-up time points.

**Randomized Controlled Trials (RCTs)**

One small RCT published by Van Zundert et al. in 2007 randomized 23 patients with chronic cervical radicular pain to either P-RFA of the DRG or sham treatment groups. Nine out of 11 patients in the treatment arm and four out of 12 in the three out of 12 in the sham group achieved at least 20% reduction in pain on VAS (P=0.02). At six month follow-up, more patients in the treatment group reduced their use of pain medication, but the difference was not significant. These findings must be confirmed in larger studies before drawing conclusions regarding the efficacy of pulsed RFA.

In 2008, Simopoulos et al. randomized 76 patients with chronic refractory lumbosacral radicular pain to one of two groups who received either P-RFA alone or P-RFA followed immediately by continuous RFA. Two months after the procedure 70% and 82%, respectively, reported successful reduction of pain. These effects were lost by eight months in most patients. The between-group difference was not
significant. The authors concluded that additional RCTs are required to determine the effectiveness of P-RFA to the DRG for lumbosacral pain.

In 2012, Fujii et al. reported on the use of P-RFA in a small RCT of 27 patients. P-RFA was performed on the DRG for lumbosacral radicular pain, and control group was treated with nerve root block. VAS pain scores decreased significantly for each group post-treatment, but even at one year, there were no differences in outcomes between the two treatment groups.

In 2015, Koh et al. published the results of a small RCT (n=62 patients with chronic refractory lumbar radicular pain) that assessed the effects of combining P-RFA and transforaminal epidural injection (TFEI). Because this was a combination treatment, compared to sham, the efficacy of RFA alone was not able to be determined. In addition, since this study recruited patients after they had already been treated with TFEI, the results of this study do not provide the efficacy of PRF as a first-line treatment. Lastly, this study had a very short follow-up time of 3 months.

In 2016, Lee et al. evaluated the comparative effectiveness of P-RFA administered to the DRG and transforaminal epidural steroid injections (TFESI) for the treatment of radicular pain due to disc herniation. The RCT included 38 patients who received previous TFESI treatments for spinal radicular pain. The randomized patients (P-RFA group n=19; TFESI group n=19) were treated within 2-6 weeks after the first TFESI and evaluated at two, four, eight, and twelve weeks. No statistically significant differences in effectiveness were noted at any point in the follow-up period between the two treatment groups. One important limitation of this RCT was that the study reported a high attrition rate, losing 13.6% of patients to follow-up.

In 2017, Halim et al. published the results of a small RCT evaluating percutaneous cervical nucleoplasty (PCN) versus P-RFA of the DRG for treatment of cervical disc herniation. The trial involved 34 patients with radicular pain treated with either PCN (n=17) or PRF (n=17). At three months, both groups had significant reduction in pain, although neither was superior to other. This study is limited by small sample size and short-term outcomes Studies evaluating long-term outcomes supporting clinical efficacy are lacking.

Ablation/Denervation of the Ganglion Impar

Systematic Reviews

In 2018, Hayes published the results of a review that evaluated radiofrequency thermocoagulation (RFT) of the ganglion impar for the treatment of chronic coccydynia in adults, including three small (n=10 to 41) retrospective case series that were deemed of very-poor-quality. The review indicated that there is also possible overlap in patients in two of the included studies due to overlap of investigators. All three studies reported improvements in pain from baseline at follow-up ranging from 6-12 months. According to the Hayes review:
“Individual study limitations include nonrandomized, noncomparative studies, small to very small sample sizes, and absence of power analyses. None of the studies evaluated physical functioning, emotional functioning, or patients’ rating of improvement, which are all considered critical outcomes in the assessment of chronic pain in clinical trials.”

Hayes reported a rating of “D2” for use of ganglion impar RFT for the treatment of chronic coccydynia in adults due to a limited number of studies of very-poor individual study quality.

Nonrandomized Studies

The following nonrandomized study was not included in the Hayes review described above:

In 2014, Gopal and McCrory published the results of a retrospective review of 20 patients with a clinical diagnosis of coccydynia and failed medical management treated with pulsed radio frequency (P-RFA) applied to the Ganglion of Impar. The authors reported a 50% or greater improvement in pain at six and 12 months follow-up in 15 (75%) patients.

