2024 Quick Reference Guide – Radio Frequency Ablation Facet Joint

Reimbursement 2024

Coding and Payment Guide for Medicare Reimbursement: The following are the 2024 Medicare coding and national payment rates for Radio Frequency Ablation (Facet Joint) procedures performed in an ambulatory surgical center, physician office, or outpatient hospital.

Therapeutic Procedures

		Physician			Ambulatory Surgery Center		Outpatient Hospital		
CPT/ HCPCS Codes[1]	Description	National Average Payment [2] (Non-Facility)	National Average Payment [2] (Facility)	Global Period	Status Indicator[3]	ASC National Average Payment[2]	Status Indicator[4]	APC Code[5]	OPPS National Average Payment[2]
*64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	$431	$188	10	G2	$898	J1	5431	$1,842
(+)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)	$251	$65	ZZZ[6]	N1	N/A PACKAGED	N	N/A PACKAGED	
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	$434	$188	10	G2	$898	J1	5431	$1,842
(+)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.)	$236	$57	ZZZ[6]	N1	N/A PACKAGED	N	N/A PACKAGED	
64999	Unlisted procedure, nervous system. [Use when the provider performs facet joint nerve destruction without fluoroscopy or CT imaging guidance]	Carrier Price		YYY[7]	N/A Packaged		T	5441	$282

Diagnostic Procedures

Diagnostic Procedures below are often required prior to coverage for the therapeutic procedures above. The provider is responsible for verifying payer policy as to the appropriate code used for each procedure.

CPT®,[1]	Description
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic: single level.
(+)64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic: second level. (List separately in addition to code for primary procedure.)
(+)64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic: third and any additional level(s). (List separately in addition to code for primary procedure.)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level.
(+)64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level. (List separately in addition to code for primary procedure.)
(+)64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s). (List separately in addition to code for primary procedure.)

Medicare Local Coverage Determinations[8]

Please check with your local contractor. In the absence of an LCD, Medicare contractors will follow the NCD.

Palmetto GBA (AL, GA, TN, SC, VA, WV, NC)	LCD# L38765 LCA #A58350
Novitas JL (CO, NM, OK, TX, AR, LA, MS, DE, DC, MD, NJ, PA)	LCD #L34892 LCA# A56670
Noridian JE (CA, NV, HI)	LCD# L38801 LCA# A58403
Noridian JF (AK, AZ, ID, MT, WY, ND, OR, SD, UT, and WA)	LCD# L38803 LCA# A58405
NGS (IL, MN, WI, CT, NY, ME, MA, NH, RI, VT)	LCD# L35936 LCA# A57826
WPS (MI, IN, IA, KS, NE, MO, MN)	LCD# L38841 LCA #A57553
CGS (KY, OH)	LCD# L38773 LCA# A58364
First Coast (FL, Puerto Rico, Virgin Islands)	LCD# L33930 LCA# A57787

To locate the LCDs listed above: Go to: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx ENTER LCD # in Document ID (+) Add on

code. Only reimbursed in combination with the appropriate primary code

*Payer coverage limitations exist for facet joint denervation/destruction in the thoracic spine. Check with payer prior to performing procedure.

Indications for Use: The Boston Scientific Radiofrequency Generators, associated Radiofrequency Lesion Probes and RF Cannula are indicated for use in procedures to create radiofrequency lesions for the treatment of pain or for lesioning only peripheral nerve tissue for functional neurosurgical procedures. The Boston Scientific RF Injection Electrodes are used for percutaneous nerve blocks with local anesthetic solution or for radiofrequency lesioning of peripheral nerve tissue only. The Boston Scientific LCED and Stereotactic TCD Electrodes are indicated for use in radiofrequency (RF) heat lesioning of nervous tissue including the Central Nervous System.

Warnings: The Boston Scientific RF devices may cause interference with active devices such as neurostimulators, cardiac pacemakers, and defibrillators. Interference may affect the action of these active devices or may damage them. For appropriate guidance, consult the instructions for use for these active devices. Refer to the Instructions for Use provided with Boston Scientific generators, electrodes and cannulas for potential adverse effects, warnings and precautions prior to using these products. Caution: U.S. Federal law restricts this device to sale by or on the order of a physician.

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Information included herein is current as of November 2023 but is subject to change without notice. Rates for services are effective January 1, 2024.

Sequestration Disclaimer: Rates referenced in these guides do not reflect Sequestration; automatic reductions in federal spending that will result in a 2% across-the-board reduction to ALL Medicare rates as of January 1, 2022. (Budget Control Act of 2011)

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2. "National Average Payment" is the amount Medicare determines to be the maximum allowance for any Medicare covered procedure. Actual payment will vary based on the maximum allowance less any applicable deductibles, co-insurance etc.
3. ASC Status indicators: N1: Packaged service/item; no separate payment made. G2: Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
4. Outpatient Status Indicators: N: Items and Services Packaged into APC Rates. Payment is packaged into payment for other services. Therefore, there is no separate APC payment. T: Procedure or Service, Multiple Procedure Reduction applies
   J1: Hospital Part B services paid through a comprehensive APC.
5. APC Codes: 5431 Level 1 Nerve Procedures, 5441 Level 1 Nerve Injections
6. "ZZZ" are surgical codes, they are add-on codes that you must bill with another service. There is no post-operative work included in the MPFS payment
7. "YYY" are contractor-priced codes, for which contractors determine the global period. The global period for these codes will be 0, 10, or 90 days.
8. List of local Medicare carriers is not an exhaustive list. LCD Link. Please go to the appropriate Medicare contractor specific website to find the most updated state coverage jurisdiction.

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