MEDICAL POLICY – 7.01.555
Facet Joint Denervation

BCBSA Ref. Policy: 7.01.116

Effective Date: Aug. 1, 2022
Last Revised: July 12, 2022
Replaces: 7.01.116

RELATED MEDICAL POLICIES:
7.01.107 Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)
7.01.125 Occipital Nerve Stimulation

Select a hyperlink below to be directed to that section.

- POLICY CRITERIA
- DOCUMENTATION REQUIREMENTS
- CODING
- RELATED INFORMATION
- EVIDENCE REVIEW
- REFERENCES
- HISTORY

∞ Clicking this icon returns you to the hyperlinks menu above.

Introduction

Back pain is a common symptom and disability in some people. Despite extensive knowledge of the bones, nerves, muscles, tendons, and structures of the spine, it is still very difficult to identify a specific source of back pain for many people. A part of the spine felt to cause pain for some people are the facet joints. Facet joints connect the bones of the spine (vertebrae) to stabilize your back and help your spine move. Arthritis or boney changes can develop in these small joints. It is felt that nerves can be compressed by the arthritic changes and lead to pain. Studies have shown that for a small number of people, back pain can be improved by destruction of these nerves (denervation). The nerves are destroyed using a form of electrical waves known as non-pulsed radiofrequency waves. Often the denervation must be repeated every 6 to 12 months because the nerves grow back. Because only a small number of people respond to this treatment, it is important to undergo temporary nerve blocks to identify who will get relief from the radiofrequency treatment. This service must be pre-approved by the plan before it is covered. Records that show at least two successful temporary nerve blocks are needed. Studies have shown that other methods of destroying these nerves (such as pulsed radiofrequency, heat, laser, chemical or freezing) do not work.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can
be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

**Policy Coverage Criteria**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Medical Necessity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-pulsed radiofrequency denervation:</td>
<td>Non-pulsed radiofrequency denervation of cervical facet joints (C2-3 and below), thoracic, and lumbar facet joints is considered medically necessary when ALL of the following criteria are met:</td>
</tr>
<tr>
<td>• Cervical</td>
<td>• There is no prior spinal fusion surgery in the vertebral level being treated</td>
</tr>
<tr>
<td>• Lumbar</td>
<td>• Patient has experienced disabling low back (lumbosacral) or neck (cervical) pain for greater than three (3) months, suggestive of facet joint origin and other causes of cervical or lumbar pain such as disc herniation or narrowing of the vertebral canal have been excluded as documented in the medical record and radiographic imaging</td>
</tr>
<tr>
<td>• Thoracic</td>
<td>• Pain has failed to respond to three (3) months of conservative management, which may consist of therapies such as oral analgesics (nonsteroidal anti-inflammatory medications, acetaminophen), manipulation or physical therapy, and a home exercise program</td>
</tr>
<tr>
<td>OR</td>
<td>• There has been a successful trial of two controlled medial branch blocks (MBBs) with at least 80% pain relief for the duration of the anesthetic prior to performing the second MBB (see Related Information)</td>
</tr>
<tr>
<td>OR</td>
<td>• If there has been a prior successful radiofrequency denervation, a minimum time of six (6) months has elapsed since prior RF treatment (per side, per anatomical level of the spine)</td>
</tr>
</tbody>
</table>
**Procedure** | **Medical Necessity**
---|---
| | o There should be a progress note supporting response to prior RF treatment

**Additional diagnostic medial branch blocks** | If there has been a prior successful radiofrequency denervation, additional diagnostic medial branch blocks for the same level of the spine are not medically necessary.

--- | ---
**Procedure** | **Investigational**
---|---
**Radiofrequency denervation** | Radiofrequency denervation is considered investigational for the treatment of chronic spinal/back pain for all uses that do not meet the criteria listed above.