Ablation/Denervation of the Intraosseous Basivertebral Nerve

Randomized Controlled Trials (RCTs)

In 2018, Fischgrund et al. evaluated the effectiveness of RF ablation of the basivertebral nerve (BVN), specifically using the Intracept System, for relief of chronic low back pain. A total of 225 patients at 18 sites were enrolled: 147 patients were randomized to the Intracept System group (received treatment) and 78 were randomized to the sham group (received sham surgery). Longest follow-up was 12-months and the only outcomes assessed were subjective, patient-reported ODI and VAS scores. At 3 months the ODI improvement observed in the Intracept group was statistically superior to the sham group (p=0.019). The investigators reported that the improvements were sustained throughout the 12-month follow-up period. Limitations of this study include lack of long-term outcome data for the primary efficacy endpoint (comparative change in ODI from baseline to 3 months) and, as reported by the study investigators:

“comparison of the difference in outcome score between the sham and treatment groups does not represent the clinical utility of the Intracept Procedure because a sham treatment is not a clinically acceptable treatment for chronic low back pain (CLBP) nor is a sham response likely to occur in an open label setting.”

Nonrandomized Study

In 2017, Becker et al. published the results of a single-arm, industry-sponsored study of 17 individuals with chronic low back pain, with a follow-up of 12 months. Outcomes evaluated were self-reported measures: the ODI, VAS score, and SF-36 scores. Statistically significant improvement in ODI observed at three months was maintained through the 12-month follow-up. The mean baseline VAS score decreased from 61 ± 22 to 45 ± 35 at three months follow-up (p<0.05), and the mean baseline physical component
Ablative Procedures to Treat Back and Neck Pain
(All Lines of Business Except Medicare)

Summary increased from 34.5 ± 6.5 to 41.7 ± 12.4 at three months follow-up (p=0.03). Limitations of this study include the small sample size and the non-randomized, unblinded, single-arm study design.

Ablation/Denervation of the Sacrum and/or Sacroiliac Joint (SIJ)

Systematic Reviews

In 2015, Maas et al. published the results of a Cochrane review that assessed the effectiveness of RF denervation procedures for the treatment of patients with chronic low back pain (CLBP) due to various etiologies, including two small RCTs for SI joint pain (n < 50 patients). The reviewed stated that low-quality evidence revealed no differences pain (mean difference [MD] of -2.12, 95% CI -5.45 to 1.21) or function (MD -14.06, 95% CI -30.42 to 2.30) over the short term compared to placebo, and one study showed a small effect on both pain and function over the intermediate term (6 months). Quality of evidence for the outcomes assessed in the review ranged from low- to very-low.

In 2017 (updated 2018), Hayes published the results of a review that evaluated RFA for sacroiliac joint (SIJ) denervation as a treatment for chronic low back pain, including seven studies (three RCTS, two were cross-over) evaluating conventional RFA and one study comparing non-pulsed RFA with cooled RFA (C-RFA). Overall the body of evidence was considered to be of low quality. The studies reported consistently better functional outcomes and decreased use of analgesics with non-pulsed RFA compared to either baseline or comparator treatments. However, the evidence regarding overall success of the treatment and pain relief were conflicting. In addition, the review stated that there was “insufficient evidence to establish definitive patient selection criteria for conventional RFA as a treatment for SIJ-mediated chronic LBP.”

Limitations of the body of evidence for both types of RFA included:
- a large proportion of the studies were observational and non-comparative in design
- the majority of RCTs (2/3) were cross-over studies
- follow-up times were generally short (between 3-6 months)
- comparator groups differed between studies (e.g., sham, steroid injections, another type of RFA)
- inconsistent/conflicting outcomes between studies

The review concluded the following:
- “The lack of a standard RF denervation technique for RFA prevents definitive conclusions regarding the efficacy and safety of the procedure. An inherent challenge to the efficacy of RFA is the variable anatomy of targeted lateral branch nerves in the SIJ.
- Longer-term studies are needed to determine the duration of pain relief associated with RFA versus alternative treatments, and to evaluate the efficacy and safety of repeated treatments.
- Patients with LBP related to the SIJ are a heterogeneous group; therefore, treatment results can be variable. While the evaluated studies all selected patients for RFA based on positive results of diagnostic blocks, the criteria for a positive response varied among the studies.
Good-quality studies comparing the effectiveness of conventional RFA with cooled RFA for chronic LBP are lacking. Therefore, questions remain as to the comparative efficacy and safety of these treatments.”

