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RADIO FREQUENCY ABLATION 2025 REIMBURSEMENT GUIDE

FOR MORE PROCEDURE PAYMENT GUIDES, **CLICK HERE**

This reimbursement guide, for radio frequency ablation, provides coding and payment information for physicians and facilities to receive Medicare reimbursement. The Medicare payment amounts provided are national average payments. Actual reimbursement will vary based on different factors.

Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding, or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

This guide is intended to fully inform users. Sites of services must be based upon each patient's acuity of care needs. For radio frequency ablation procedures, few inpatient hospital admissions are expected.

INCLUDED IN THIS GUIDE:

Under each section in this guide are CPT codes and Medicare National Average Payments for physicians, Ambulatory Surgery Centers, and Hospital Outpatient.

1. Radio Frequency Ablation Facet Joint Reimbursement 2025
2. Radio Frequency Ablation Knee Joint Reimbursement 2025
3. Radio Frequency Ablation Sacroiliac Joint Reimbursement 2025
4. Facet Intervention Procedures — Medicare Prior Authorization Requirements

RADIO FREQUENCY ABLATION FACET JOINT REIMBURSEMENT 2025

Coding and Payment Guide for Medicare Reimbursement: The following are the 2025 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

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	$417	$187	10	G2	$925	J1	5431	$1,953
(+)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)	$241	$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	$421	$187	10	G2	$925	J1	5431	$1,953
(+)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.)	$226	$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[1]	N/A Packaged		T	5441	$295

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

RADIO FREQUENCY ABLATION KNEE JOINT REIMBURSEMENT 2025

Coding and Payment Guide for Medicare Reimbursement: The following are the 2025 Medicare coding and national payment rates for Radio Frequency Ablation (Knee Joint) procedures performed in an ambulatory surgical center, physician office, or outpatient hospital.

DIAGNOSTIC PROCEDURES

PROCEDURES		PHYSICIAN			AMBULATORY SURGERY CENTER		OUTPATIENT HOSPITAL		
CPT®[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]
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	$212	$80	000	G2	$372	T	5442	$693

THERAPEUTIC PROCEDURES

64624	Destruction by neurolytic agent, genicular nerve branches including guidance, when performed	$371	$143	10	G2	$925	J1	5431	$1,953

MEDICARE LOCAL COVERAGE DETERMINATIONS[8]

In the absence of an LCD, Medicare determines medical necessity on a case-by-case basis.

First Coast Service Options (FL)	LCD #L33933 LCA #A57788
NGS (IL, MN, WI, CT, NY, ME, MA, NH, RI, VT)	LCD #L36850 LCA #A57452

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.

RADIO FREQUENCY ABLATION SACROILIAC JOINT REIMBURSEMENT 2025

Coding and Payment Guide for Medicare Reimbursement: The following are the 2025 Medicare coding and national payment rates for Radio Frequency Ablation (Sacroiliac Joint) procedures performed in an ambulatory surgical center, physician office, or outpatient hospital.

DIAGNOSTIC PROCEDURES

PROCEDURES		PHYSICIAN			AMBULATORY SURGERY CENTER		OUTPATIENT HOSPITAL		
CPT®[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]
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with imaging guidance (ie, fluoroscopy or computed tomography)	$217	$80	000	G2	$372	T	5442	$693

THERAPEUTIC PROCEDURES

64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	$452	$191	10	G2	$925	J1	5431	$1,953

HOSPITAL OUTPATIENT MEDICARE PRIOR AUTHORIZATION REQUIREMENTS FOR FACET INTERVENTION PROCEDURES

Traditional Medicare, CMS will require a prior authorization/affirmation for facet joint interventions starting July 1,2023. Impacted procedures — Hospital based Joint Facet Injections and Radio Frequency Facet Ablations procedures requiring prior authorization.

Please refer to your Medicare Administrative Contractor (MAC) for up-to-date prior authorization information.

Effective date of CMS Affirmation / prior authorization requirement: **07/01/2023**
Date Medicare MACs will begin to receive authorization requests: **06/18/2023**

Hospital accounts Identify accounts that perform Paravertebral Facet Joint Injections and/Ablations

- Ensure awareness of the CMS requirement- July 1, 2023 RFA claims must include Authorization / Affirmation #
- At the Hospital — Identify the individual responsible for obtaining the prior authorizations
- Share the contact information of the doctor's office scheduling patient procedures
- Share the approved BSC Medicare RFA prior authorization education document(s) with LCD and LCA links
- Ask Hospital contact if they will complete the required authorization or delegate to the physician's office
- Share the webinar trainings scheduled from their MAC. (If applicable)

Physician accounts identify providers scheduling Injections or Radio Frequency Ablations at Hospitals after 7-1-2023

- Educate Doctors performing Facet Interventions in Hospitals on the new CMS requirement starting July 1st
- Identify the office staff responsible for scheduling and obtaining the prior authorizations
- Share the contact information of the hospital scheduling the procedure
- Share the approved BSC Medicare RFA prior authorization education document(s) with LCD and LCA links
- Share the webinar trainings scheduled from their MAC (if applicable)

7/1/2023: Confirm authorization number has been received for procedures at Hospitals prior to procedure

Things to remember:

- Involve your Regional Reimbursement Manager (RRM) to educate Offices and Hospitals.
- CMS expects a 10-14 day turn around for case review for approvals
- The affirmation # must be placed on the hospital claim or it will be denied
- Retro Authorizations (after the fact) will not be allowed by CMS
- Facet Injections or Ablations performed in ASC, Physician office or Critical Access Hospital- NO authorization required

See important notes on the uses and limitations of this information on the next page.

THERAPEUTIC CPT CODES (RFA)

- 64633 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance; cervical or thoracic single facet joint.
- (+)64634 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance; cervical or thoracic each additional facet joint.
- 64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance; lumbar or sacral single facet joint.
- (+)64636 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance; lumbar or sacral each additional facet joint.

DIAGNOSTIC CPT CODES (INJECTION)

- 64490 Injections(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoscopy or CT), cervical or thoracic; single level.
- (+) 64491 Injections(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoscopy or CT), cervical or thoracic; second level. (List separately)
- 64492 Injections(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoscopy or CT), cervical or thoracic; third and any additional)
- (+)64493 Injections(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoscopy or CT), lumbar or sacral; single level.
- (+)64494 Injections(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoscopy or CT), lumbar or sacral; second level.
- (+)64495 Injections(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoscopy or CT), lumbar or sacral; third and any additional levels.

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

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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. P3: Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non-facility PERVUs; payment based on MPFS non-facility PERVUs.
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, 5442: Level 2 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 90days.
8. List of local Medicare carriers is not an exhaustive list. Please go to the appropriate Medicare contractor specific website to find the most updated state coverage jurisdiction.

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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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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