**Therapeutic medial branch blocks** | Therapeutic medial branch blocks are considered investigational.

**All other methods of facet denervation** | All other methods of denervation are considered investigational for the treatment of chronic spinal/back pain, including, but not limited to:
- Pulsed radiofrequency denervation
- Laser denervation
- Chemodenervation
  - Alcohol, phenol, or high-concentration local anesthetics
- Cryodenervation
- Cooled radiofrequency ablation for facet denervation (e.g., COOLIEF)
- Endoscopic radiofrequency denervation

**Documentation Requirements**

For requests for non-pulsed radiofrequency denervation of cervical facet joints (C2-3 and below) and lumbar facet joints, please provide the following current clinical notes:

- The level and side (right or left) you are planning to treat
- Documentation that no prior spinal fusion surgery was done in the vertebral level (the specific area) being treated
- Detailed history and physical with notes detailing how long the patient has experienced disabling low back or neck pain
- Evidence that suggests the pain is arising from the facet joint and documentation that other causes of the pain have been ruled out (e.g., copy of imaging showing absence of disc herniation or narrowing of the vertebral canal)
### Documentation Requirements

- Conservative treatment tried/failed for at least 3 months (conservative treatment may consist of therapies such as oral analgesics [nonsteroidal anti-inflammatory medications, acetaminophen], manipulation or physical therapy, and a home exercise program)

- Documentation of successful trial of controlled diagnostic medial branch blocks. Documentation shows at least 80% pain relief for the duration of anesthetic from the first medical branch block before the second medical branch block is performed:
  - Medial branch blocks should consist of 2 separate positive blocks on different days with local anesthetic only (no steroids or other drugs)
  - Medial branch blocks should involve the vertebral levels being considered for radiofrequency treatment and should not be conducted under intravenous sedation unless specifically indicated (e.g., the patient is unable to cooperate with the procedure)

- If there has been a prior successful radiofrequency denervation:
  - There should be documentation that a minimum of six (6) months has passed since prior radiofrequency treatment (per side, per vertebral level of the spine)
  - Clinical note showing response to prior radiofrequency treatment

### Coding

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (CT or fluoroscopy); cervical or thoracic, single facet joint</td>
</tr>
<tr>
<td>64633</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>64634</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint</td>
</tr>
<tr>
<td>64635</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>64999</td>
<td>Unlisted procedure, nervous system</td>
</tr>
</tbody>
</table>
Definition of Terms

**Diagnosis of facet-mediated pain:** This requires the establishment of pain relief following dual medial branch blocks (MBBs) performed at different sessions. Neither physical exam nor imaging has adequate diagnostic power to confidently distinguish the facet joint as the pain source.

**Facet joints (also referred to as zygapophyseal or Z-joints):** These enable the spine to bend and twist. Each vertebra has a set of facet joints at the top and bottom. Two medial branch (MB) nerves innervate the zygapophyseal joints.

**Region:** All injections performed in cervical/thoracic or all injections performed in lumbar (not sacral) spinal areas.

**Session:** All injections/blocks/RF procedures performed on one day and includes medial branch blocks (MBB), intraarticular injections (IA), facet cyst ruptures, and RF ablations.

**Diagnostic Medial Branch Block Criteria**

- A successful trial of controlled diagnostic medial branch blocks consists of 2 separate positive blocks on different days with local anesthetic only (no steroids or other drugs), **OR**

- A placebo-controlled series of blocks, under fluoroscopic guidance, that has resulted in at least an 80% reduction in pain for the duration of the local anesthetic used (e.g., 3 hours longer with bupivacaine than lidocaine).

- No therapeutic intra-articular injections (i.e., steroids, saline, or other substances) should be administered for a period of at least 4 weeks prior to the diagnostic medial branch block.

- The diagnostic blocks should involve the levels being considered for RF treatment and should not be conducted under intravenous sedation unless specifically indicated (e.g., the patient is unable to cooperate with the procedure).

