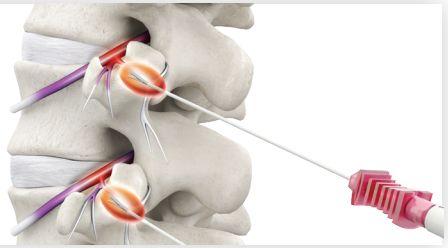
Procedure coding and Medicare payment

# Radiofrequency ablation



| | | Physician fees[2] | | Relative value units (RVUs)[2] | | Hospital outpatient[3] | | | Ambulatory surgery center (ASC)[3] |
|---|---|---|---|---|---|---|---|---|---|
| **CPT code[1]** | **Description** | **Payment in office** | **Payment in facility** | **Non facility RVUs** | **Facility RVUs** | **Device code[4]** | **Ambulatory payment classification (APC)** | **APC payment** | **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 | $417 | $187 | 12.89 | 5.77 | | 5431 | $1,953 | $925 |
| **64634** | Cervical or thoracic, each additional facet joint (list separately in addition to code for primary procedure) | $241 | $65 | 7.46 | 2.00 | | 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 | $421 | $187 | 13.00 | 5.77 | **C1889** Implantable/ insertable device, not otherwise classified device | 5431 | $1,953 | $925 |
| **64636** | Lumbar or sacral, each additional facet joint (list separately in addition to code for primary procedure) | $226 | $57 | 7.00 | 1.76 | | N/A | N/A | N/A |
| **Genicular nerve/peripheral nerve** | | | | | | | | | |
| **64624** | Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed | $371 | $143 | 11.46 | 4.41 | **A4649** Surgical supply; miscellaneous (cannulae) | 5431 | $1,953 | $925 |
| **64625** | Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) | $452 | $191 | 13.96 | 5.90 | | | | |
| **64640** | Destruction by neurolytic agent; other peripheral nerve or branch | $241 | $117 | 7.45 | 3.62 | | 5443 | $891 | $170 |
| **Unlisted code** | | | | | | | | | |
| **64999** | Unlisted procedure, nervous system | Contractor priced | Contractor priced | N/A | N/A | | 5441 | $295 | Not on Medicare ASC list |

## References


1. Current Procedural Terminology 2024, American Medical Association. Chicago, IL 2024. CPT is a registered trademark of the American Medical Association. Current Procedural Terminology (CPT®) is copyright 2024 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
2. 2025 CMS PFS Final Rule, Addendum B (published November 1, 2024). Medicare national average physician payment rates listed in this document are based on the November 2024 release of the relative value file and conversion factor of 32.3465. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f.
3. 2025 CMS OPPS/ASC Final Rule, Addendum AA, B and J (published November 1, 2024). https://www.cms.gov/medicare/regulations-guidance/fee-for-service-payment-regulations.
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 products used, consistent with the specific payer's guidelines.**

## Interventional Spine

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 November 12, 2024, 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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