Clinical Policy: Nerve Blocks and Neurolysis for Pain Management

Reference Number: OH.CP.MP.170 Coding Implications

Date of Last Revision: 07/23 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Statement

In compliance with Ohio Medicaid, Buckeye Health Plan must ensure coverage of medically necessary procedures. The plan covers all the services in the amount, duration, and scope that is no less than that covered by FFS Ohio Medicaid and in accordance with 42 CFR 438.210, with limitations, exclusions, and clarifications provided in the Ohio Medicaid Managed Care Provider Agreement and the Ohio Administrative Code. Buckeye Health Plan will not impose hard limits or restrictions on coverage of medically necessary services. Prior to making determinations regarding coverage of services and procedures, Buckeye Health Plan will conduct a medical necessity review for all requests to include non-covered services and any request for services over an established benefit(s).

Description

Nerve blocks are the temporary interruption of conduction of impulses in peripheral nerves or nerve trunks created by the injection of local anesthetic solutions. They can be used to identify the source of pain or to treat pain.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that invasive pain management procedures performed by a physician are **medically necessary** when *the relevant criteria are met and the patient receives only one procedure per visit, with or without radiographic guidance.*

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I. Occipital Nerve Block

A. *An initial injection* of a local anesthetic for the diagnosis of suspected occipital neuralgia is **medically necessary** when all of the following are met:

1. Patient has unilateral or bilateral pain located in the distribution of the greater, lesser and/or third occipital nerves;
2. Pain has two of the following three characteristics:
   a. Recurring in paroxysmal attacks lasting from a few seconds to minutes;
   b. Severe intensity;
   c. Shooting, stabbing, or sharp in quality;
3. Pain is associated with dysaesthesia and/or allodynia apparent during innocuous stimulation of the scalp and/or hair, and at least one of the following:
   a. Tenderness over the affected nerve branches;
   b. Trigger point at the emergence of the greater occipital nerve or in the distribution of C2.

B. *Therapeutic occipital nerve blocks* are **medically necessary** when all of the following are met:

1. There was temporary relief from the initial/previous injection;
2. The member/enrollee has failed 3 months of conservative treatment including all of the following:
   a. Heat, rest and/or physical therapy, including massage;
   b. NSAIDS, unless contraindicated or not tolerated;
   c. Oral anticonvulsant medications (e.g., carbamazepine, gabapentin, pregabalin) or tricyclic antidepressants;
   d. Activity modification to address triggers;
3. No more than 4 injections are to be given within 12 months (includes diagnostic injection).

C. *Occipital nerve block* for the diagnosis or treatment of other types of headaches, including migraine and cervicogenic headaches, is considered **not medically necessary** as effectiveness has not been established.

Note: Please refer to CP.PHAR.232 OnabotulinumtoxinA (Botox) for requests for Botox injections for migraines

II. Sympathetic Nerve Blocks have limited evidence to prove effectiveness of treatment and consideration will be made on a case by case basis. The criteria below provide a basis for documenting patient-specific clinical information to help guide clinical decision making.

i. *First or second sympathetic nerve block*:

1. Diagnosis of *complex regional pain syndrome* (CRPS) (also called reflex sympathetic dystrophy) and all of the following:
   a. Pain is being managed by a pain management specialist with experience treating CRPS;
   b. The member/enrollee is in an active rehabilitation regimen;

c. Failed ≥ 3 weeks of conservative therapies such as activity modification, exercises, topical capsaicin cream, and oral medical management such as nonsteroidal anti-inflammatories, antidepressants, anticonvulsants and glucocorticoids;
d. Two or more of the following findings of the involved digit/extremity:
   i. Hyperalgesia or allodynia (pain sensation in response to a typically non-painful stimulus);
   ii. Evidence of edema and/or sweating changes and/or sweating asymmetry;
   iii. Evidence of temperature asymmetry (>1°C) and/or skin color changes and/or asymmetry;
   iv. Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).

ii. *Additional sympathetic nerve blocks for CRPS* may be considered **medically necessary** when all of the following are met:
1. Nerve blocks are given at least a week apart;
2. There was an immediate positive response to the first or second nerve block (e.g., improved temperature and decreased pain).

iii. *Additional sympathetic nerve blocks* without documented benefit from the first or second are **not medically necessary.**

iv. Sympathetic nerve blocks for any other indication, including ischemic limb pain, are **not medically necessary** as there is a lack of evidence to support effectiveness.

III. Celiac Plexus Nerve Block/Neurolysis

A. *Celiac plexus nerve block/neurolysis* is **medically necessary** for either of the following indications:
1. Chronic neuralgic pain secondary to pancreatic cancer, all of the following:
   a. Diagnosis of pancreatic cancer with severe visceral abdominal/back pain;
   b. Strong analgesics such as opioids are no longer effective or their side effects decrease quality of life;
   c. No malignancy in an area of somatic innervation such as the peritoneum or diaphragm.
2. Refractory pain due to chronic pancreatitis with non–dilated pancreatic duct.

B. A repeat *celiac plexus nerve block* for refractory pain from chronic pancreatitis with non-dilated pancreatic duct is **medically necessary** when both of the following are met:
1. At least three months have passed since previous injection;
2. There was a clinical benefit from the initial celiac block.

