Corporate Medical Policy

Ablation and Neural Therapy Procedures for Headache and Pain Management

File Name: ablation_and_neural_therapy_procedures_for_headache_and_pain management
Origination: 8/2015
Last Review: 2/2024

Description of Procedure or Service

A neuroma is a pathology of a peripheral nerve that develops as part of a normal reparative process.Neuromas may develop after injury to a nerve or as a result of chronic irritation, pressure, stretch, poor repair of nerve lesions or previous neuromas, laceration, crush injury, or blunt trauma. Neuromas typically appear about 6 to 10 weeks after trauma with most presenting within 1 to 12 months after injury or surgery. They may gradually enlarge over a period of 2 to 3 years and may or may not be painful. Pain from a neuroma may be secondary to traction on the nerve by scar tissue, compression of the sensitive nerve endings by adjacent soft tissues, ischemia of the nervous tissue, or ectopic foci of ion channels that elicit neuropathic pain. Individuals may describe the pain as a low-intensity dull pain or intense paroxysmal burning pain, often triggered by external stimuli such as touch or temperature. Neuroma formation has been implicated as a contributor of neuropathic pain in residual limb pain, postthoracotomy, postmastectomy, and postherniorrhaphy pain syndromes. They may coexist with phantom pain or can predispose to it.

Morton Neuroma

Morton intermetatarsal neuroma is a common and painful compression neuropathy of the common digital nerve of the foot that may be referred to by other names, including interdigital neuroma, interdigital neuritis, and interdigital or Morton metatarsalgia. It is histologically characterized by perineural fibrosis, endoneurial edema, axonal degeneration, and local vascular proliferation. Thus, some investigators do not consider Morton neuroma to be a true neuroma; instead, they consider it to be an entrapment neuropathy that occurs secondary to compression of the common digital nerve under the overlying transverse metatarsal ligament. The incidence and prevalence of Morton neuroma are not clear, but it appears 10-fold more often in women than in men with an average age at presentation of around 50 years.

The pain associated with Morton neuroma is usually a throbbing, burning, or shooting pain that is localized to the plantar aspect of the foot. It is typically located between the 3rd and 4th metatarsal heads, although it may appear in other proximal locations. The pain may radiate to the toes and can be associated with paresthesia. The pain can be severe, and the condition may become debilitating to the extent that individuals are apprehensive about walking or touching their foot to the ground. It is aggravated by walking in shoes with a narrow toe box or high heels that cause excessive pronation and excessive forefoot pressure; removal of tight shoes typically relieves the pain.

Although a host of imaging methods may be used to aid diagnosis of Morton neuroma, including plain radiographs, magnetic resonance imaging, and ultrasonography, objective findings are unique to this condition and are primarily used to establish a clinical diagnosis. Thus, an individual's toes often show splaying or divergence. Individuals may describe the feeling of a "lump" on the foot bottom or a feeling of walking on a rolled-up or wrinkled sock. Clinical

examination with medial and lateral compression may reproduce the painful symptoms with a palpable “click” on interspace compression (Mulder sign).

Treatment of Morton Neuroma

Management of individuals with a diagnosis of Morton neuroma typically starts with conservative approaches, such as the use of metatarsal pads in shoes, and orthotic devices that alter supination and pronation of the affected foot. These approaches are aimed at reducing pressure and irritation of the affected nerve. They may provide some relief, but do not alter the underlying pathology. There is scant evidence to support the effectiveness or comparative effectiveness of these practices.

Historically, surgical intervention is considered the definitive therapy. The most common procedure is open excision of the interdigital nerve pathology through a dorsal or plantar approach. A second procedure, referred to as nerve decompression with neurolysis or translocation of the affected part of the interdigital nerve has been used to treat Morton neuroma.