In 2018, Sun et al. published the results of a meta-analysis evaluating the efficacy and safety of C-RFA in treating chronic SIJ pain, including seven studies (N=240 patients). Only two of the included studies were RCTS, which were small in size. The remaining five studies were all observational in nature, and four of them were retrospective in design. The authors noted that the sample size of the included studies was small and heterogeneity existed in terms of patient selection, with some studies including patients with failed back surgery syndrome and/or previous back surgery while other studies excluded patients with history of spinal surgery. Follow-up times also varied from 3-24 months, with only one study reporting outcomes beyond 12 months. The reviewers concluded that further high-quality, large-scale RCTs were required to validate the findings reported by the review.

**Randomized Controlled Trials (RCTs)**

In 2017, Juch et al. conducted three multicenter, non-blinded, randomized controlled trials (RCTS) to evaluate the effectiveness of radiofrequency denervation of the facet joints (n=251), sacroiliac joints (n=228), or a combination of both (n=202). Regarding the sacroiliac joint trial, the mean difference between pain intensity between the RFA and control groups at three months was -0.71 (95% CI: -1.35 to -0.06). The authors concluded, “(t)he findings do not support the use of radiofrequency denervation to treat chronic low back pain from these sources (facet joint, sacroiliac joint, or both).” Limitations of this RCT include lack of blinding, short follow-up, and lack of documentation regarding the use of sedation, which could skew trial results. In addition, based on the diagnostic block protocol and the level of pain relief from the block considered sufficient to proceed to ablation precludes generalizability of the results of this study.

**Nonrandomized Studies**

In 2017, Tinnirello et al. published the results of a small retrospective study (n=43) comparing two RF devices, Simplicity III (conventional, non-pulsed RFA), and Sinergy (cooled RFA, C-RFA), which are specifically designed to denervate the sacroiliac joint (SIJ). There were greater improvements in pain and function, based on self-reported scales, in the patients who were treated with C-RFA at both six and 12 months post-treatment, compared to those treated with conventional RFA. However, the authors concluded that RCTs were needed to confirm the implication made that “Sinergy C-RFA is the preferred RF denervation option for treating SIJ-derived pain and the disability associated with it.”

**Thoracic Pain**

In 2016 (updated in 2018), Hayes published the results of a review that evaluated RFA for thoracic spinal indications, including two studies that used nonpulsed RFA and two studies that used pulsed RFA (P-RFA). Both studies on nonpulsed RFA were retrospective uncontrolled cohort studies that evaluated nonpulsed RFA for thoracic pain of unknown or mixed etiology. The two P-RFA studies included one RCT.
(n=96) that treated patients with post-herpetic neuralgia compared to sham treatment, and one retrospective cohort study (n=49) that treated patients with postsurgical thoracic pain with either P-RFA, intercostal nerve RFA, RFA of the DRG, or pharmacologic therapy. Hayes rated the use of both pulsed and non-pulsed RFA for treatment of pain originating from the thoracic spinal region as a “D2” due to “conflicting evidence from a limited number of studies.” Per the Hayes review:

“Common individual study limitations resulting in downgrading of study quality included retrospective uncontrolled designs, lack of controls and blinding in some studies, and limited follow-up. Two studies enrolled patients with highly specific indications, limiting the applicability of the findings to broader populations. Substantial uncertainty remains regarding the use of RFA for thoracic pain of broader etiologies, the comparative efficacy of RFA versus alternative therapy, optimal treatment protocols, and long-term efficacy and safety.”

