

Clinical Policy: Nerve Blocks for Pain Management

Reference Number: LA.CP.MP.170

Last Review Date: 12/2020

Coding Implications

Revision Log

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

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.

Note: For sacroiliac nerve block and radiofrequency neurotomy, please refer to LA.MP.166 Sacroiliac Joint Interventions

Policy/Criteria

It is the policy of Louisiana Healthcare Connections 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.

Note: Please refer to LA.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 provides 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 ($>1^{\circ}\text{C}$) 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 (eg, 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 chronic neuralgic pain secondary to pancreatic cancer when all of the following are met:
 - 1. Diagnosis of pancreatic cancer with severe visceral abdominal/back pain;
 - 2. Strong analgesics such as opioids are no longer effective or their side effects decrease quality of life;
 - 3. No malignancy in an area of somatic innervation such as the peritoneum or diaphragm.
- B. *Repeat celiac plexus nerve blocks or neurolysis* 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
Genicular nerve blocks, neurolysis and radiofrequency neurotomy of the articular nerve are considered experimental/investigational because effectiveness has not been established. There is insufficient evidence to determine safety and effectiveness.

VI. Peripheral/Ganglion Nerve Blocks

- 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-herniorrhaphy 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-herniorrhaphy 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.** *Peripheral/ganglion nerve blocks or neurolysis* for any condition not indicated elsewhere in this policy, including chronic pain, are considered experimental/investigational as there is ongoing research but insufficient evidence to establish efficacy.

Background

Local Injections for Cervicogenic and Occipital Neuralgia

Greater occipital nerve blocks have been advocated as a diagnostic test for cervicogenic headache and occipital neuralgia. The effectiveness of greater occipital nerve block in patients with primary headache syndromes is controversial. The International Headache Society (IHS) defines occipital neuralgia as unilateral or bilateral paroxysmal, shooting or stabbing pain in the posterior part of the scalp, in the distribution of the greater, lesser or third occipital nerves, sometimes accompanied by diminished sensation or dysaesthesia in the affected area and commonly associated with tenderness over the involved nerve(s).¹ The IHS includes relief of pain following a local anesthetic block of the affected nerve as part of their diagnostic criteria for occipital neuralgia. Thus, the principal indication for occipital block is diagnosis. Another indication is the treatment of chronic occipital neuralgia, often with a series of therapeutic blocks combining local anesthetic and corticosteroid. Pain relief is typically prompt and may last several weeks or even months. At that time the injection may be repeated.

Sympathetic Nerve Blocks

Sympathetic nerves may be injected for several reasons:

- Diagnostic - to determine the source of pain, e.g., to identify or pinpoint a nerve that acts as a pathway for pain; to determine the type of nerve that conducts the pain; to distinguish between pain that is central (within the spinal cord) or peripheral (outside the spinal cord) in origin; or to determine whether a neurolytic block or surgical lysis of the nerve should be performed;

- Therapeutic - to treat painful conditions that respond to nerve blocks (e.g., celiac block for pain of pancreatic cancer); and
- Prognostic - to predict the outcome of long-lasting interventions (e.g., lumbar sympathectomy).

The response to sympathetic blockade is the best diagnostic test for CRPS. If the patient has had a technically successful sympathetic block and does not obtain significant relief, then the patient probably does not have CRPS. Over two thirds of patients will obtain significant relief with minimal effect on motor and sensory function because the sympathetic fibers are the least myelinated (as compared to motor and sensory nerve fibers) these fibers are the first to be affected by the local anesthetic.

A 2014 case report and literature review identified only five cases, and no Level I or II evidence-based trials to support the use of sympathetic nerve block for ischemic pain.¹⁶ The authors presented two cases of patients who experienced severe pain due to ischemia despite full regional nerve blocks.¹⁶ The available literature is not sufficient to support the use of sympathetic nerve blocks for ischemic limb pain.

Celiac Plexus Nerve Block/Neurolysis

Although its analgesic effectiveness is similar to analgesic drugs, celiac plexus neurolysis offers pain reduction without the significant adverse effects of opiates.² A multidisciplinary, international guideline issued a strong recommendation based on moderate quality evidence for celiac plexus neurolysis as a treatment for pain associated with advanced pancreatic cancer.² Furthermore, a 2011 Cochrane review stated that celiac plexus block (neurolysis) significantly reduced opiate use and lowered pain compared to the control group.³

