Clinical Policy: Peripheral Nerve Blocks

Reference Number: MC.CP.MP.170
Date of Last Revision: 04/24

Coding Implications
Revision Log

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

Description

This policy outlines the medical necessity criteria for peripheral nerve blocks. This policy criteria is sourced from Local Coverage Determinations (LCDs) Peripheral Nerve Blocks (L33933 and L36850) as well as data from randomized control trials.

Benefits of peripheral nerve blocks (PNB), when indicated, include the avoidance of respiratory suppression, and other complications of general anesthesia (GA), as well as the provision of analgesia while minimizing opioid use.[8] Risks of receiving PNBs include nerve injury, hematoma, local anesthetic systemic toxicity, allergic reaction, infection, myotoxicity, and secondary injury.[8] For this reason, nerve blocks should only be performed when they have been proven to be safe and effective in order to reduce unnecessary risks to the recipient.

A very low-quality body of evidence regarding genicular nerve blocks (GNB) suggests that GNB combined with corticosteroid appears safe, but findings are inconsistent as to whether GNB resulted in statistically or clinically significant improvements in pain and daily function. The benefits and long-term effectiveness of genicular nerve blocks over standard therapies has not yet been established, and therefore not proven to be beneficial.[5]

Note: For criteria applicable to non-Medicare plans, please see CP.MP.170 Nerve Blocks and Neurolysis for Pain Management.

Policy/Criteria

I. It is the policy of Medicare health plans affiliated with Centene Corporation® that peripheral nerve blocks will be considered medically reasonable and necessary for conditions such as the following diagnostic and therapeutic purposes:

A. When pain appears to be due to a classic mononeuritis but the neuro-diagnostic studies have failed to provide a structural explanation; [1,3]
B. When peripheral nerve injuries/entrapment or other extremity trauma leads to complex regional pain syndrome; [1,3]
C. When selective peripheral nerve blockade is used diagnostically in those cases in which the clinical picture is unclear; [1,3]
D. When an occipital nerve block is used to confirm the clinical impression of the presence of occipital neuralgia; [1,3]
E. When the suprascapular nerve block is used to confirm the diagnosis of suspected entrapment of the nerve; [1,3]
F. When the trigeminal nerve is blocked centrally at the trigeminal ganglion, along one of the three divisions or at one of the many peripheral terminal branches (i.e., supraorbital nerve);[1]

G. Nerve block or continuous peripheral nerve block as preemptive analgesia when a single injection peripheral nerve block provides post-surgical pain control, one of the following:[1,3]
    a. During the transition to oral analgesics;
    b. In those procedures which cause severe pain normally uncontrolled by oral analgesics;
    c. In cases otherwise requiring control with intravenous or parenteral narcotics;
    d. In cases where the patient cannot tolerate treatment with narcotics due to allergy or side effects, etc.

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.

II. It is the policy of Medicare health plans affiliated with Centene Corporation that the following are considered not medically necessary:[1,3]
A. More than three injections per anatomic site (e.g., specific nerve, plexus or branch as defined by the CPT code description) in a six-month period;
B. More than two anatomic sites (e.g., specific nerve, plexus or branch as defined by the CPT code description) injected at any one session.
C. "Dry needling" of ganglion cysts, ligaments, neuromas, peripheral nerves, tendon sheaths and their origins/insertions, or any tissue are non-covered procedures.

III. It is the policy of Medicare health plans affiliated with Centene that there is insufficient evidence to support the use of peripheral nerve blocks for the following indications:[1,3]
A. 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;
B. Genicular nerve blocks and neurolysis for the treatment of knee osteoarthritis;
C. Peripheral nerve blocks with or without the use of electrostimulation, and the use of electrostimulation alone for neuropathies or peripheral neuropathies caused by underlying systemic diseases.

Background

Centers for Medicare & Medicaid Services[1,3]

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: post-herniorrhaphy 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 be effective at providing long term relief.

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 2023, 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
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)
20561	Needle insertion(s) without injection(s); 3 or more muscles
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
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed
64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed
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 (list separately in addition to code for primary procedure)
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves
64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve
64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed
64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
64447	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed
64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
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
64455	Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, morton's neuroma)
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	08/23	08/23
Added criteria III.B. regarding genicular nerve blocks.	02/24	02/24
Annual review. Added the following note under section I. "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." Added "and neurolysis" to III.B. References reviewed and updated.	04/24	04/24

References

1. Local Coverage Determination: peripheral nerve blocks (L36850). Centers for Medicare and Medicaid Services Web site. http://www.cms.hhs.gov/mcd/search.asp. Published May 1, 2017 (revised November 21, 2019). Accessed March 20, 2024.
2. Local Coverage Article: peripheral nerve blocks (A57452). Centers for Medicare and Medicaid Services Web site. http://www.cms.hhs.gov/mcd/search.asp. Published November 21, 2019 (revised October 1, 2023). Accessed March 20, 2024.
3. Local Coverage Determination: peripheral nerve blocks (L33933). Centers for Medicare and Medicaid Services Web site. http://www.cms.hhs.gov/mcd/search.asp. Published October 10, 2015 (revised October 8, 2019). Accessed March 20, 2024.
4. Local Coverage Article: peripheral nerve blocks (A57788). Centers for Medicare and Medicaid Services Web site. http://www.cms.hhs.gov/mcd/search.asp. Published October 3, 2018 (revised October 1, 2023). Accessed March 20, 2024.
5. Health Technology Assessment: Genicular nerve block for treatment of knee osteoarthritis. Hayes. www.hayesinc.com. Published December 7, 2023. Accessed April 4, 2024.
6. Shanahan EM, Robinson L, Lyne S, et al. Genicular nerve block for pain management in patients with knee osteoarthritis: a randomized placebo-controlled trial. *Arthritis Rheumatol*. 2023; 75(2):201-209.
7. Güler T, Yurdakul FG, Önder ME, et al. Ultrasound-guided genicular nerve block versus physical therapy for chronic knee osteoarthritis: a prospective randomised study. *Rheumatol Int*. 2022; 42(4):591-600.
8. Jeng CL, Rosenblatt MA. Overview of peripheral nerve blocks. UpToDate. www.uptodate.com. Updated December 6, 2023. Accessed April 4, 2024.

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. The 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 Health Plan-level administrative policies and procedures.

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

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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.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.