A third approach that has been investigated to treat refractory Morton neuroma involves several minimally invasive procedures aimed at in situ destruction of the pathology: intralesional alcohol injections, radiofrequency ablation (RFA), and cryoablation (also known as cryoneurolysis, cryolysis, or cryoanalgesia). Dehydrated ethanol has been shown to inhibit nerve function in vitro, has high affinity for nerve tissue, and causes direct damage to nerve cells via dehydration, cell necrosis, and precipitation of protoplasm, leading to neuritis and a pattern of Wallerian degeneration. Technically, ethanol is a sclerosant that causes chemical neurolysis of the nerve pathology, but is considered an ablative procedure for this Policy. The use of ultrasound guidance during this procedure has been shown to increase surgical accuracy, improve outcomes, and shorten procedure duration. RFA uses heat generated by an electrode that conducts electromagnetic energy into a tissue or lesion to denature proteins and destroy cells. RFA has been used to ablate a wide range of disparate tissues or lesions that include osteoid osteoma, cardiovascular system pathologies, cervical pain syndromes, liver, lung and other cancers, and varicosities. Cryoablation uses a coolant to chill a cryoprobe to temperatures below -75 degrees Celsius, which when inserted into a lesion freezes and kills the tissue that is treated. It has been used to treat Morton neuroma and other chronic nerve pain syndromes as well as many other conditions in which RFA has been used.

Plantar Fasciitis

Plantar fasciitis is a common cause of foot pain in adults, characterized by deep pain in the plantar aspect of the heel, particularly on arising from bed. While the pain may subside with activity, in some individuals the pain may persist, impairing activities of daily living. On physical examination, firm pressure will elicit a tender spot over the medial tubercle of the calcaneus. The exact etiology of plantar fasciitis is unclear, although repetitive injury is suspected. Heel spurs are a common associated finding, although it has never been proven that heel spurs cause the pain. Asymptomatic heel spurs can be found in up to 10% of the population. Most cases of plantar fasciitis are treated with conservative therapy, including rest or minimization of running and jumping, heel cups, and nonsteroidal anti-inflammatory drugs. Local steroid injection may also be used. Improvement may take up to 1 year in some cases.

Knee Osteoarthritis

Knee osteoarthritis (OA) is common, costly, and often the cause of substantial disability. Among U.S. adults, the most common causes of disability are arthritis and rheumatic disorders. Treatment for OA of the knee aims to alleviate pain and improve function. However, most treatments do not modify the natural history or progression of OA and are not considered

curative. Nonsurgical modalities used include exercise; weight loss; various supportive devices; acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen; nutritional supplements (glucosamine, chondroitin); and intra-articular viscosupplements. Corticosteroid injection may be considered when relief from NSAIDs is insufficient or the individual is at risk from gastrointestinal adverse effects. If symptom relief is inadequate with conservative measures, invasive treatments may be considered. Operative treatments for symptomatic OA of the knee include arthroscopic lavage and cartilage débridement, osteotomy, and, ultimately, total joint arthroplasty. Surgical procedures intended to repair or restore articular cartilage in the knee (eg, abrasion arthroplasty, microfracture techniques, autologous chondrocyte implantation) are appropriate only for younger individuals with focal cartilage defects secondary to injury and are not addressed in this policy.

Headache

Headaches are common neurologic disorders and are among the top reasons that individuals seek medical care. Headaches affect approximately 50% of the general population in a given year and over 90% of people have a lifetime history of headache.

Occipital Neuralgia

Occipital neuralgia is a specific type of headache that is located on one side of the upper neck, back of the head, and behind the ears, and sometimes extending to the scalp, forehead, and behind the eyes. The pain, which may be piercing, throbbing, or electric-shock-like, follows the course of the greater and lesser occipital nerves. Occipital neuralgia is believed to occur due to pressure or irritation to the occipital nerves, which may result from injury, entrapment by tight muscles, or inflammation. Treatment may include massage and rest, muscle relaxants, nerve blocks, and injection of steroids directly into the affected area.

Cervicogenic Headache

Cervicogenic headache is a headache that is secondary to a disorder of the cervical spine. The pain may be referred from facet joints, intervertebral discs, or soft tissue. The pain is constant rather than throbbing, and may be aggravated by movements of the neck or pressure to certain areas on the neck. The first 3 cervical spinal nerves can refer pain to the head. The C1 suboccipital nerve innervates the atlanto-occipital joint; the C2 spinal nerve and the C3 dorsal ramus have close proximity to and innervate the C2-C3 facet joint. The C2-3 facet joint is the most frequent source of a cervicogenic headache. A diagnosis of a cervicogenic headache may be confirmed by an anesthetic block of the lateral atlanto-axial joint, the C2-3 facet joint, or the C3-4 facet joint. Treatment may include nerve blocks, physical therapy, and exercise.

Migraine/other Non Migraine Headache

Migraines are the second-most common headache disorder. They are characterized by severe pain on one or both sides of the head, nausea, and, at times, disturbed vision. Migraines can be categorized by headache frequency, and by the presence or absence of aura. Chronic migraines are defined as attacks at least 15 days per month for more than 3 months, with features of migraine at least 8 days per month.

