



# Radiofrequency ablation

CPT code <sup>1</sup>	Description	Physician fees <sup>2</sup>		Relative value units (RVUs) <sup>2</sup>		Hospital outpatient <sup>3</sup>		Ambulatory surgery center (ASC) <sup>3</sup>	
		Payment in office	Payment in facility	Non facility RVUs	Facility RVUs	Device code <sup>4</sup>	Ambulatory payment classification (APC)	APC payment	ASC payment
<b>Spine</b>									
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	\$433	\$187	13.10	5.65	C1889 Implantable/ insertable device, not otherwise classified device	5431	\$1,798	\$854
64634	Cervical or thoracic, each additional facet joint (list separately in addition to code for primary procedure)	\$255	\$65	7.71	1.97		N/A	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	\$437	\$187	13.22	5.66		5431	\$1,798	\$854
64636	Lumbar or sacral, each additional facet joint (list separately in addition to code for primary procedure)	\$240	\$58	7.25	1.74		N/A	N/A	N/A
<b>Genicular nerve/peripheral nerve</b>									
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	\$385	\$142	11.64	4.31	A4649 Surgical supply; miscellaneous (cannulae)	5431	\$1,798	\$854
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	\$467	\$190	14.13	5.75				
64640	Destruction by neurolytic agent; other peripheral nerve or branch	\$244	\$116	7.37	3.50				
<b>Unlisted code</b>									
64999	Unlisted procedure, nervous system	Contractor priced	Contractor priced	N/A	N/A		5441	\$272	Not on Medicare ASC list

## References

1. Current Procedural Terminology 2022, American Medical Association. Chicago, IL 2022. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2022 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2. 2023 CMS PFS Final Rule, Addendum B (available on CMS website, published November 2, 2022). Medicare national average physician payment rates listed in this document are based on the November 2022 release of the relative value file and conversion factor of 33.0607.
3. 2023 CMS OPFS/ASC Final Rule, Addendum AA, B and J (available on CMS website, published November 1, 2022).
4. Healthcare Common Procedure Coding System (HCPCS) Level II codes are maintained by the Centers for Medicare and Medicaid Services.

## 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 non-thermal facet joint denervation including chemical, low-grade 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.

## Indications for use

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

**This document is intended solely for the use of healthcare professionals. Reimbursement, coding, coverage and payment information is provided for general information only and is not intended to provide coverage, coding, payment, medical treatment or legal advice. Stryker does not warrant, promise, guarantee or make any statement that the codes supplied in this guide are appropriate for any individual patient or that the use of this information will result in coverage or payment for treatment using any Stryker products or that any payment received will reimburse a provider’s costs. The information is not intended to guarantee or increase payment by any payor. Laws, regulations and policies concerning reimbursement are complex, subject to change and updated regularly.**

**Stryker does not assume any responsibility for coding decisions, nor does it recommend codes for specific patients’ procedures. The provider is solely responsible for reporting the codes that accurately describe the services furnished to a particular patient as well as the patient’s medical condition. It is the provider’s responsibility to determine and document that the services provided are medically necessary and that the site of service is appropriate. It is the health care provider’s responsibility to report the patient diagnosis, the procedures performed and the**

## Interventional Spine

A physician must always rely on his or her own professional clinical judgment when deciding whether to use a particular product when treating a particular patient. We do not dispense medical advice and recommend that physicians be trained in the use of any particular product before using it. The information presented is intended to demonstrate Stryker’s products. A physician must always refer to the package insert, product label and/or instructions for use, including the instructions for cleaning and sterilization (if applicable), before using any of Stryker’s products. Products may not be available in all markets because product availability is subject to the regulatory and/or medical practices in individual markets. Please contact your representative if you have questions about the availability of Stryker’s products in your area.

Stryker defers to specialty society guidelines, payer policies and guidelines, Medicare and the AMA regarding the submission of claims and the appropriate coding for procedures and products.

Reimbursement has three components, coding, coverage and payment. All three must be aligned for providers to receive reimbursement for the services they furnish. Payment rates are calculated and represent the national unadjusted payment rates. Payment to individual providers will vary based on a number of variables, including geographic location.

This information in this document is accurate as of December 5, 2022, and all coding and reimbursement information is subject to change without notice. Please contact your Medicare Administrative Contractor or Private Payer for billing, payment and coverage information.

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