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# 2021 Quick Reference Guide – Radio Frequency Ablation Facet Joint

## Reimbursement 2021

**Coding and Payment Guide for Medicare Reimbursement**: The following are the 2021 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 | $419 | $216 | 10 | G2 | $809 | J1 | 5431 | $1,754 |
| (+)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) | $190 | $64 | 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 | $415 | $213 | 10 | G2 | $809 | J1 | 5431 | $1,754 |
| (+)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.) | $173 | $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 | $261 |

## 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# L36471 LCA #A56687 |
| Novitas JL (CO, NM, OK, TX, AR, LA, MS, DE, DC, MD, NJ, PA) | LCD #L34892 LCA# A56670 |
| Noridian JE (CA, NV, HI) | LCD# L34993 LCA# A57727 |
| Noridian JF (AK, AZ, ID, MT, WY, ND, OR, SD, UT, and WA) | LCD# L34995 LCA# A57728 |
| NGS (IL, MN, WI, CT, NY, ME, MA, NH, RI, VT) | LCD# L35936 LCA# A57826 |
| WPS (MI, IN, IA, KS, NE, MO, MN) | LCD# L35996 LCA #A57553 |
| CGS (KY, OH ) | LCD# L34832 LCA# A56463 |
| First Coast (FL, Puerto Rico, Virgin Islands) | LCD# L33814 LCA# A57639 |

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 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: For a patient with a cardiac pacemaker, contact the pacemaker company to determine whether the pacemaker needs to be converted to fixed rate pacing during the radiofrequency procedure. Refer to the Instructions for Use provided with Boston Scientific generators, electrodes and cannulas for potential adverse effects, additional 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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**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, 2021. (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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