Diagnostic criteria for tension headaches include the presence of at least two of the following characteristics: bilateral headache location, non-pulsating pain, mild-to-moderate intensity, and headache not aggravated by physical activity.

Cluster headaches are less common than tension or migraine headaches. They are characterized by severe unilateral orbital, supraorbital, and/or temporal pain that also includes other symptoms in the eye and/or nose on the same side (e.g., rhinorrhea, eyelid edema or drooping).

Nerve Radiofrequency Ablation

Nerve radiofrequency ablation (RFA) is a minimally invasive method that involves use of heat and coagulation necrosis to destroy tissue. A needle electrode is inserted through the skin and then into the tissue to be ablated. A high-frequency electrical current is applied to the target tissue. A small sphere of tissue is coagulated around the needle by the heat generated. It is theorized that the thermal lesioning of the nerve destroys peripheral sensory nerve endings, resulting in the alleviation of pain. Cooled radiofrequency (RF) treatment is a variation of nerve RFA using a special device that applies more energy at the desired location without excessive heat diffusing beyond the area, causing less tissue injury away from the nerve. The goal of ablating the nerve is the same.

For the indications assessed in this policy, nerve RFA should be distinguished from RF energy applied to areas other than the nerve to cause tissue damage. Some individuals have been treated for plantar fasciitis with a fasciotomy procedure using an RF device. This procedure does not ablate a specific nerve.

Nerve RFA is also distinguished from pulsed RF treatment, which has been investigated as a treatment for different types of pain. The mechanism of action of pulsed RF treatment is uncertain, but it is thought not to destroy the nerve. If it does produce some degree of nerve destruction, it is thought to cause less damage than standard RFA. Some studies refer to pulsed RF treatment as ablation.

Cryoneurolysis

Cryoneurolysis is being investigated to alleviate pain. Temperatures of -20° to -100°C applied to a nerve cause Wallerian (anterograde axonal) degeneration, with disruption of nerve structure and conduction but maintenance of the perineural and epineural elements of the nerve bundle. Wallerian degeneration allows complete regeneration and recovery of nerve function in about 3 to 5 months. The iovera° cryoablation system is a portable handheld device that applies percutaneous and targeted delivery of cold to superficial peripheral nerves.

Regulatory Status

Alcohol injection for Morton neuroma is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

Although RFA probes and generators and cryoablation equipment have received FDA 510(k) marketing clearance, none appear to be specifically indicated for treatment for Morton neuroma or any other specific peripheral neuroma.

In 2005, the SInergy® (Kimberly-Clark/Baylis), a water-cooled single-use probe, was cleared by FDA, listing the Baylis Pain Management Probe as a predicate device. The intended use is with an RF generator to create RF lesions in nervous tissue.

In 2011, NeuroTherm® NT 2000 (NeuroTherm) was cleared for marketing by FDA through the 510(k) process. FDA determined that this device was substantially equivalent to existing devices for use in lesioning neural tissue. Existing predicate devices included the NeuroTherm NT 1000, Stryker Multi-Gen, and Cosman G4 RF Generator.

In 2013, the Cryo-Touch IV (iovera°; Myoscience) was cleared for marketing by FDA through the 510(k) process. Predicate devices were the Cryo-Touch II and Cryo-Touch III.

In 2017, the COOLIEF Cooled Radiofrequency Probe (Avanos, previously known as Halyard Health) was cleared for marketing by the FDA through the 510(k) process to be used in conjunction with a radiofrequency generator to create lesions in nervous tissue (K163461). The device is also indicated for "creating radiofrequency lesions of the genicular nerves for the management of moderate to severe knee pain of more than 6 months with conservative therapy, including medication, in patients with radiologically-confirmed osteoarthritis (grade 2-4) and a positive response (> 50% reduction in pain) to a diagnostic genicular nerve block."

Related Policies

Injection Therapy for Headache (Migraine and Other) and Non-Spine Management
Facet Joint Denervation
Corporate Reimbursement Policy: Bundling Guidelines
Anesthesia Services

Note: This policy does not address the use of these techniques to provide anesthesia for surgical procedures.

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

Minimally invasive ablation procedures, including but not limited to radiofrequency ablation, cryoablation and alcohol/anesthetic/steroid injections are considered investigational for all applications and diagnoses. BCBSNC does not provide coverage for investigational services or procedures.