- These diagnostic blocks should be targeted to the likely pain generator. Single-level blocks lead to more precise diagnostic information, but multiple single-level blocks require several visits and additional exposure to radiation.
Evidence Review

Description

Percutaneous radiofrequency (RF) facet denervation is used to treat neck and back pain originating in facet joints with degenerative changes. Diagnosis of facet joint pain is confirmed by response to nerve blocks. The goal of facet denervation is long-term pain relief. However, the nerves regenerate and, therefore, repeat procedures may be required.

Background

Facet joint denervation is performed under local anesthetic and with fluoroscopic guidance. A needle or probe is directed to the median branch of the dorsal ganglion innervating the facet joint, where multiple thermal lesions are produced, typically by a RF generator. A variety of terms may be used to describe RF denervation (e.g., rhizotomy, rhizolysis). In addition, the structures to which the RF energy is directed may be referred to as facet joint, facet nerves, medial nerve or branch, median nerve or branch, or dorsal root ganglion.

Alternative methods of denervation include pulsed RF, laser, chemodenervation and cryoablation, cooled radiofrequency denervation, and endoscopic radiofrequency ablation. Pulsed RF consists of short bursts of electric current of high voltage in the RF range but without heating the tissue enough to cause coagulation. RF is suggested as a possibly safer alternative to thermal RF facet denervation. Temperatures do not exceed 42°C at the probe tip versus temperatures in the 60°C range reached in thermal RF denervation, and tissues may cool between pulses. It is postulated that transmission across small unmyelinated nerve fibers is disrupted but not permanently damaged, while large myelinated fibers are not affected. With chemical denervation, injections with a diluted phenol solution, a chemical ablating agent, are injected into the facet joint nerve. Endoscopic radiofrequency ablation (rhizotomy) is an alternative to percutaneous electrode RFA. It is a posterior endoscopic method using a cannula with a video camera at one end and a specially designed radiofrequency bipolar electrode.
Summary of Evidence

For individuals with suspected facet joint pain who receive diagnostic medial branch blocks, the evidence includes systematic reviews, a small randomized trial, and observational studies. The relevant outcomes are other test performance measures, symptoms, and functional outcomes. There is considerable controversy about the role of these blocks, the number of positive blocks required, and the extent of pain relief obtained. Studies have reported the use of single or double blocks and at least 50% or 80% improvement in pain and function. This evidence has suggested that there are relatively few patients who exhibit pain relief following two nerve blocks, but that these select patients may have pain relief for several months following RF denervation. Other large series have reported the prevalence and false-positive rates following controlled diagnostic blocks, although there are issues with the reference standards used in these studies because there is no criterion standard for the diagnosis of facet joint pain. There is level I evidence for the use of medial branch blocks for diagnosing chronic lumbar facet joint pain and level II evidence for diagnosing cervical and thoracic facet joint pain. The evidence available supports a threshold of at least 75% to 80% pain relief to reduce the false-positive rate. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with facet joint pain who receive radiofrequency ablation (RFA), the evidence includes systematic reviews and RCTs. The relevant outcomes are symptoms, functional outcomes, quality of life, and medication use. While the evidence is limited to randomized controlled trials with small sample sizes, RF facet denervation appears to provide at least 50% pain relief in carefully selected patients. Diagnosis of facet joint pain is difficult. However, response to controlled medial branch blocks and the presence of tenderness over the facet joint appears to be reliable predictors of success. When RF facet denervation is successful, repeat treatments appear to have similar success rates and duration of pain relief. Thus, the data indicate that, in carefully selected individuals with lumbar or cervical facet joint pain, RF treatments can improve outcomes. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with facet joint pain who receive therapeutic medial nerve branch blocks or alternative methods of facet joint denervation the evidence includes a systematic review, randomized trials without a sham control, and uncontrolled case series. The relevant outcomes are symptoms, functional outcomes, quality of life, and medication use. Pulsed RF does not appear to be as effective as conventional RF denervation, and there is insufficient evidence to evaluate the efficacy of other methods of denervation (e.g., alcohol, laser, cryodenervation) on facet joint pain or the effect of therapeutic medial branch blocks on facet joint pain. The
evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