All Other Ablative Procedures

Pulsed RFA

Systematic Reviews

In 2016 (updated 2018), Hayes published the results of a review that evaluated RFA for cervical spinal indications, including four small RCTs (n=23 to 62) and one small retrospective uncontrolled study that evaluated P-RFA. Two studies evaluated treatment of cervical radicular pain, while two studies focused on cervical radiculopathy due to disc herniation. Two RCTs found greater benefits of P-RFA versus sham treatment, one RCT found no difference between P-RFA and percutaneous cervical nucleoplasty (PCN) treatments, and one RCT found that P-RFA combined with nerve blockade was more efficacious than RFA alone. Limitations of the body of evidence include:

- differences across studies in indications and pain etiologies,
- varying P-RFA treatment protocols, outcome measures and definitions of treatment success
- limited long-term follow-up beyond one year
- conflicting results between studies

Limitations of the individual studies included in the review include one or more of the following:

- small sample sizes
- significant loss to follow-up,
- lack of blinding in some studies
- studies statistically underpowered or no power analysis
- uncontrolled study was deemed of poor quality

The review concluded that “uncertainty remains regarding the optimal P-RFA treatment parameters, including lesion temperatures, patient selection criteria, and long-term comparative efficacy and safety.”
This review also evaluated P-RFA for thoracic spinal pain, which is summarized in the “Miscellaneous Non-Covered Indications for Facet Pain: Thoracic Pain” section above.

In 2016 (updated 2018), Hayes published the results of a review that evaluated RFA for facet joint denervation for low back pain (LBP), including two studies evaluating P-RFA and one study comparing nonpulsed to P-RFA. All three studies compared P-RFA to different comparator treatments. Two of the three studies reported no difference in pain relief between P-RFA and comparator treatment. The review stated that there was a small body of low-quality evidence that suggested that P-RFA was equivalent but not superior to sham therapy, steroid injections, and/or combined nonpulsed + P-RFA. Additionally, per the Hayes review:

“comparison of data among studies was hindered by differences in patient inclusion criteria (e.g., patients with prior surgeries or unoperated patients, patients with varying responses to medial branch blocks), treatment protocols (type of electrodes, varying electrode placement, different ablation temperatures, numbers of procedures), follow-up times, and definitions of response and recurrence (complete or partial pain relief, pain relief duration).”

The review graded the use of P-RFA to treat LBP as a “D2” due to the paucity of evidence and indicated that additional studies were needed before any definitive conclusions can be reached about treatment effect.

**Randomized Controlled Trials**

A number of small RCTs were not included in the Hayes reviews above.

In 2016, Arsanious et al. published the results of an RCT that evaluated if immediate post-procedural pain scores and post-procedural oral analgesic use were reduced in patients receiving P-RFA via the Neuro-Therm© radiofrequency generator immediately followed by continuous non-pulsed RFA versus non-pulsed RFA alone, for facet joint pain, including 55 patients. The results noted patients receiving P-RFA prior to non-pulsed RFA had less post-procedural pain and reduced analgesic requirements during the first 24 hours. The investigators concluded that long-term follow-up and studies with a larger population were needed to determine the efficacy of P-RFA in this adjunctive setting.

In 2016, Jena et al. published the results of an RCT that evaluated P-RFA for management of low back pain, including 40 patients with chronic discogenic low back pain who received non-pulsed RFA plus intradiscal triamcinolone or P-RFA plus intradiscal triamcinolone. The authors reported that at 6-month follow-up the non-pulsed group had statistically significant improved VAS pain scores and improved function by the straight leg raise test.

Also in 2016, Wang et al. published the results of an RCT that evaluated the efficacy of cervical nerve root block (CNRB), P-RFA, and CNRB plus P-RFA for cervical radicular pain in 62 patients. The patients were randomized into three groups and received either CNRB, P-RFA, or CNRB plus P-RFA. At 6-months follow-up, the combination therapy yielded statistically significant lower pain intensity numeric rating
scale (NRS) scores and higher global perceived effect (GPE) overall improvement scores, than either CNRB or P-RFA alone. There were no statistically significant differences in NRS or GPE between the CNRB and P-RFA groups. The investigators concluded that follow-up of 6 months “is still too short to determine the long-term effects of this combined procedure. A study with a larger sample size and longer duration of follow-up may help to confirm the safety and efficacy of this combined approach.”

In 2017, Chang et al. compared the effectiveness of bipolar P-RFA and monopolar P-RFA in patients with chronic lumbosacral radicular pain, including 50 patients. Patients in both groups showed significant improvement in pain intensity NRS scores at 3-month follow-up compared to baseline scores. Reductions in the NRS scores over time were significantly larger in the bipolar P-RFA group. Three months after treatment, 19 patients (76.0%) in the bipolar group and 12 patients (48.0%) in the monopolar group reported pain relief of ≥50%.

