Pain Management

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➲ Instructions for Use

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Coverage Rationale

Stimulators for Pain Management

Stimulators for pain management, e.g., percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT) for pain therapy and are covered when criteria are met. Refer to the Medicare Advantage Medical Policy titled Electrical Stimulators.

Massage Therapy

Massage therapy is not covered except if it is part of multi-modality authorized treatment plan appropriate to the member's diagnosis plan with a licensed therapist in attendance. Refer to the Medicare Advantage Medical Policy titled Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospital.

Sacroiliac (SI) Joint Denervation

Medicare does not have a National Coverage Determination (NCD) for SI joint denervation. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Sacroiliac (SI) Joint Denervation.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Ablative Treatment for Spinal Pain.

Injection, Anesthetic Agent, Greater Occipital Nerve

Medicare does not have a National Coverage Determination (NCD) for injection, anesthetic agent, greater occipital nerve. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Injection, Anesthetic Agent, Greater Occipital Nerve.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache).

Decompression and Transection or Avulsion of Greater Occipital Nerve for Treatment of Headaches

Medicare does not have a National Coverage Determination (NCD) for decompression and transection or avulsion of the greater occipital nerve for the treatment of headaches. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache).

Radiofrequency Ablation (RFA) of Intraosseous Basivertebral Nerve (BVN) for Spinal Pain (e.g., Intracept® System)

Medicare does not have a National Coverage Determination (NCD) for RFA of intraosseous BVN for spinal pain. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for RFA of the Intraosseous BVN for Spinal Pain.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Ablative Treatment for Spinal Pain.

Genicular Neve Block (GNB) and Radiofrequency Ablation (RFA) for the Treatment of Chronic Knee Pain

Medicare does not have a National Coverage Determination (NCD) for GNB and RFA to treat chronic knee pain. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for GNB and RFA for Treatment of Chronic Knee Pain.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Cooled Radiofrequency Ablation (CRFA) of Genicular Nerve

Medicare does not have a National Coverage Determination (NCD) for CRFA of genicular nerve. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist.

For coverage guidelines, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Percutaneous Cryoneurolysis for the Treatment of Chronic Pain (e.g., iovera° System)

Medicare does not have a National Coverage Determination (NCD) for percutaneous cryoneurolysis for the treatment of chronic pain. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Percutaneous Cryoneurolysis for the Treatment of Chronic Pain.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Pulsed Radiofrequency Ablation (RFA) for Spinal Pain

Medicare does not have a National Coverage Determination (NCD) for pulsed RFA for spinal pain. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Pulsed RFA and/or Cooled RFA for Spinal Pain.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Ablative Treatment for Spinal Pain.

Cooled Radiofrequency Ablation (RFA) or Cryoablation for Spinal Pain

Medicare does not have a National Coverage Determination (NCD) for cooled RFA or cryoablation for spinal pain. Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist. and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Pulsed RFA and/or Cooled RFA for Spinal Pain.

For coverage guidelines for states/territories with no LCDs/LCAs, refer to the UnitedHealthcare Commercial Medical Policy titled Ablative Treatment for Spinal Pain.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
Sacroiliac (SI) Joint Denervation	
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography) [Refer to the UnitedHealthcare Commercial Medical Policy titled Ablative Treatment for Spinal Pain]
Injection, Anesthetic Agent, Greater Occipital Nerve	
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve
Decompression and Transection or Avulsion of Greater Occipital Nerve for Treatment of Headaches	
64722	Decompression: unspecified nerve(s) (specify)
64744	Transection or avulsion of; greater occipital nerve
RFA of Intraosseous BVN for Spinal Pain	
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (List separately in addition to code for primary procedure)
22899	Unlisted procedure, spine [when used to report the Intracept procedure]
GNB and RFA for the Treatment of Chronic Knee Pain	
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
CRFA of Genicular Nerve	
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
64999	Unlisted procedure, nervous system [when used to report any method of radiofrequency ablation]
Percutaneous Cryoneurolysis for the Treatment of Chronic Pain	
0440T	Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve
0441T	Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve
0442T	Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial plexus, pudendal nerve)
Pulsed RFA for Spinal Pain	
64999	Unlisted procedure, nervous system [when used to report pulsed RFA for Spinal Pain]
22899	Unlisted procedure, spine
Cooled RFA for Spinal Pain	
22899	Unlisted procedure, spine [when used to report cooled radiofrequency ablation]