Radiofrequency ablation of peripheral nerves to treat pain is considered investigational for all applications and diagnoses. BCBSNC does not provide coverage for investigational services or procedures.

Cryoneurolysis of peripheral nerves to treat pain is considered investigational for all applications and diagnoses. BCBSNC does not provide coverage for investigational services or procedures.

Ablation of peripheral nerves to treat pain is considered investigational for all applications and diagnoses, with the exception of facet joint pain. BCBSNC does not provide coverage for investigational services or procedures.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When ablation and neural therapy procedures for headache and pain management are covered

Not applicable.

When ablation and neural therapy procedures for headache and pain management are not covered

Minimally invasive ablation procedures, including but not limited to RFA, cryoablation and alcohol/anesthetic/steroid injections, are considered investigational for all applications and diagnoses.

Radiofrequency ablation of peripheral nerves to treat pain is considered investigational for all applications and diagnoses.

Cryoneurolysis of peripheral nerves to treat pain is considered investigational for all applications and diagnoses.

Ablation of peripheral nerves to treat pain is considered investigational for all applications and diagnoses, with the exception of facet joint pain.

Policy Guidelines

The overall body of evidence evaluating the efficacy of minimally invasive ablation techniques is weak, consisting of case series reporting on outcomes following ablative treatment. There are no controlled studies to compare outcomes with those of surgery in patients who all are surgical candidates.

For individuals who have Morton neuroma who receive intralesional alcohol injection(s), the evidence includes retrospective case series. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. The body of evidence is limited, consisting of case series reporting on treatment response of patients with refractory Morton neuroma. The available series have generally reported that some patients experience pain relief and express satisfaction with the procedure. Some evidence has suggested that surgery after failed cases of alcohol injections is more complex and challenging than in untreated patients due to the presence of fibrosis. There is a lack of controlled trials comparing alcohol injections to alternative therapies and there are no controlled studies comparing outcomes for alcohol injections to those for surgery in patients who are surgical candidates. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have Morton neuroma who receive RFA, the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. Fourcase series have reported outcomes of RFA to treat Morton neuroma. The body of evidence is highly heterogeneous in terms of RFA protocols, descriptions of prior conservative management, patient characteristics, follow-up durations, outcome measures, and reporting of outcomes. Variable proportions of patients require surgery after RFA, making the benefit of RFA for avoiding more invasive treatment uncertain. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have Morton neuroma who receive cryoablation, the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity.

