Medical Coverage Policy

Pulsed Radiofrequency for the Treatment of Chronic Pain

☐ Device/Equipment  ☐ Drug  ☐ Medical  ☐ Surgery  ☐ Test  ☒ Other

Effective Date: 2/19/2008  Policy Last Updated: 3/19/2013

☐ Prospective review is recommended/required. Please check the member agreement for preauthorization guidelines.

☒ Prospective review is not required.

Description:
Used in the treatment of chronic spinal pain, pulsed radiofrequency is a nondestructive alternative to standard radiofrequency neurolysis. It is not considered a true radiofrequency therapy as it does not destroy or damage nerves. The procedure requires percutaneous advancement of a radiofrequency electrode to a specified site under imaging guidance. Next, radiofrequency energy is applied to the targeted pain-producing area with a pulsed time cycle that delivers short bursts of radiofrequency current instead of continuous radiofrequency flow. By pulsing the electrical current, the needle remains relatively cool (up to 42 degrees Celsius compared to temperatures of 60-90 degrees Celsius with continuous radiofrequency). The tissue cools slightly between each burst, reducing the risk of destroying nearby tissue and preventing any long-term damage to the nerve. It is claimed that this disrupts the transmission of impulses across small unmyelinated fibers without destroying them while larger fibers remain protected by the myelin sheath.

Pulsed radiofrequency does not appear to be as effective as non-pulsed radiofrequency denervation, and there is insufficient evidence to evaluate the efficacy of laser denervation or cryodenervation for facet joint pain. Therefore, these techniques are considered not medically necessary.

Medical Criteria:
None

Policy:
Pulsed radiofrequency treatment for pain is considered not medically necessary because there is insufficient evidence in the published medical literature to demonstrate its safety and efficacy in the treatment of spinal pain.

Coverage:
Benefits may vary between groups/contracts. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement, or Benefit Booklet for applicable not medically necessary benefits/coverage.

Coding:
At this time there are no specific CPT codes to describe pulsed radiofrequency. Providers should file using the unlisted code below:
64999
Also known as:
Cold radiofrequency

Related to:
Not applicable

Published:
Provider Update, June 2013
Provider Update, May 2012
Provider Update, May 2011
Provider Update, May 2010
Provider Update, July 2009
Provider Update, June 2008

References:


History:
3/19/13 Annual Review
2/21/12 Annual Review
3/1/11 Annual Review
3/16/10 Annual Review
4/7/09 Annual Review
2/19/08 New policy approved

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supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice.