Medtronic

Radiofrequency Ablation (RFA) for nerve tissue

2026 coding and payment guide

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Physician coding and payment

January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[1]	Medicare Work RVUs[2]	Medicare national average for physician services provided in:[†,3]	
			Office	Facility
Genicular Nerve Ablation[a,b,c,d]	**64624** Destruction by neurolytic agent, genicular nerve branches including imaging guidance when performed	2.44	$411	$133
Sacroiliac Joint Nerve Ablation[c,e,f,g,m]	**64625** Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	3.31	$496	$177
Facet Joint Nerve Ablation[h,l,m]	**64633** Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT), cervical or thoracic, single facet joint	3.24	$459	$173
	+64634 cervical or thoracic, each addl facet joint	1.29	$267	$58
	64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT), lumbar or sacral, single facet joint	3.24	$465	$173
	+64636 lumbar or sacral, each addl facet joint	1.13	$252	$51
Other Nerve Ablation[j]	**64640** Destruction by neurolytic agent, other peripheral nerve or branch	1.93	$268	$112

HCPCS II device codes

Device C-codes

For hospital outpatient, code C1886 may be used to report the ablation catheter device, in addition to the CPT code for the ablation procedure

HCPCS II device codes[4]	HCPCS II code description
C1886	Catheter, extravascular tissue ablation, any modality (insertable)

The device C-codes above are applicable to this therapy. To determine if there is a C-code for a particular Medtronic device, click here for a C-code finder search by model number, product name, C-code, C-code description, or product category.

[†] Rates shown reflect the CY 2026 Medicare Physician Fee Schedule for clinicians who did not qualify as participants in Advanced Alternative Payment Model (APM). Physicians and other eligible clinicians who qualify as participants in an Advanced APM under the Quality Payment Program may receive higher payment rates.

Hospital outpatient coding and payment

Effective January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[1]	APC[5]	APC Level	Status indicator[5,k]	Relative weight[5]	Medicare national average[5]
Genicular Nerve Ablation[B,c,d,l]	**64624** Destruction by neurolytic agent, genicular nerve branches including imaging guidance when performed	5431	Level 1	J1	21.8238	$1,995
Sacroiliac Joint Nerve Ablation[c,e,f,g,m]	**64625** Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	5431	Level 1	J1	21.8238	$1,995
Facet Joint Nerve Ablation[h,l,m]	**64633** Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT), cervical or thoracic, single facet joint	5431	Level 1	J1	21.8238	$1,995
	+64634 cervical or thoracic, each addl facet joint	-	-	N	-	-
	64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT), lumbar or sacral, single facet joint	5431	Level 1	J1	21.8238	$1,995
	+64636 lumbar or sacral, each addl facet joint	-	-	N	-	-
Other Nerve Ablation[j]	**64640** Destruction by neurolytic agent, other peripheral nerve or branch	5443	Level 3	T	9.8849	$904

ASC coding and payment

January 1, 2026 – December 31, 2026

Procedure	CPT procedure code and description[1]	Payment indicator[6,n]	Multiple procedure discounting[o]	Relative weight[6]	Medicare national average[6]
Genicular Nerve Ablation[b,d,l,p]	**64624** Destruction by neurolytic agent, genicular nerve branches including imaging guidance when performed	G2	Y	16.8435	$949
Sacroiliac Joint Ablation[f,g,m,p,q]	**64625** Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	G2	Y	16.8435	$949
Facet Joint Ablation[m,r,s]	**64633** Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT), cervical or thoracic, single facet joint	G2	Y	16.8435	$949
	+64634 cervical or thoracic, each addl facet joint	N1	N	-	-
	64635 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT), lumbar or sacral, single facet joint	G2	Y	16.8435	$949
	+64636 lumbar or sacral, each addl facet joint	N1	N	-	-
Other Nerve Ablation[j]	**64640** Destruction by neurolytic agent, other peripheral nerve or branch	P3	Y	-	$197

Notes

Special note: CPT codes for pulsed and cooled radiofrequency ablation

Instructions within the CPT manual currently state: "Do not report a code labeled as destruction when using therapies that are not destructive of the target nerve (eg, pulsed radiofrequency), use 64999" and "Do not report 64633, 64634, 64635, 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."

These instructions specifically require use of 64999 for pulsed radiofrequency. However, different interpretations may exist on how to code enhanced (cooled) radiofrequency. Of note, the Medtronic Accurian™ RFA probe generally creates RF lesions at a set temperature of 80 degrees Celsius, as illustrated in the Accurian™ Enhanced RF Probe Kit manual.[t] Providers are advised to clearly document the device parameters (eg, probe temperature, tissue temperature, duration, active tip length, within the procedure report).

Providers are encouraged to reach out to their specialty societies and/or to contact the specific payer for interpretation of the CPT manual instructions and for further guidance on coding for enhanced (cooled) radiofrequency.