Most recently in 2017, Do et al. published the results of an RCT comparing intra-articular lumbar facet joint P-RFA and intra-articular lumbar facet joint corticosteroid injections (CI) in 60 patients with lumbar facet joint pain. Changes in pain intensity NRS scores for pain were assessed at baseline and three additional time points. Both groups had significantly reduced NRS scores for pain at each time point compared to baseline scores. At six months of follow-up, there was no significant difference in pain scores between the groups.

Of note, most of the RCTs described above evaluated P-RFA as an adjunctive treatment. This limits the ability to draw definitive conclusions regarding the efficacy of P-RFA as a stand-alone treatment for back pain originating from any source. All of the identified RCTs suffered from small sample size and lack of reporting of long-term outcomes.

**Cooled RFA**

**Systematic Reviews**

In 2014, Leggett et al. published a systematic review evaluating RCTs on RFA for chronic low back pain of various etiologies including pain associated with SI joints. This review included two small RCTs (n=14 and 34) that evaluated continuous cooled RFA (C-RFA). One RCT was found to have high risk of bias with regards to blinding of both the participants and the providers, and the other RCT had an unclear risk of bias in terms of blinding. The reviewers reported that although the two studies suggested that continuous C-RFA was “efficacious in reducing SI joint pain, with only two available RCTs, more data on the efficacy of RFA for sacroiliac joint pain would strengthen this conclusion”.

In 2017 (updated 2018), Hayes published the results of a review that evaluated RFA for sacroiliac joint (SIJ) denervation as a treatment for chronic low back pain, four studies (two RCTs) evaluating cooled RFA (C-RFA), and one study evaluating comparing non-pulsed RFA to C-RFA. Overall the body of evidence was considered to be of low quality. The review reported that consistently better functional outcomes and decreased use of analgesics with C-RFA compared to either baseline or comparator treatments. However, the evidence regarding overall success of the treatment and pain relief were conflicting. In
addition, the review stated that there was “insufficient evidence to establish definitive patient selection criteria for cooled RFA as a treatment for SIJ-mediated chronic LBP.”

Limitations of the body of evidence:
- a large proportion of the studies were observational and non-comparative in design
- follow-up times were generally short (between 3-6 months)
- comparator groups differed between studies (e.g., sham, another type of RFA)
- inconsistent/conflicting outcomes between studies

The review concluded the following:
- Longer-term studies are needed to determine the duration of pain relief associated with C-RFA and to evaluate the efficacy and safety of repeated treatments.
- “Good-quality studies comparing the effectiveness of conventional RFA with cooled RFA for chronic LBP are lacking. Therefore, questions remain as to the comparative efficacy and safety of these treatments.”

Cryoablation

Nonrandomized Studies

In 2007, Birkenmaier et al., published the results of a small case series of 46 patients treated with medial branch cryoablation in the treatment of lumbar facet joint pain.\textsuperscript{30} At 6-weeks follow-up, only 72% of patients were self-reportedly pain free or had major improvement of pain. However, those with reduced pain reported improvement up to 12-month follow-up. Similar results have been reported in two other small prospective case series (n=50 and 76), with reductions in pain reported at 6- to 12-months follow-up in 40%-50% of patients.\textsuperscript{31,32} These results have also been confirmed in a more recent retrospective observational study (n=91).\textsuperscript{33} However, this retrospective study relied on a patient-completed questionnaire, which were initiated at a median of 1.7 years after the intervention.

All of the studies identified evaluating cryoablation where limited to treatment of lumbar facet pain and suffer from small sample size, heterogeneity in diagnostic parameters and ablation targeting techniques between studies, and lack of control groups.