Only two retrospective case series on the use of cryoablation to treat peripheral nerve pain were identified in the literature review. The case series were heterogeneous regarding cryoablation protocols and length of follow-up. Outcome measures did not provide information on functional end points. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have peripheral neuroma(s) other than Morton neuroma who receive ablation no published literature was identified. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have plantar fasciitis who receive radiofrequency ablation of the peripheral nerves, the evidence includes two randomized controlled trials (RCT). Relevant outcomes include symptoms, functional outcomes, and quality of life. One RCT evaluated only 17 individuals, and randomized outcomes were only assessed out to 4 weeks post-treatment. A second RCT evaluated 36 individuals out to 12 weeks. Both trials found RFA associated with pain reduction, but to be more confident in the efficacy of this treatment, controlled trials with larger samples and longer follow-up would be necessary. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have knee osteoarthritis who receive radiofrequency ablation of the peripheral nerves, the evidence includes systematic reviews of randomized controlled trials (RCTs), RCTs with 24 to 200 individuals, and non-randomized comparative studies with up to 12 months of follow-up. Relevant outcomes include symptoms, functional outcomes, and quality of life. Knee OA is a common disorder in older adults. RFA of the genicular nerves has the potential to alleviate pain and improve function in this population and might also delay or eliminate the need for TKA. At this time, there is high heterogeneity in methods and comparators. The 2 multi-center trials conducted in the U.S. used anesthetic nerve block under fluoroscopic guidance and compared efficacy of cooled RFA to either steroid injection or hyaluronic acid injection. Both studies reported a responder rate of approximately 70% at 6 months, which was significantly greater than the control conditions. Given that OA of the knee is a common condition, study in a larger number of individuals, preferably blinded with active and sham controls and follow-up of at least 12 months, is needed to determine the benefits and potential harms of this treatment. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have knee osteoarthritis or total knee arthroplasty who receive cryoneurolysis of peripheral nerves, the evidence includes 2 RCTs with 304 individuals and a comparative, retrospective cohort study of 57 particpants. Relevant outcomes include symptoms, functional outcomes, and quality of life. Cryoneurolysis in individuals with knee osteoarthritis resulted in a greater decrease in Western Ontario McMaster Universities Osteoarthritis Index (WOMAC) pain score, WOMAC total score, and visual analog scale score at 30 days compared with sham-treated controls. However, subsequent measurements showed no significant benefit of cryoneurolysis on WOMAC score at 60 days or visual analog scale scores at 60 or 90 days. Perioperative cryoneurolysis was shown in a retrospective comparison to reduce the length of stay and opioid use in individuals undergoing total knee arthroplasty. These results need to be confirmed in an RCT. Several technical issues including the optimal number of applications for each nerve, the duration of treatment, and the duration of thawing before moving the cannula have not been resolved. The most effective method for determining probe insertion location (eg, ultrasound-guided or based on anatomic landmarks) also need to be established. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have occipital neuralgia or cervicogenic headache/migraine who receive RFA or cryoneurolysis of peripheral nerves, the evidence includes RCTs and systematic reviews of RCTs. Relevant outcomes are symptoms, functional outcomes, and quality of life. No RCTs of RFA for chronic occipital neuralgia have been identified. Three RCTs of RFA for a cervicogenic headache have been published, none of which were high quality. Pain is a subjective, patient-reported measure that is particularly susceptible to placebo effect. Randomized trials with sham or active-controls are needed to evaluate the efficacy of this treatment. One controlled trial found a temporary benefit of cryoneurolysis for cervicogenic headache, but the effect was not significantly better than injection of corticosteroid and local anesthetic. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Neural therapy involves the injection of a local anesthetic such as procaine or lidocaine with or without steroids into various tissues such as scars, acupuncture points, tendon and ligament insertions, peripheral nerves, autonomic ganglia, and other tissues to treat chronic pain and illness. When the anesthetic agent is injected into traditional acupuncture points, this treatment may be called neural acupuncture.

The practice of neural therapy is based on the belief that energy flows freely through the body. It is proposed that injury, disease, malnutrition, stress, and scar tissue disrupt this flow, creating disturbances in the electrochemical function of tissues and energy imbalances called “interference fields.” Injection of a local anesthetic is believed to re-establish the normal resting potential of nerves and flow of energy. Alternative theories include fascial continuity, the ground (matrix) system, and the lymphatic system.

There is a strong focus on treatment of the autonomic nervous system, and injections may be given at a location other than the source of the pain or location of an injury. Neural therapy is promoted mainly to relieve chronic pain. It has also been proposed to be helpful for allergies, hay fever, headaches, arthritis, asthma, hormone imbalances, libido, infertility, tinnitus, chronic bowel problems, sports or muscle injuries, gallbladder, heart, kidney, or liver disease, dizziness, depression, menstrual cramps, and skin and circulation problems.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: *20999, 64454, 64455, 64620, 64624, 64630, 64632, 64640, 64999*

ICD-10 diagnosis codes: G43.001, G43.009, G43.011, G43.019, G43.101, G43.109, G43.111, G43.119, G43.401, G43.409, G43.411, G43.419, G43.501, G43.509, G43.511, G43.519, G43.601, G43.609, G43.611, G43.619, G43.701, G43.709, G43.711, G43.719, G43.801, G43.809, G43.811, G43.819, G43.821, G43.829, G43.831, G43.839, G43.901, G43.909, G43.911, G43.919, G44.001, G44.009, G44.011, G44.019, G44.021, G44.029, G44.031, G44.039, G44.041, G44.049, G44.051, G44.059, G44.091, G44.099, G44.1, G44.201, G44.209, G44.211, G44.219, G44.221, G44.229, G44.301, G44.309, G44.311, G44.319, G44.321, G44.329, G44.40, G44.41, G44.51, G44.52, G44.53, G44.59, G44.81, G44.82, G44.83, G44.84, G44.85, G44.86, G44.89, G50.0, G50.1, M16, M16.0, M16.1, M16.10, M16.11, M16.12, M16.2, M16.3, M16.30, M16.31, M16.32, M16.4, M16.5, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M17, M17.0, M17.1, M17.10, M17.11, M17.12, M17.2, M17.3, M17.30, M17.31. M17.32, M17.4, M17.5, M17.9, M19, M19.0, M19.01, M19.011, M19.012, M19.019, M19.02, M19.021, M19.022, M19.029, M19.03,M19.031, M19.032, M19.039, M19.04, M19.041,