McCormick et al (2014) stated that while cooled radiofrequency ablation (C-RFA) appeared to be a promising technology for joint denervation, outcomes of this technique for the treatment of lumbar facet syndrome have not been described. The authors concluded that the findings in this case series study suggested that C-RFA may improve function and to a lesser degree pain at long-term follow-up. However, a randomized, controlled trial is needed. A subsequent RCT (McCormick et al, 2019) of small sample size and only 6 month follow-up showed no significant differences between C-RFA and traditional RFA for the treatment of lumbar facet joint pain.

Clinical outcomes from a pilot study evaluating endoscopic radiofrequency ablation (rhizotomy) were presented as a professional society conference abstract, (Yeung et al. 2011). A RCT, (Xue et al 2020), suggests that radiofrequency ablation under endoscopic guidance may achieve more accurate and definite denervation on the nerves, which may lead to longer lasting pain relief. Sample size was small (N-60). There is insufficient evidence identified in the published medical literature to determine the safety and efficacy of endoscopic radiofrequency ablation for the treatment of facet joint related pain.

### Ongoing and Unpublished Clinical Trials

Currently, ongoing and unpublished trials that might influence this review are listed in Table 1.

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT02073292*</td>
<td>A Randomized Controlled Trial Comparing Thermal and Cooled Radiofrequency Ablation Techniques of Thoracic Facets' Medial Branches to Manage Thoracic Pain</td>
<td>61</td>
<td>Dec 2022</td>
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<tr>
<td>NCT03066960</td>
<td>Long Term Efficacy of Radiofrequency Neurotomy for Chronic Zygapophysial (Facet) Joint Related Neck Pain</td>
<td>44</td>
<td>Dec 2022</td>
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<tr>
<td>NCT02148003</td>
<td>Effect of the Temperature Used in Thermal Radiofrequency Ablation on Outcomes of Lumbar Facets</td>
<td>237</td>
<td>Feb 2024</td>
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<tr>
<td>NCT No.</td>
<td>Trial Name</td>
<td>Planned Enrollment</td>
<td>Completion Date</td>
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</tr>
<tr>
<td></td>
<td>Medial Branches Denervation Procedures: A Randomized Double-Blinded Trial</td>
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</tbody>
</table>

NCT: national clinical trial.

* Denotes industry-sponsored or cosponsored trial.

**Clinical Input Received From Physician Specialty Societies and Academic Medical Centers**

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from four physician specialty societies and five academic medical centers (six responses) while this policy was under review in 2010. Input supported the use of radiofrequency denervation for facet joint pain. Those providing input supported the use of two diagnostic blocks achieving a 50% reduction in pain.

**Practice Guidelines and Position Statements**

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

**American Association of Neurological Surgeons and Congress of Neurological Surgeons**

In 2014, the American Association of Neurological Surgeons and the Congress of Neurological Surgeons (CNS) updated their joint guidelines on the treatment of degenerative disease of the lumbar spine. The two groups provided grade B recommendations: (1) intra-articular injections of lumbar facet joints were not suggested for the treatment of facet-mediated chronic low back
pain; (2) medial nerve blocks were suggested for the short-term relief of facet-mediated chronic low back pain; and (3) lumbar medial nerve ablation is suggested for the short-term (3- to 6-month) relief of facet-mediated pain in patients who have chronic lower back pain without radiculopathy from degenerative disease of the lumbar spine.

