Medical Policy:
Peripheral Nerve Block (Commercial)

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<th>POLICY NUMBER</th>
<th>DATE OF LAST REVIEW</th>
<th>APPROVED BY</th>
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<td>MG.MM.ME.64C3</td>
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<td>MPC (Medical Policy Committee)</td>
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IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

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Definitions

Peripheral nerves can be the cause of pain in a variety of conditions. Sometimes the nerves are the source of the pain and sometimes the nerves merely are carrying impulses from painful tissues.

Examples may include: postherniorrhaphy pain (ilioinguinal/iliohypogastric/genitofemoral), iliac crest harvest syndromes (cluneal nerve, lateral femoral cutaneous nerve), carpal tunnel syndrome (median nerve), Morton's neuroma, facial pain and headaches (trigeminal and occipital nerve).

Peripheral nerve blocks may be used for both diagnostic and therapeutic purposes. Diagnostically, a peripheral nerve block allows the clinician to isolate the specific cause of pain in an individual patient. The injection of local anesthetic, with or without steroid may also provide an extended therapeutic benefit. If the patient does not achieve sustained relief a denervation procedure via chemical, cryoneurolysis or radiofrequency may not be effective at providing long term relief.
Guideline

Note: the term "Morton's neuroma" is used in this guideline generically to refer to a swollen inflamed nerve in the ball of the foot, including the more specific conditions of Morton's neuroma (lesion within the third intermetatarsal space), Heuter's neuroma (first intermetatarsal space), Hauser's neuroma (second intermetatarsal space) and Iselin's neuroma (fourth intermetatarsal space). This guideline applies to each such condition.

Peripheral nerve blocks are considered medically reasonable and necessary for normally temporary conditions, such as the following (1–7), for diagnostic and therapeutic purposes:

1. When pain appears to be due to a classic mononeuritis, but neuro-diagnostic studies have failed to provide a structural explanation. In this scenario, selective peripheral nerve blockade can usually clarify the situation (for diagnostic purposes and not long term treatment).

2. When peripheral nerve injuries/entrapment or other extremity trauma leads to complex regional pain syndrome.

3. When selective peripheral nerve blockade is used diagnostically in those cases in which the clinical picture is unclear (for diagnostic purposes and not long term treatment).

4. When an occipital nerve block is used to confirm the clinical impression of the presence of occipital neuralgia.

   Chronic headache/occipital neuralgia can result from chronic spasm of the neck muscles as the result of either myofascial syndrome or underlying cervical spinal disease. It may be unilateral or bilateral, constant or intermittent. Nerve injury secondary to localized head trauma or trauma to the nerve from a scalp laceration can also cause this condition. Most commonly it is caused by an entrapment of the occipital nerve in its course from its origin from the C2 nerve root to its entrance into the scalp through the mid portion of the superior nuchal line. Blockage of the occipital nerve can confirm the clinical impression of occipital neuralgia particularly if the clinical picture is not entirely typical. If only temporary relief of symptoms is obtained, neurolysis of the greater occipital nerve may be considered via multiple techniques including radiofrequency and cryoanalgesia. In addition, the lesser and third occipital nerves can be involved in the pathology of headaches, and can be treated in a similar manner.

5. When the suprascapular nerve block is used to confirm the diagnosis of suspected entrapment of the nerve.

   Entrapment of the suprascapular nerve as it passes through the suprascapular notch can produce a syndrome of pain within the shoulder with weakness of supraspinatus and infraspinatus muscles. When the history and examination point to the diagnosis, a suprascapular nerve block leading to relief of pain can confirm it. This may be followed by injection of depository steroids that sometime provide lasting relief.

6. When the trigeminal nerve is blocked centrally at the trigeminal ganglion, or along one of the three divisions or at one of the many peripheral terminal branches (i.e., supraorbital nerve).

7. Nerve blocks as preemptive analgesia; either:

   a. When a single injection peripheral nerve block provides post-surgical pain control; any:

      i. During the transition to oral analgesics
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ii. In those procedures which cause severe pain normally uncontrolled by oral analgesics

iii. In cases otherwise requiring control with intravenous or parenteral narcotics

iv. In cases where the member cannot tolerate treatment with narcotics due to allergy or side effects, etc.

b. When a continuous peripheral nerve block provides the same as above, and furthermore may provide extended relief (i.e. 1–5 or more days) as a result of chronic administration of anesthetic.