CLINICAL PRACTICE GUIDELINES

American Society of Interventional Pain Physicians (ASIPP)

The 2013 ASIPP guidelines for interventional techniques in chronic spinal pain recommend the following:\textsuperscript{34}

- Lumbar Spine:
For patients testing positive for facet joint pain, “the recommended treatment for lumbar facet pain is with radiofrequency neurotomy or therapeutic facet joint nerve blocks”

“The evidence for conventional radiofrequency neurotomy in managing chronic low back pain of facet joint origin in the lumbar spine is good for short- and long-term relief.” (Two systematic reviews, six RCTs and 10 observational studies)

“The evidence for therapeutic facet joint interventions is limited for pulsed radiofrequency.” (One RCT)

- **Sacroiliac Joint:**
  - “For sacroiliac joint interventions, the evidence for cooled radiofrequency neurotomy is fair; and for both pulsed radiofrequency and conventional radiofrequency neurotomy the evidence is limited.”
  - The assessment of the evidence for conventional radiofrequency neurotomy of the nerve supply of the sacroiliac joint was based on four systematic reviews, all of which reported limited efficacy.
  - The assessment of the evidence for cooled RFA as “fair” was supported by one systematic review which included two RCTs, one small (n <100) nonrandomized comparative study, one small observational study, and one case report. The guideline noted that both RCTs had “potential shortcomings with the control group”.

- **Cervical Spine:**
  - “The evidence for therapeutic cervical facet joint interventions is fair for conventional cervical radiofrequency neurotomy.”
  - RFA for cervical facet joint pain is recommended in “managing chronic neck pain after the appropriate diagnosis from controlled diagnostic blocks.”

- **Thoracic Spine:**
  - “The evidence for radiofrequency neurotomy is limited.”
  - RFA for thoracic facet pain “may be performed based on emerging evidence.”

**American Association of Neurological Surgeons and Congress of Neurological Surgeons (AANS/CNS)**

In 2014, the AANS and CNS published joint guidelines on the treatment of degenerative disease of the lumbar spine, recommending the following:\(^{35}\)

- “Lumbar medial nerve ablation is suggested for the short-term (3- to 6-month) relief of facet-mediated pain in patients who have chronic lower-back pain without radiculopathy from degenerative disease of the lumbar spine.” This was a grade “B” recommendation, based on four RCTs.
• “Diagnostic facet blocks by the double-injection technique with an improvement threshold of 80% are an option for predicting a favorable response to facet medial nerve ablation by thermocoagulation for facet-mediated chronic low-back pain without radiculopathy in patients with degenerative disease of the lumbar spine.” This was a grade “C”, based on a single RCT.

National Institute for Health and Care Excellence (NICE)

In 2016, NICE published a guideline on the management of low back pain in patients over 16 years old, recommending the following with regards to conventional (non-pulsed) RFA:

• “Consider referral for assessment for radiofrequency denervation for people with chronic low back pain when:
  o non-surgical treatment has not worked for them and
  o the main source of pain is thought to come from structures supplied by the medial branch nerve and
  o they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.

• Only perform radiofrequency denervation in people with chronic low back pain after a positive response to a diagnostic medial branch block.”

This guideline was updated in October of 2018 with no changes to the recommendations.

POLICY SUMMARY

Non-Pulsed Radiofrequency Ablation (RFA) for Facet Pain

Thoracic Pain

There is insufficient evidence regarding the safety and efficacy of non-pulsed RFA for facet pain in the thoracic region. There is a lack of RCTs and the few studies identified were of small sample size. In addition, current clinical practice guidelines indicate that the evidence for RFA of thoracic facet pain is limited.

Non-Pulsed Radiofrequency Ablation (RFA) for Non-Facet Pain

Dorsal Root Ganglion Pain

There is insufficient evidence regarding the safety and efficacy of non-pulsed RFA for pain related to the dorsal root ganglion. The body of evidence consists mainly of observational studies, with only a small number of RCTs identified. RCTs evaluating RFA of the DRG are heterogeneous in terms of the diagnostic methods, types of RFA, and comparator groups used. In addition, no clinical practice guidelines were identified that addressed the use of non-pulsed RFA of the DRG to alleviate back or neck pain.
Ganglion impar Pain

There is a paucity of evidence regarding the safety and efficacy of non-pulsed RFA for pain related to the ganglion impar. The body of evidence consisted of four small retrospective case series. In addition, no clinical practice guidelines were identified that addressed the use of non-pulsed RFA of the ganglion impar to alleviate back pain.