**American Society of Interventional Pain Physicians**

In 2020, the American Society of Interventional Pain Physicians published guidelines on use of facet joint interventions for management of chronic spinal pain. Use of facet joint nerve blocks for diagnosis of facet joint pain is recommended with a moderate to strong strength of recommendation for the lumbar spine (evidence level I to II), moderate strength for the cervical spine (evidence level II), and moderate strength for the thoracic spine (evidence level II); a criterion standard of ≥80% pain relief was included for these recommendations. RFA is recommended for treatment of pain in the lumbar spine (moderate strength recommendation; evidence level II), cervical spine (moderate strength recommendation; evidence level II), and thoracic spine (weak to moderate strength recommendation; evidence level III). Facet joint nerve blocks are recommended for treatment of pain in the lumbar spine (moderate strength recommendation; evidence level II), cervical spine (moderate strength recommendation; evidence level II), and thoracic spine (weak to moderate strength recommendation; evidence level III). Treatment of facet joint pain with intraarticular injections is a weak strength recommendation with lower levels of evidence (level III, IV, and V evidence for the thoracic, lumbar, and cervical spine respectively).

**International Working Group Consensus Guidelines**

International consensus guidelines from 13 different pain societies (2020) provide recommendations regarding interventions for lumbar facet joint pain specifically. When used for diagnosis, the guidelines suggest that intra-articular injections are more diagnostic than medial branch blocks, but note that intra-articular injections have a high technical failure rate and provide less predictive value when administered prior to radiofrequency ablation (grade B evidence, low level of certainty). For therapeutic treatment of lumbar facet pain the guideline recommends against use of medial branch blocks or intra-articular injections (grade D evidence, moderate level of certainty), although acknowledges certain clinical scenarios which may warrant these techniques, such as a contraindication to radiofrequency ablation.
National Institute for Health and Care Excellence

In 2016, the National Institute for Health and Care Excellence (NICE) published guidance on the assessment and management of low back pain and sciatica in those over 16 years of age. The NICE recommended that RF denervation can be considered for patients with chronic low back pain when “non-surgical treatment has not worked for them and the main source of pain is thought to come from structures supplied by the medial branch nerve and they have moderate or severe levels of localized back pain.” RF denervation should only be performed “after a positive response to a diagnostic medial branch block.” The NICE cautioned that the length of pain relief after RF denervation is uncertain, and that results from repeat RF denervation procedures are also uncertain.

North American Spine Society Guideline

In 2020, the North American Spine Society (NASS) published guidance on the diagnosis and management of nonspecific low back pain in those 18 years of age and older. NASS recommends that in facet joint procedures, for patients responsive to a single diagnostic intra-articular injection with 50% relief, it is suggested that intra-articular steroids will provide no clinically meaningful improvement at 6 months (grade B level of evidence; fair evidence). Additionally, in these patients there is insufficient evidence to recommend for or against using radiofrequency neurotomy or periarticular phenol injections (grade I, insufficient or conflicting evidence). There is insufficient evidence for or against the use of single-photon emission computerized tomography (SPECT) imaging or the use of uncontrolled medial branch blocks versus pericapsular blocks for the diagnosis of zygapophyseal joint pain (both grade 1, insufficient or conflicting evidence). There is insufficient evidence to recommend for or against using a 50% pain reduction following medial branch blockade to diagnose zygapophyseal joint pain (grade 1, insufficient or conflicting evidence). The use of cryodenervation has insufficient evidence for the treatment of zygapophyseal joint pain (grade I, insufficient or conflicting evidence); however, thermal radiofrequency ablation is suggested for patients with zygapophyseal joint low back pain, with relief durable for at least 6 months following the procedure (grade B, fair evidence). Cooled radiofrequency ablation of sacral lateral branch nerves and the dorsal ramus of L5 can be considered for sacroiliac joint pain diagnosed by dual blocks (grade C, poor quality evidence).
Medicare National Coverage

There is no national coverage determination.

Regulatory Status

A number of RF generators and probes have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. In 2005, the SInergy® (Kimberly Clark/Baylis), a water-cooled single-use probe, was cleared by the FDA, listing the Baylis Pain Management Probe as a predicate device. The intended use is with an RF generator to create RF lesions in nervous tissue.