Hospital inpatient coding and payment — Effective October 1, 2025 – September 30, 2026

ICD-10-PCS codes[7] are used by hospitals for inpatient procedures. The codes are one of the key elements making up hospital inpatient DRG assignment and Medicare DRG reimbursement.

Radiofrequency nerve ablation procedure codes are assigned from two ICD-10-PCS code tables depending on the type of nerve: ICD-10-PCS code table 005, Destruction of Central Nervous System and Cranial Nerves, is used for ablation of cranial nerves, including the extracranial portion.

ICD-10-PCS code table 015, Destruction of Peripheral Nervous System, is used for ablation of peripheral nerves.

Root operation 5-Destruction includes ablation procedures. Following 005 or 015, the remaining characters in the complete ICD-10-PCS code identify the specific nerve and the approach. The type of radiofrequency (standard, enhanced [cooled], or pulsed) is not a factor in assignment of the ICD-10-PCS code.

Annual references

1. CPT Copyright © 2025 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS restrictions apply to government use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.
2. PFS 2026 Final Rule CMS-1832-F Addenda. Cms.gov. Published October 31, 2025. https://www.cms.gov/files/zip/cy-2026-pfs-final-rule-addenda.zip. Although the total RVU consists of three components, only the physician work RVU is shown.
3. PFS 2026 Final Rule CMS-1832-F | CMS. Cms.gov. Published October 31, 2025. https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f. Local physician rates will vary based on location specific factors not reflected in this document.
4. HCPCS 2025 Level II Professional Edition. American Medical Association; 2024. These codes are used by the entity that purchased and supplied the medical device. For Medicare hospital outpatient claims, C codes are required. For Medicare ASC claims, C codes are not reported unless the device is eligible for transitional pass-through payment. For non-Medicare hospital or ASC claims, please consult payer specific contracts for whether the C code would be billed.
5. OPPS 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1834-fc. Rates shown reflect the unadjusted OPPS payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
6. ASC 2026 Final Rule CMS-1834-FC | CMS. Cms.gov. Published November 21, 2025. https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices/cms-1834-fc. Rates shown reflect the unadjusted ASC payment rates. Actual reimbursement may vary based on hospital-specific factors, such as wage index, geographic adjustments, and other CMS payment modifiers.
7. AAPC. ICD-10-PCS Code Book 2026. AAPC; 2025.

Important information

a. Per CPT manual instructions, code 64624 requires destruction of each of the superolateral, superomedial, and inferomedial genicular nerve branches. If neurolytic destruction is not performed to all three nerve branches, physicians should append reduced services –52 to code 64624. Because the code is defined for multiple branches, only one unit of 64624 is assigned regardless of the number of genicular nerve branches destroyed on the same side. See also CPT Assistant, December 2019, p.8.

b. Per CPT manual instructions, code 64454 for injection of anesthetic agent to the genicular nerve branches is not coded separately with neurolytic destruction code 64624. National Correct Coding Initiative (NCCI) edits also do not permit code 64454 to be assigned with code 64624.

c. Medically Unlikely Edits (MUE) allow 1 unit for 64624 and 1 unit for 64525. To show radiofrequency ablation on both left and right sides during the same operative episode, submit 64624-50 with 1 unit or 64625-50 with 1 unit. NCCI Policy Manual 1/1/2023, Chapter I, V.3.a.ii . Centers for Medicare and Medicaid Services. Transmittal 1421, CR 8853. http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1421OTN.pdf. Released August 15, 2014. Accessed November 30, 2022.

d. The definition of code 64624 includes image guidance. NCCI edits do not permit fluoroscopy, CT, ultrasound or MRI codes 76000, 76380, 76942, 76998, 77002, 77012 and 77021 to be coded separately.

e. The definition of code 64625 includes image guidance specifically given as fluoroscopy or CT. CPT manual instructions state that fluoroscopy and CT codes 77002, 77003 and 77012 may not be coded separately, but ultrasound used in radiofrequency ablation of sacroiliac joint nerves may be coded separately using 76999. However, NCCI edits do not permit fluoroscopy, CT, ultrasound or MRI codes 76000, 76380, 76942, 76998, 77002, 77003, 77012 and 77021 to be coded separately.

f. The published vignette for code 64625 references radiofrequency ablation at 60o C, indicating that 64625 may be assigned for standard and enhanced (cooled) radiofrequency ablation. CPT Changes 2020: An Insider's View, p.79.

g. For sacroiliac nerve ablation, code 64625 is assigned for ablation of the L5 dorsal ramus and the S1, S2, and S3 nerves (lateral branches). However, per CPT manual instructions, code 64625 cannot be assigned during the same procedure as 64635 for facet joint nerve ablation (medial branches) even though lateral and medial branches could be seen as separate anatomic locations (Coding Clinic for HCPCS, 3rd Q 2024). Also, because code 64625 is defined for multiple nerves, only one unit of 64625 is assigned per side. (See also CPT Assistant, June 2020, p.14.)

