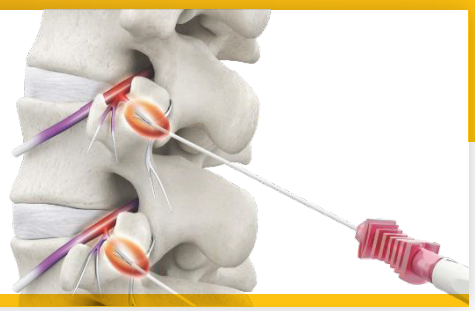
Radiofrequency ablation



Physician[1]

CPT® code[2]	Description	Payment in office	Payment in facility	Relative value units (RVUs)		Global period
				Nonfacility RVUs	Facility RVUs	
Spine						
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	$459	$173	13.74	5.17	10
+64634	Cervical or thoracic, each additional facet joint (list separately in addition to code for primary procedure)	$267	$58	7.98	1.73	ZZZ
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	$465	$173	13.93	5.18	10
+64636	Lumbar or sacral, each additional facet joint (list separately in addition to code for primary procedure)	$252	$51	7.53	1.52	ZZZ
Genicular nerve/peripheral nerve						
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	$412	$133	12.32	3.99	10
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	$496	$177	14.85	5.29	10
64640	Destruction by neurolytic agent; other peripheral nerve or branch	$268	$112	8.02	3.34	10
Unlisted code						
64999	Unlisted procedure, nervous system	CP	CP	N/A	N/A	YYY

ZZZ: Add-on codes that must be billed with another service. The Medicare PFS payment doesn't include post-operative work ZZZ codes.
YYY: The carrier is to determine whether the global concept applies and establishes post-operative period, if appropriate, at time of pricing.
CP: Carrier-priced

Ambulatory surgery center (ASC)[3]

CPT® code[2]	Description	Payment indicator	Multiple procedure discounting	ASC payment
Spine				
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	G2	Y	$949
+64634	Cervical or thoracic, each additional facet joint (list separately in addition to code for primary procedure)	N1	N/A	N/A
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	G2	Y	$949
+64636	Lumbar or sacral, each additional facet joint (list separately in addition to code for primary procedure)	N1	N/A	N/A
Genicular nerve/peripheral nerve				
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	G2	Y	$949
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	G2	Y	$949
64640	Destruction by neurolytic agent; other peripheral nerve or branch	P3	Y	$197
Unlisted code				
64999	Unlisted procedure, nervous system	IO	N/A	Not on Medicare ASC list

G2: Non-office based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
N1: Packaged service/item; no separate payment made.
P3: Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS non facility PE RVUs; payment based on MPFS non facility PE RVUs.
IO: Surgical procedure not on ASC allowable list.

Hospital outpatient[3]

CPT® code[2]	Description	Status indicator	Ambulatory payment classification (APC)	APC payment
Spine				
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	J1	5431	$1,995
+64634	Cervical or thoracic, each additional facet joint (list separately in addition to code for primary procedure)	N	N/A	N/A
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	J1	5431	$1,995
+64636	Lumbar or sacral, each additional facet joint (list separately in addition to code for primary procedure)	N	N/A	N/A
Genicular nerve/peripheral nerve				
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	J1	5431	$1,995
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	J1	5431	$1,995
64640	Destruction by neurolytic agent; other peripheral nerve or branch	T	5443	$904
Unlisted code				
64999	Unlisted procedure, nervous system	T	5441	$314

J1: Hospital Part B services paid through a comprehensive APC
N: Items and services packaged into APC rates
T: Procedure or service, multiple procedure reduction applies

HCPCS II device codes[4]

C1886
Catheter, extravascular tissue ablation, any modality (insertable)

A4649
Surgical supply; miscellaneous

Notes:

- "N/A" indicates that this concept does not apply, or that Medicare has not developed fee schedules in those settings of care.
- Codes 64633, 64634, 64635, 64636, & 64999 (spine) and codes 64624 & 64640 (knee) on destruction by neurolytic agent for RF ablation may be performed as bilateral procedures. If performing radiofrequency on both sides of the body, report these codes using the appropriate bilateral modifier (50).
- Do not report codes 64633, 64634, 64635, and 64636 for nonthermal facet joint denervation including chemical, lowgrade thermal energy (<80 degrees Celsius), or any form of pulsed radiofrequency. To appropriately report any of these modalities, use 64999.
- Diagnostic procedures are performed with the intent to determine if radiofrequency ablation should be considered as a treatment for pain management. Please refer to applicable Medicare local coverage determination for additional information.

References

1. 2026 CMS PFS Final Rule, Addendum B (published November 3, 2025). Medicare national average physician payment rates listed in this document are based on the 11/3/25 release of the relative value file and non-qualifying APM conversion factor of 33.4009. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f.
2. Current Procedural Terminology 2025, American Medical Association. Chicago, IL 2025. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2025 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
3. 2026 CMS OPPS/ASC Final Rule, Addendum AA, B and J (published November 21, 2025). https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc.
4. Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare and Medicaid Services.

Indications for use

For Stryker products, refer to Indications for Use section within the Instructions for Use (IFU).

Questions? Contact IVS reimbursement support

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