FDA product code: GXD

References


### History

<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>05/12/14</td>
<td>New PR policy replacing 7.01.116, same title. Policy coverage on non-pulsed RF now considered medically necessary for level C2-3 (is investigational at C2 in policy 7.01.116) when criteria are met including two controlled medial branch blocks (MBBs) with an indication of at least 80% relief for the duration of the anesthetic prior to performing the second MBB. Unlisted CPT code 64999 removed; there are CPT codes</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/16/16</td>
<td>Coding update. Added 64999.</td>
</tr>
<tr>
<td>11/01/16</td>
<td>Annual Review, approved October 11, 2016. Literature search. No changes to policy statement. Policy moved into new format. Removed unlisted CPT code 64999 from coding section.</td>
</tr>
<tr>
<td>03/01/18</td>
<td>Minor update; added Documentation Requirements section. Updated Related Policy number; 6.01.23 changed to 6.01.524.</td>
</tr>
<tr>
<td>07/01/18</td>
<td>Interim Review, minor update approved June 22, 2018. Added cooled radiofrequency ablation to list of all other methods of denervation which are considered investigational. Reference 45 added.</td>
</tr>
<tr>
<td>12/01/18</td>
<td>Annual Review, approved November 21, 2018. Policy updated with literature review; no references added. Policy statements unchanged.</td>
</tr>
<tr>
<td>02/01/19</td>
<td>Annual Review, approved January 4, 2019. Policy updated with literature review through September 2018; no references added. Policy statements unchanged.</td>
</tr>
<tr>
<td>08/01/19</td>
<td>Interim Review, approved July 9, 2019. Reference added. Added endoscopic radiofrequency ablation/rhizotomy to the list of denervation methods considered investigational for the treatment of facet joint related pain. Added CPT code 64999.</td>
</tr>
<tr>
<td>04/01/20</td>
<td>Delete policy, approved March 10, 2020. This policy will be deleted effective July 2, 2020, and replaced with InterQual criteria for dates of service on or after July 2, 2020.</td>
</tr>
<tr>
<td>06/10/20</td>
<td>Interim Review, approved June 9, 2020, effective June 10, 2020. This policy is reinstated immediately and will no longer be deleted or replaced with InterQual criteria on July 2, 2020.</td>
</tr>
<tr>
<td>08/01/22</td>
<td>Interim Review, approved July 12, 2022. Changed radiofrequency denervation to thoracic facet joints from investigational to medically necessary.</td>
</tr>
<tr>
<td>Date</td>
<td>Comments</td>
</tr>
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<td>---------</td>
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</tr>
<tr>
<td>08/23/22</td>
<td>Minor clarifying edit, parenthetical word “rhizotomy” removed from endoscopic radiofrequency denervation bullet. Minor edit made to procedure section, to align with Thoracic policy criteria. Policy intent unchanged.</td>
</tr>
<tr>
<td>10/01/22</td>
<td>Update to Related Policies. Removed related policy 7.01.120 Facet Arthroplasty due to archival.</td>
</tr>
</tbody>
</table>

**Disclaimer:** This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2022 Premera All Rights Reserved.

**Scope:** Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.
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Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-6396, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@LifeWiseHealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).


Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-596-3440 (TTY: 711).


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-596-3440 （TTY：711）。

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ترجمة: إذا كنت تتحدث اللغة الألمانية، يمكنك زيارة خدمة المساعدة للغات للحصول على خدمات المساعدة الرسومية. الرجاء الاتصال ب 800-596-3440 (ATS : 711).

ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 800-596-3440 (ATS : 711).

ΠΡΟΣΟΧΗ: Αν οικοδομαί την ολλανδική, διαθέσιμες είναι ελεύθερες της υπηρεσίας της μεταφράσης για τους Λευκούς Τύπους. Επικοινωνήστε με 800-596-3440 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-596-3440 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sévis ed pou lang ki disponib gratis pou ou. Rele 800-596-3440 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-596-3440 (TTY: 711).


ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-596-3440 (TTY: 711).