The optimal timing of celiac plexus neurolysis for pain due to pancreatic cancer is not known.² Advocates of an earlier approach argue that pain is more effectively addressed by neurolysis when treated earlier, and opiate-related side effects may also be reduced compared to later treatment. However, the effects of celiac plexus neurolysis diminish over time, which would leave a patient with fewer options as the cancer progresses and pain becomes more severe. Repeat celiac plexus neurolysis is effective only about 30% of the time and is not recommended.^{2, 17}

Intercostal Nerve Blocks

Intermittent intercostal nerve blocks can be used to control pain in the chest and upper abdomen, such as pain associated with rib fractures or chronic pain due to post herpetic neuralgia. Intercostal nerve blocks can be performed using anatomic landmarks or with ultrasound guidance, which can be used to minimize the chance of intravascular injection and pneumothorax and to increase reliable dermatomal coverage.^{4, 8}

For isolated injuries, such as single rib fracture, nonsteroidal anti-inflammatory drugs with or without opioids would be the initial treatment. For more severe injuries, particularly if ventilation is compromised, intercostal nerve blocks may be needed. For patients with multiple rib fractures, there is a need to perform the procedure at multiple intercostal levels. Repeated blockade may be needed for prolonged relief upon return of pain and/or deterioration in

functional status. For repeat blocks or other interventions, patient must have been responsive to prior interventions with improvement in physical and functional status.^{5, 8}

Regional anesthesia plays an important role in thoracic surgery, particularly with regard to post-operative pain control. The first choice of regional anesthesia for thoracic surgery is epidural analgesia or thoracic paravertebral block. In general, the analgesic efficiencies of both these types of anesthesia are equivalent; however, thoracic paravertebral block has some advantages over epidural analgesia, including fewer complications. When these two blocks are contraindicated, intercostal nerve block or interpleural block should be considered.^{6, 7}

Genicular Nerve Blocks and Radiofrequency Neurotomy

The genicular nerve is a sensory nerve that surrounds the knee and provides innervation for the joint. Genicular nerve blocks, neurolysis and radiofrequency neurotomy are emerging interventions for knee pain. The limited evidence regarding genicular nerve blocks for determining appropriateness of treatment with genicular radiofrequency ablation has reached conflicting results.^{9, 10} A few small studies suggest that genicular radiofrequency neurotomy may be effective for relief of pain, but further research is needed to establish safety and efficacy.
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Peripheral/Ganglion Nerve Block.

Chronic pain can be treated with a number of pharmacologic and nonpharmacologic therapies which generally fall into six major categories: pharmacologic, physical medicine, behavioral medicine neuromodulation, interventional and surgical approaches. Optimal outcomes result from multiple approaches. Interventional approaches, such as peripheral nerve injections may provide short-term analgesia. However, evidence is limited for significant improvements in long-term outcomes.³⁶

Cancer pain can be caused by complex interactions among cancer cells, the peripheral and central nervous systems, and the immune system. Peripheral pain receptors may become activated, sensitized or injured with certain cancers. Neuropathic pain may arise from nerve tissue damage and cancer patients may experience mild to severe pain. At least 15% will experience no relief or have severe adverse effects from interventions to address their pain. Nerve blocks or other interventional procedures may be appropriate as part of a comprehensive pain management program.^{37,38}

Peripheral Nerve Blocks for Prevention or Treatment of Headaches

Peripheral nerve blocks have been proposed as a treatment for migraines in pregnancy and refractory migraines. However, evidence is limited to support this indication. In a series of 13 pregnant women with migraine refractory to medication, injection of local anesthetic into one or more peripheral nerve resulted in elimination of pain in seven women, pain reduction in two and no response in four women. Larger studies are necessary to better define the efficacy of this approach.³⁴

Peripheral Nerve Blocks for Diagnosis and Treatment of Post-Herniorrhaphy Groin Pain

Persistent pain following inguinal hernia surgery is relatively common and a comprehensive pain management program is recommended. A prospective study, including elective primary open

hernia repairs, found persistent pain occurred in 16.5-16.1 percent of patients at six months and five years.³⁹ Acute pain persisting more than eight weeks is most likely neuropathic due to primary or secondary nerve injuries. Post-herniorrhaphy neuralgia should be suspected if pain persists beyond six to eight weeks. These patients should undergo imaging to exclude nonneuropathic causes. Patients with positive response to initial nerve block can be treated every 1-3 weeks until pain relief is sustained. Those who do not obtain pain relief may require groin nerve sacrifice.³⁹

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019 American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. 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 |
| 64624 | Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed |

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

| Reviews, Revisions, and Approvals | Date | Approval Date |
|--------------------------------------|------------|---------------|
| Converted corporate to local policy. | 12/01/2020 | |

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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. LHCC 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.

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 LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. 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. LHCC 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

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