C. *Repeat celiac plexus nerve blocks or neurolysis,* for any indication other than those noted above, are **not medically necessary** as there is a lack of evidence to support effectiveness.

IV. Intercostal Nerve Block/Neurolysis

A. *Intercostal nerve block/neurolysis* is **medically necessary** for chronic neuralgic pain secondary to an injured intercostal nerve as a result of a rib fracture, a thoracotomy incision or chronic pain due to post herpetic neuralgia, or other neuropathic process when all of the following are met:
1. Suspected organic problem;
2. Non-responsiveness to conservative modalities of treatment;
3. Pain and disability of moderate to severe degree;
4. No evidence of contraindications such as infection or pain of predominately psychogenic origin.

V. Genicular Nerve Blocks, Neurolysis and Genicular Nerve Radiofrequency Neurotomy
There is insufficient evidence to determine safety and effectiveness of *genicular nerve blocks, neurolysis* and *radiofrequency neurotomy of the articular nerve.*

VI. Peripheral/Ganglion Nerve Blocks
Note: If administered as part of a surgery or other procedure, coding for peripheral/ganglion nerve blocks should follow proper coding practices and would not be subject to prior authorization or payment separately from the procedure.

A. *Peripheral nerve blocks for diagnosis and treatment of malignant pain* are considered **medically necessary** as part of a comprehensive pain management program.

B. *Peripheral nerve blocks for diagnosis or treatment of post-herniorrhaphy pain are* considered **medically necessary** when all of the following criteria are met:

1. A first diagnostic peripheral nerve block when all of the following are met:
   a. Diagnosis of post-herniorrhapy neuralgia;
   b. Groin pain has persisted for three months after surgical hernia repair;
   c. Less invasive pain management methods such as NSAIDs and/or opiates have not relieved the pain;
   d. Imaging studies have ruled out non-neuropathic causes of pain;
   e. Documentation indicates that pain is not attributable to any other cause;

2. Therapeutic peripheral nerve block(s) for treatment of post-herniorrhapy pain when all of the following are met:
   a. There was temporary relief from the initial/previous injection;
   b. Injections are given at least a week apart.

C. *Peripheral nerve blocks for prevention or treatment of headaches,* including, but not limited to: migraine headaches, treatment-refractory migraines in pregnancy, and short-lasting unilateral neuralgiform headaches, are considered **not medically necessary** as effectiveness has not been established.

D. There is insufficient evidence in the published peer-reviewed literature to support the use of *peripheral nerve blocks for the treatment of trigeminal neuralgia.*

E. There is insufficient evidence in the published peer-reviewed literature to support the use of *peripheral/ganglion nerve blocks or neurolysis* for any condition not indicated elsewhere in this policy, including chronic pain. There is ongoing research but insufficient evidence to establish efficacy.

VII. Intraosseous Radiofrequency Nerve Ablation of the Basivertebral Nerve

There is insufficient evidence to determine the safety and effectiveness *of intraosseous radiofrequency nerve ablation of the basivertebral nerve* (e.g. Intracept® Intraosseous Nerve Ablation System.) for the treatment of chronic low back pain

Coding Implication

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve
64408	Injection(s), anesthetic agent(s) and/or steroid; vagus nerve
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve
64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves
64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve
64435	Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve
64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve
64447	Injection(s), anesthetic agent(s); femoral nerve
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed
64505	Injection, anesthetic agent; sphenopalatine ganglion
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
64517	Injection, anesthetic agent; superior hypogastric plexus
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64530	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring
64620	Destruction by neurolytic agent, intercostal nerve

CPT® Codes	Description
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
64640	Destruction by neurolytic agent; other peripheral nerve or branch
64680	Destruction by neurolytic agent, with or without radiologic monitoring; celiac plexus
64999	Unlisted procedure, nervous system

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
C25.0 through C25.9	Malignant neoplasm of pancreas
G44.85	Primary stabbing headache
G50.1	Atypical facial pain
G54.0 through G54.9	Nerve root and plexus disorders
G56.40 through G56.43	Causalgia of upper limb
G57.70 through G57.73	Causalgia of lower limb
G89.22	Chronic post-thoracotomy pain
G89.4	Chronic pain syndrome
G90.50 through G90.59	Complex regional pain syndrome I (CRPS I)
M54.81	Occipital neuralgia
K86.0	Alcohol-induced chronic pancreatitis
K86.1	Other chronic pancreatitis
R07.81 through R07.89	Other chest pain
R10.10 through R10.12	Pain localized to upper abdomen
S22.41X+ through S22.49X+	Multiple fractures of rib

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy created and approved.	08/18	08/18

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Centene Policy CP.MP. updated with OH Addendum	12/22	12/22
Policy moved to Ohio Specific template and Addendum language integrated into policy template as Policy Statement and Procedure. Annual Review with no material changes made to review criteria.	07/23	07/23

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. Buckeye Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a

health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Buckeye Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by Buckeye Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom Buckeye Health Plan has no control or right of control. Providers are not agents or employees of Buckeye Health Plan.

This clinical policy is the property of Buckeye Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.