M19.042, M19.049, M19.07, M19.071, M19.072, M19.079, M19.1, M19.11, M19.111, M19.112, M19.119, M19.12, M19.121, M19.122, M19.129, M19.13, M19.131, M19.132, M19.139, M19.14, M19.141, M19.142, M19.149, M19.17, M19.171, M19.172, M19.179, M19.2, M19.21, M19.211, M19.212, M19.219, M19.22, M19.221, M19.222, M19.229, M19.23, M19.231, M19.232, M19.239, M19.24, M19.241, M19.242, M19.249, M19.27, M19.271, M19.272, M19.279, M19.9, M19.90, M19.91, M19.92, M19.93, M25.551, M25.552, M25.559, M25.561, M25.562, M25.569. M54.2, M54.81, M79.10, M79.11, M79.12, M79.7, R51

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.147, 12/11/14

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.97, 4/23/15

Specialty Matched Consultant Advisory Panel – 2/2016

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.154, 1/14/2016

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.147, 6/16/2016

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.97, 6/16/2016

Specialty Matched Consultant Advisory Panel – 2/2017

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.147, 6/8/2017

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.97, 6/8/2017

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.154, 9/14/2017

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Specialty Matched Consultant Advisory Panel – 2/2020

Medical Director review

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.147, 6/18/2020

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BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.154, 9/10/2020

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Specialty Matched Consultant Advisory Panel – 2/2022

Specialty Matched Consultant Advisory Panel – 2/2023

Specialty Matched Consultant Advisory Panel 2/2024

Medical Director Review 2/2024

Policy Implementation/Update Information

10/1/15 New policy issued. Ablation procedures of any type for treatment of all peripheral neuromas are considered investigational. Policy noticed 10/1/15 for policy effective date 12/30/15. (sk)

4/1/16 Specialty Matched Consultant Advisory Panel review 2/24/2016. (sk)

5/31/16 Reference added. Description section updated. Policy Guidelines updated. Radiofrequency ablation of peripheral nerves to treat pain associated with plantar fasciitis or knee osteoarthritis is considered investigational. Policy noticed 5/31/2016 for effective date 8/30/2016. (sk)

3/31/17 References added. Policy Guidelines updated. Specialty Matched Consultant Advisory Panel review 2/22/2017. (sk)

7/28/17 References added. Policy Guidelines updated. (sk)

1/12/18 Reference added. (sk)

4/27/18 Specialty Matched Consultant Advisory Panel review 2/28/2018. (sk)

3/12/19 References added. Investigational policy statements added on cryoneurolysis for knee osteoarthritis or total knee arthroplasty and on radiofrequency ablation for occipital neuralgia and cervicogenic headache. Description section updated. Regulatory Guidelines updated. Policy Guidelines updated. Specialty Matched Consultant Advisory Panel review 2/20/2019. Policy noticed 3/12/2019 for effective date 5/14/2019. (sk)

1/14/20 CPT codes 64454 and 64624 added to Billing/Coding section. (sk)

3/10/20 References added. Regulatory Guidelines updated. Policy Guidelines updated. Specialty Matched Consultant Advisory Panel review 2/19/2020. (sk)

9/22/20 Medical Director review. Policy title changed from Ablation Procedures for Peripheral Neuromas and Peripheral Nerves to Ablation and Neural Therapy Procedures for Headache and Pain Management. Description section updated. Related policies added. Policy statements updated for clarity. When Not Covered section updated for clarity. Policy Guidelines updated. Codes 64620, 64630, 64455, 64999 and 20999 added to Billing/Coding section. ICD-10 diagnosis codes added. Notification given 9/22/2020 for policy effective date 11/24/2020. (sk)

3/9/21 References added. Policy Guidelines updated. Specialty Matched Consultant Advisory Panel review 2/17/2021. (sk)

10/19/21 References added. Policy Guidelines updated. ICD-10 diagnosis code G44.86 added to Billing/Coding section. (sk)

3/8/22 Specialty Matched Consultant Advisory Panel review 2/16/2022. (sk)

3/7/23 Policy Guidelines updated. Specialty Matched Consultant Advisory Panel review 2/15/2023. (sk)

4/1/24 Policy Guidelines updated. Specialty Matched Consultant Advisory Panel review 2/2024. Medical Director Review 2/2024. (rp)