Additional management using medications, behavioral therapy, and physical therapy should be used (when appropriate) in conjunction with peripheral nerve block. Injection of depot steroids, may offer only temporary relief. In some cases, neurolysis may be appropriate to provide lasting relief.

Preemptive analgesia starts before surgery, and a presumption of medical necessity is being made before the fact. Therefore, based on generally accepted clinical standards and evidence in peer reviewed medical literature the surgical procedure must be of such nature that the patient would benefit from the preemptive analgesia.

Limitations/Exclusions

1. The signs and symptoms that justify peripheral nerve blocks should be resolved after 1–3 injections at a specific site. They cannot be for clinical situations (as mentioned below) where nerve blocks are not medically necessary per the guideline criteria above.

2. More than 3 injections per anatomic site (e.g., specific nerve, plexus or branch as defined by the CPT code description) in a 6 month period will be denied. These blocks should last ≥ 2 months in order to be deemed successful. In rare exceptions with appropriate documentation, there is a limit of 3 blocks per 6 month period.

3. More than 2 anatomic sites (e.g., specific nerve, plexus or branch as defined by the CPT code description) injected at any one session will be denied. If the member does not achieve progressively sustained relief after receiving 2–3 repeat peripheral nerve block injections on the same anatomical site, then alternative therapeutic options should be explored.

4. There is insufficient evidence to support the use of peripheral nerve blocks in the treatment of diabetic peripheral neuropathy, peripheral neuropathies caused by other underlying systemic diseases or peripheral neuropathies causes such as degenerative or idiopathic reasons. Medical management using systemic medications is clinically indicated for the treatment of these conditions.

5. At present, the literature and scientific evidence supporting the use of peripheral nerve blocks with or without the use of electrostimulation, and the use of electrostimulation alone for neuropahties or peripheral neuropathies caused by underlying systemic diseases is insufficient to warrant coverage. These procedures are considered investigational and are not eligible for coverage for the treatment of neuropathies or peripheral neuropathies caused by underlying systemic diseases. Use of physical medicine and rehabilitation CPT/HCPCS codes (97032, 97139, G0282, G0283) for treatment of neuropathies or peripheral neuropathies caused by underlying systemic
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6. The use of ultrasound guidance in conjunction with these non-covered injections is also considered not medically necessary and will result in denial.

7. Injection into neuromas may be indicated to relieve pain or dysfunction resulting from inflammation or other pathological changes. Proper use of this modality with local anesthetics and/or steroids should be short-term, as part of an overall management plan including diagnostic evaluation, in order to clearly identify and properly treat the primary cause.

8. Injection therapies for tarsal tunnel syndrome (which include any so-called "Baxter's injections") and for Morton's neuroma (CPT code 64455) do not involve the structures described by CPT code 20550 and 20551 or direct injection into other peripheral nerves but rather the focal injection of tissue surrounding a specific focus of inflammation on the foot.

9. Injections for plantar fasciitis are addressed by CPT code 20550, not CPT code 64450. Injections for calcaneal spurs are addressed as are other tendon origin/insertions by CPT code 20551. Injections to include both the plantar fascia and the area around a calcaneal spur, are to be reported using only CPT code 20551 with a unit of service of “1”.

10. Medical necessity for injections of > 2 sites at one session, or for frequent or repeated injections, is questionable and not supported by peer literature that is indexed in PubMed of the US National Library of Medicine of the National Institutes of Health (NIH).

11. "Dry needling" of ganglion cysts, ligaments, neuromas, peripheral nerves, tendon sheaths and their origins/insertions, or any tissue are non-covered procedures.

Applicable Coding

To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy.

Applicable CPT and Diagnosis Codes

References


Specialty-matched clinical peer review

Revision history

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<td>03/18/2020</td>
<td>ConnectiCare, Inc. has adopted the clinical criteria of its parent corporation, EmblemHealth. Reformatted and reorganized policy, transferred content to new CCI template</td>
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