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
Sacroiliac (SI) Joint Denervation				
N/A	L39383 Sacroiliac Joint Injections and Procedures	A59154 Billing and Coding: Sacroiliac Joint Injections and Procedures	Part A and B MAC	CGS
	L39455 Sacroiliac Joint Injections and Procedures	A59233 Billing and Coding: Sacroiliac Joint Injections and Procedures	Part A and B MAC	NGS
	L39462 Sacroiliac Joint Injections and Procedures	A59244 Billing and Coding: Sacroiliac Joint Injections and Procedures	Part A and B MAC	Noridian
	L39464 Sacroiliac Joint Injections and Procedures	A59246 Billing and Coding: Sacroiliac Joint Injections and Procedures	Part A and B MAC	Noridian
	L39402 Sacroiliac Joint Injections and Procedures	A59192 Billing and Coding: Sacroiliac Joint Injections and Procedures	Part A and B MAC	Palmetto**
	L39475 Sacroiliac Joint Injections and Procedures	A59257 Billing and Coding: Sacroiliac Joint Injections and Procedures	Part A and B MAC	WPS*
Injection, Anesthetic Agent, Greater Occipital Nerve				
N/A	L33933 Peripheral Nerve Blocks	A57788 Billing and Coding: Peripheral Nerve Blocks	Part A and B MAC	First Coast
	L36850 Peripheral Nerve Blocks	A57452 Billing and Coding: Peripheral Nerve Blocks	Part A and B MAC	NGS
	L35456 Nerve Blockade for Treatment of Chronic Pain and Neuropathy	A56034 Billing and Coding: Nerve Blockade for Treatment of Chronic Pain and Neuropathy	Part A and B MAC	Noridian
	L35457 Nerve Blockade for Treatment of Chronic Pain and Neuropathy	A52725 Billing and Coding: Nerve Blockade for Treatment of Chronic Pain and Neuropathy	Part A and B MAC	Noridian
RFA of the Intraosseous BVN for Spinal Pain				
N/A	L39420 Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain	A59205 Billing and Coding: Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain	Part A and B MAC	Palmetto**
	L39642 Intraosseous Basivertebral Nerve Ablation	A59466 Billing and Coding: Intraosseous Basivertebral Nerve Ablation	Part A and B MAC	Noridian
	L39644 Intraosseous Basivertebral Nerve Ablation	A59468 Billing and Coding: Intraosseous Basivertebral Nerve Ablation	Part A and B MAC	Noridian

NCD	LCD	LCA	Contractor Type	Contractor Name
GNB and RFA for the Treatment of Chronic Knee Pain				
N/A	L33933 Peripheral Nerve Blocks	A57788 Billing and Coding: Peripheral Nerve Blocks	Part A and B MAC	First Coast
	L36850 Peripheral Nerve Blocks	A57452 Billing and Coding: Peripheral Nerve Blocks	Part A and B MAC	NGS
Percutaneous Cryoneurolysis for the Treatment of Chronic Pain				
N/A	N/A	A59752 Billing and Coding: Cryoneurolysis Instructions	Part A and B MAC	Noridian
	N/A	A59753 Billing and Coding: Cryoneurolysis Instructions	Part A and B MAC	Noridian
Pulsed RFA and/or Cooled RFA for Spinal Pain				
N/A	L33930 Facet Joint Interventions for Pain Management	A57787 Billing and Coding: Facet Joint Interventions for Pain Management	Part A and B MAC	First Coast
	L35936 Facet Joint Interventions for Pain Management	A57826 Billing and Coding: Facet Joint Interventions for Pain Management	Part A and B MAC	NGS
	L38765 Facet Joint Interventions for Pain Management	A58350 Billing and Coding: Facet Joint Interventions for Pain Management	Part A and B MAC	Palmetto**
	L38841 Facet Joint Interventions for Pain Management	A58477 Billing and Coding: Facet Joint Interventions for Pain Management	Part A and B MAC	WPS*

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

Policy History/Revision Information

Date	Summary of Changes
04/01/2025	**Applicable Codes** • Removed CPT code 27599 **Supporting Information** • Archived previous policy version MMP070.09

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate’s requirements need to be followed.