Intraosseous Basivertebral Nerve Pain

There is insufficient evidence regarding the safety and efficacy of non-pulsed RFA for pain related to the basivertebral nerve. The body of evidence consists of one RCT and one small observational case series. The RCT was limited by a lack of long-term outcome data for the primary efficacy endpoint and lack of an ideal comparator group. In addition, no clinical practice guidelines were identified that addressed the use of non-pulsed RFA of the basivertebral nerve to alleviate back pain.

Sacroiliac Joint Pain

There is insufficient evidence regarding the safety and efficacy of any type of ablative treatment for facet or non-facet pain in the thoracic region. The small number of RCTs that were identified compared non-pulsed RFA to were heterogeneous in terms of comparator groups and whether the treatment consistently led to improved outcomes. Most studies identified only reported short-term follow-up of 3-6 months. In addition, no clinical practice guidelines were identified that strongly supported the use of non-pulsed RFA to alleviate sacroiliac-related back pain.

Thoracic Pain

There is insufficient evidence regarding the safety and efficacy of non-pulsed RFA for non-facet pain in the thoracic region. There is a lack of RCTs and the few studies identified were of small sample size. In addition, no guidelines were identified that addressed any type of non-pulsed RFA as treatment of thoracic pain of non-facet origin.

All Other Ablative Procedures

Pulsed RFA

There is insufficient evidence regarding the safety and efficacy of pulsed RFA for facet or non-facet pain of the back or neck. The small number of RCTs that were identified for any given pain generator were typically small in sample size, reported short-term follow-up, were heterogeneous in terms of comparator groups and whether the treatment consistently led to improved outcomes. In addition, no clinical practice guidelines were identified that strongly supported the use of pulsed RFA to alleviate back or neck pain of any origin.
Cooled RFA

There is insufficient evidence regarding the safety and efficacy of cooled RFA for facet or non-facet pain of the back or neck. The small number of RCTs that were identified for any given pain generator were typically small in sample size, reported short-term follow-up, were heterogeneous in terms of comparator groups and whether the treatment consistently led to improved outcomes. In addition, no clinical practice guidelines were identified that strongly supported the use of cooled RFA to alleviate back or neck pain of any origin.

Cryoablation

There is insufficient evidence regarding the safety and efficacy of cryoablation for facet or non-facet pain of the back or neck. All of the studies identified evaluating cryoablation where limited to treatment of lumbar facet pain and suffer from small sample size, heterogeneity in diagnostic parameters and ablation protocol, and lack of control groups. In addition, no clinical practice guidelines were identified that addressed the use of cryoablation to alleviate back or neck pain of any origin.

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and PHP Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

U.S. Food & Drug Administration (FDA)

Several radiofrequency and cryosurgery devices have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. Radiofrequency (RF) probes and lesion generators are considered class II devices. The FDA has approved over 60 RF probes (product code: GXI) and over 40 RF lesion generators (product code: GXD). Below are examples of these devices.

- NeuroTherm® NT 2000 (NeuroTherm, Inc.) received 510K clearance in 2011. The FDA determined that this device was substantially equivalent to existing devices for use in lesioneing neural tissue in the peripheral nervous system. Existing predicate devices included the NeuroTherm NT 1000
(cleared in 2006), Stryker Interventional Pain RF Generator and RF Electrodes and Cannulae (2004), and Cosman G4 RF Generator (cleared in 2008).

- The Stryker MultiGen™ 2 RF Generator System received 510K clearance in 2017 for “coagulation of soft tissues in orthopedic, spinal, and neurosurgical applications. Examples include, but are not limited to: Facet Denervation, Trigeminus Neuralgia, Peripheral Neuralgia and Rhizotomy.”38 This system may be used for both pulsed and non-pulsed/conventional RFA, depending on the setting.

- COOLIEF* Cooled Radiofrequency Kit (Halyard Health, Inc.) received 510K clearance (K163236) in 2016 to be used in combination with the HALYARD* Radiofrequency (RF) Generator (PMG-BASIC/PMG-ADVANCED) for “the creation of Radio-Frequency (RF) heat lesions in nervous tissue for the relief of pain.”39

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

MEDICAL POLICY CROSS REFERENCES

- Providence Health Plans Medical Policy: Back: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (Medicare Only), SUR125

REFERENCES


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