n05698

Nerve Blocks and Ablation Therapy for the Treatment of Pain

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

The purpose of this policy is to provide guidance for Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC's (NHP/NHIC/NHAS) utilization management team in rendering medical necessity decisions related to the use of nerve blocks and ablation therapy for the treatment of pain.

Policy Detail:

Refer to the appropriate Certificate of Coverage, Evidence of Coverage, Summary Plan Description, or Individual and Family Policy to determine eligibility and coverage because employer group and government contracts may vary. Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services LLC follows Medicare's National/Local (Wisconsin area) Coverage Determinations for its Medicare Advantage membership. In the absence of a Medicare LCD/NCD Network Health will use this internal policy criteria for medical necessity determinations for Medicare Advantage membership.

I. Description
   - A. Peripheral nerve blocks are used to temporarily disrupt the transmission of pain for either diagnostic or therapeutic purposes.
     1. Diagnostic block is used to isolate the cause of pain, if the cause of pain is already known the block is no longer diagnostic in purpose.
     2. Therapeutic is used to treat pain in which the cause is already known.
   - B. Destruction of nerves via ablation including the following techniques (chemical, thermal, radiofrequency, cryotherapy, or other modalities) are used to reduce acute or chronic pain by preventing the transmission of pain signals.

II. Coverage
   - A. A regional or local block administered for anesthesia in conjunction with surgery (administered the same day as the surgery) would be considered reasonable and necessary.
   - B. A peripheral nerve block administered for diagnostic purposes when the clinical picture is unclear may be considered reasonable and necessary.

III. Limitations/Exclusions
   - A. Network Health follows CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) for application to its Medicare Advantage membership, when available.
   - B. The use of ablation therapy to treat pain for all other indications other than

outlined above will be reviewed under Network Health's experimental, investigational, and/or unproven process. This includes but is not limited to peripheral nerve destruction using cryoablation/cryoneurolysis (i.e., Iovera), rhizotomy, laser, electrical, chemical, or radiofrequency ablation.

1. This would include treatment of any of the following conditions:
    a. Sacroiliac join pain
    b. knee pain
    c. hip pain
    d. back pain (for procedures/diagnosis codes not reviewed by EviCore)
    e. shoulder pain
    f. foot/heel pain
    g. headache
    h. occipital neuralgia
    i. intercostal neuralgia
    j. lower extremity pain from any of the following
        i. complex regional pain syndrome
        ii. peripheral neuropathy
        iii. peripheral nerve entrapment/compression (sciatica, tarsal tunnel syndrome)

IV. References

A. Local Coverage Article: Billing and Coding: Peripheral Nerve Blocks (A57452)
B. Local Coverage Determination (LCD): Peripheral Nerve Blocks (L36850)
C. MCG Nerve Block, Occipital ACG:A-1033
D. American Society of Anesthesiologists (ASA) Task Force on Chronic Pain Management, American Society of Regional Anesthesia and Pain Medicine (ASRA). Practice guidelines for chronic pain management: an updated report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine, Anesthesiology 2010 112:1-1
E. Choi WJ, Hwang SJ, Song JG, et al. Radiofrequency treatment relieves chronic knee osteoarthritis pain: a double-blind randomized controlled trial. Pain 2011;152:481– 487

Definitions:

None

Regulatory Citations:

UM2

Related Documents:

CPT Codes:*

0441T	Ablation, percutaneous cryoablation, includes imaging guidance, lower extremity distal/peripheral nerve
C9808	Nerve cryoablation probe (e.g. cryoICE, cryoSPHERE, cryoSPHERE MAX, cryo2) including probe and all disposable system components

C9809	Cryoablation needle (e.g. Iovera system), including needle/tip and all disposable system components
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital 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
64640	Destruction by neurolytic agent, other peripheral nerve or branch
64624	Destruction by neurolytic agent; genicular nerve branches including imaging, destruction of each of the following genicular nerve branches: superolateral, superomedial and inferomedial
64632	Destruction by neurolytic agent, plantar common digital nerve
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint
64640	Destruction by neurolytic agent, paravertebral facet joint nerve; other peripheral nerve or branch
64999	Unlisted procedure, nervous system [when specified as cooled or pulsed RF therapy (not destruction) to genicular nerve(s)]
*CPT codes are subject to change as codes are retired or new ones developed. The CPT list may not be all inclusive.	

Disclaimer:

Contract language as well as state and federal laws take precedence over any medical policy. Network Health coverage documents (i.e. Certificate of Coverage, Evidence of Coverage, Summary Plan Descriptions) outline contractual terms of the applicable benefit plan for each line of business and will be considered first in determining eligibility. Not all Network Health coverage documents are the same. Coverage may differ. Our Medicare membership follows applicable Centers for Medicare and Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Please refer to the CMS website at www.cms.gov.

Network Health reserves the right to review and update our medical policies on occasion as

medical technologies are constantly evolving. The documentation of any brand name of a test, product and/or procedure in a medical policy is in no way an endorsement of that product; it is for reference only. Network Health's medical policies are for guidance and not intended to prevent the judgment of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.

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