

Genicular Nerve Ablation

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<u>Coverage Policy</u>	Surgical 110
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All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Genicular Nerve Ablation.

Description & Definitions:

Genicular nerve ablation uses heat, cold or chemicals to disrupt nerve transmission with the goal of alleviating pain. Types of Genicular Nerve ablation are radiofrequency (RFA), pulsed radiofrequency, cooled radiofrequency {COOLIEF, lopera} cryoablation, cryoneurolysis/cryoanalgesia, or chemical neurolysis (chemodenervation).

Criteria:

Genicular Nerve Ablation is considered **not medically necessary** for any indication.

Coding:

Medically necessary with criteria:

Coding	Description
	None

Considered Not Medically Necessary:

Coding	Description
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed

U.S. Food and Drug Administration (FDA) - approved only products only.

Surgical 110

Document History:

Revised Dates:

- 2021: March, June
- 2020: March
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- 2024: February
- 2023: February
- 2022: March
- 2018: September
- 2017: June

Effective Date:

- September 2016

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

(2023, Sep 21). Retrieved Jan 25, 2024, from MCG: <https://careweb.careguidelines.com/ed27/index.html>

Deveza, L., & Bennell, K. (2022, Dec 20). Management of moderate to severe knee osteoarthritis. Retrieved Jan 25, 2024, from UpToDate: https://www.uptodate.com/contents/management-of-moderate-to-severe-knee-osteoarthritis?search=genicular%20nerve%20ablation&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H1962599098

Genicular Nerve Block for Treatment of Knee Osteoarthritis. (2023, Dec 07). Retrieved Jan 19, 2024, from Hayes - a symplr company: <https://evidence.hayesinc.com/report/htb.genicular3323>

Interventional Pain Management. (2024, Jan 01). Retrieved Jan 25, 2024, from Caredon Medical Benefits Management: <https://guidelines.caredonmedicalbenefitsmanagement.com/interventional-pain-management-2024-01-01/>

LCD: Peripheral Nerve Blocks (L36850). (2019, Nov 21). Retrieved Jan 25, 2024, from Centers for Medicare and Medicaid Services: <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=36850&ver=24>

Management of Osteoarthritis of the Knee (Non-Arthroplasty). (2021, Aug 31). Retrieved Jan 29, 2024, from American Academy of Orthopaedic Surgeons: <https://www.aaos.org/globalassets/quality-and-practice-resources/osteoarthritis-of-the-knee/oak3cpg.pdf>

Manual search results. (2024). Retrieved Jan 25, 2024, from Department of Medical Assistance Services - MES Public Portal: <https://vamedicaid.dmas.virginia.gov/manuals/provider-manuals-library#gsc.tab=0&gsc.q=genicular&gsc.sort=>

Radiofrequency Nerve Ablation for the Management of Osteoarthritis of the Knee. (2023, Dec 28). Retrieved Jan 19, 2024, from Hayes - a symplr company: <https://evidence.hayesinc.com/report/htb.peripheralknee4051>

Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage

are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to “correct or ameliorate” (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member’s condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Genicular Radiofrequency Nerve Ablation, Surgical 110, knee pain, nerves, anesthetic, needle, Cooled Radiofrequency Ablation, thermal Radiofrequency Ablation, peripheral nerve block ablation