h. According to CPT manual instructions, use of codes 64633-64636 requires image guidance. If image guidance is not performed, unlisted code 64999 must be assigned for the nerve destruction. Injection of contrast for image guidance is inherent and not coded separately.

i. According to CPT manual instructions, codes 64633-64636 are reported per joint, not per nerve. One code is assigned for each facet joint, regardless of the number of nerves destroyed at the joint. Codes 64633 and 64635 are assigned for the primary vertebral level and add-on codes +64634 and +64636 are assigned for each additional facet joint at a different vertebral level. Destruction of nerves at bilateral facet joints at the same vertebral level is shown by appending modifier –50 to primary codes 64633 and 64635. Although CPT manual instructions state that add-on codes +64634 and +64636 should be reported twice when bilateral ablation is performed, Medicare permits use of –50 with the primary codes as well as the add-on codes.

j. As defined, code 64640 can be assigned per nerve branch (see also CPT Assistant January 2018, p.7). Medicare's Medically Unlikely Edits (MUE) allow 5 units for code 64640. Denials for units in excess of the MUE value may be appealed.

k. Status Indicator (SI) shows how a code is handled for payment purposes. J1 = paid under comprehensive APC, single payment based on primary service without separate payment for other adjunctive services; N = packaged service, no separate payment; T = paid at 50% of rate when billed with another higher-weighted T procedure.

l. Per CPT manual instructions, code 64624 requires destruction of each of the superolateral, superomedial, and inferomedial genicular nerve branches. If neurolytic destruction is not performed to all three nerve branches, hospitals and ASCs may append modifier –74 code 64624 to show the reduced service. Because the code is defined for multiple branches, only one unit of 64624 is assigned regardless of the number of genicular nerve branches destroyed on the same side. See also CPT Assistant, December 2019, p.8 and Coding Clinic for HCPCS, 3rd Q 2020. See also Coding Clinic for HCPCS, 2nd Q 2018, p.11 for use of modifier –74 in the hospital outpatient and ASC setting.

m. For anatomic orientation in code assignment, the L5-S1 facet joint is innervated by the medial branch of the dorsal ramus and the L5-S1 sacroiliac joint is innervated by the lateral branch of the dorsal ramus (Coding Clinic for HCPCS 3rd Q 2024).

n. The Payment Indicator shows how a code is handled for payment purposes: G2 = surgical procedure, non-office-based, payment based on hospital outpatient rate adjusted for ASC; N1=packaged service, no separate payment available; P3=office-based procedure, payment based physician fee schedule.

o. When multiple procedures are coded and billed, payment is usually made at 100% of the rate for the first procedure and 50% of the rate for the second and all subsequent procedures. These procedures are marked "Y".

p. Because Medicare does not recognize the bilateral modifier –50 for payment in an ASC, destruction of nerves at bilateral knees, bilateral sacroiliac joints, or facet joints at the same vertebral level should either be reported with the CPT procedure code repeated on two separate lines, or reported on a single line with units of 2. Centers for Medicare and Medicaid Services. Medicare Claims Processing Manual, Chapter 14-Ambulatory Surgery Centers, section 40.5: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf. Medicare's Medically Unlikely Edits (MUE) only allow 1 unit for codes 64633 and 64635 but this value is doubled for ASCs. See Centers for Medicare and Medicaid Services. Transmittal 1421, CR 8853, 4-General Processing Instructions. http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1421OTN.pdf. Released August 15, 2014. Accessed November 30, 2022.

q. The definition of code 64625 includes image guidance specifically given as fluoroscopy or CT. CPT manual instructions state that fluoroscopy and CT codes 77002, 77003 and 77012 may not be coded separately, but ultrasound used in radiofrequency ablation of sacroiliac joint nerves may be coded separately using unlisted code 76999. However, unlisted codes are not payable in an ASC by Medicare.

r. According to CPT manual instructions, use of codes 64633-64636 requires image guidance. If image guidance is not performed, unlisted code 64999 must be assigned for the nerve destruction. However, unlisted codes are not payable in an ASC by Medicare.

s. According to CPT manual instructions, codes 64633-64636 are reported per joint, not per nerve. One code is assigned for each facet joint, regardless of the number of nerves destroyed at the joint. Codes 64633 and 64635 are assigned for the primary vertebral level and add-on codes +64634 and +64636 are assigned for each additional facet joint at a different vertebral level. Add-on codes +64634 and +64636 are packaged into the primary code and not separately payable.

t. Accurian™ Enhanced RF Probe Kit eManual. Medtronic Manual Library. Medtronic.com. https://manuals.medtronic.com/content/dam/emanuals/spinal/M708348B804E_Accurian_Enhanced_RF_Probe_Kit_eManual_revD.pdf

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