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## Subject: Nerve Block Injections

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### DESCRIPTION:

Nerve blocks consist of injection of a local anesthetic, with or without a steroid, into a peripheral nerve or a nerve ganglion. The predicted result is temporary interruption of conduction of impulses in peripheral nerves or nerve trunks (sympathetic nerves), to block pain signals and provide prolonged relief from pain.

**Summary and Analysis of Evidence:** Lee et al (2017) performed two CT-guided ganglion impar blocks on a 48-year-old woman who experienced severe intractable perineal pain, dysuria, urinary urgency, and frequent urination after rectal cancer surgery and adjuvant RT. Diagnosed with radiation-induced cystitis and vulvodynia, her symptoms persisted despite two fluoroscopy-guided ganglion impar blocks. Fluoroscopy revealed atypical needle tip positioning and radiolucent dye distribution, presumably due to radiation-induced fibrosis in the target region. CT-guided blocks allowed more accurate positioning of the needle tip. Her pain visual analog score decreased from 9 to 3. The authors concluded “CT guidance is a viable alternative to fluoroscopy guidance when performing ganglion impar blocks in fibrotic areas.” As a single case-study, these findings require validation by well-designed studies. Cardiallac et al (2016) conducted a retrospective, single-center study to evaluate the relevance of ropivacaine impar node infiltration (ganglion impar block) in patients suffering from rebel vulvodyny. The impar node infiltrations were performed by a single operator in eight patients suffering from rebel vulvodynia. Ropivacaine and iopamidol were administered in prone position with a lateral approach under scanner. The anaesthetic diagnostic block of the impar node was positive in all eight patients included in the study. Thereafter these patients benefited of 2 additional therapeutic infiltrations. Subsequently, an infiltration of the node with 100UI of botulinum toxin was performed in two patients with a bilateral approach under scanner. The analgesic efficacy was evaluated by a Visual Analogic Scale (VAS) before, immediately after, and at day 15 following the infiltration. A subjective evaluation of pain comprising the percentage of overall improvement and duration of analgesic efficacy was performed after the third

infiltration. Comparison of the VAS before and immediately after the Impar block showed in the first anesthetic block a significant decrease in pain median VAS from 51/100 to 16/100. Similarly, for the second block, VAS decreased from 52.5/100 to 15/100. The maximal pain reported on Day 15, was significantly lower after the third infiltration than that after the first. Five patients reported an overall improvement in their quality of life of over 50%, which lasted an average of six weeks. A long lasting effectiveness was obtained in the two patients who benefited of the botulinum toxin. The authors concluded “the infiltration of impar node is an interesting technique for patients suffering of rebel vulvodinia.” This small case series requires validation by larger, well-designed studies.

UpToDate review “Acute treatment of migraine in adults” (Schwedt, Garza; 2024) states, “commercially available intranasal devices supposedly facilitate blockade of the sphenopalatine ganglion (SPG) by topical application and passive diffusion of local anesthetic. However, anatomic research has shown that the SPG is not as close to the nasal mucosa as previously believed, raising doubt that SPG blockade can be accomplished through intranasal application of local anesthetic. The review further states “limited data suggest benefit of SPG blocks for treatment of acute migraine. One early trial randomly assigned patients in a 2:1 ratio to intranasal 4 percent lidocaine or saline placebo; a 50 percent reduction in headache intensity at 15 minutes was achieved by 29 patients (55 percent) treated with lidocaine compared with 6 patients (21 percent) who received placebo. A later parallel-arm, randomized pilot trial enrolled patients with chronic migraine and randomly assigned them in a 2:1 ratio to repetitive SPG blocks twice weekly for six weeks with either 0.5 percent bupivacaine or saline. With efficacy data for 38 patients, pain rating scores were lower at 15 minutes, 30 minutes, and 24 hours postprocedure for patients treated with bupivacaine compared with those treated with saline. However, patients treated bupivacaine had only a marginal absolute reduction in average pain intensity (1 to 1.5 units on the numerical rating scale) compared with placebo.” A 2022 Systematic Review and Practice Guideline for Percutaneous Interventional Strategies for Migraine Prevention published by the American Academy of Pain Medicine (Barad, 2022) stated that sphenopalatine ganglion blocks received a weak recommendation for chronic migraine prevention, due to insufficient evidence found by the committee.

UpToDate review “Management of moderate to severe knee osteoarthritis” (Devesa, Bennell; 2024) states, “for patients with symptomatic knee OA who have not responded satisfactorily to nonpharmacologic treatment and NSAIDs (or have contraindications preventing their use), a genicular nerve block may be considered if expertise is available. We suggest considering genicular nerve block for patients who have failed other treatment options and in those for whom surgery is not an option. However, our experience with this intervention is still limited, as it is not widely available, and we do not use this treatment. The superior medial genicular nerve, superior lateral genicular nerve, and inferior medial genicular nerve are localized using musculoskeletal ultrasound or fluoroscopy. Subsequently, these nerves are ablated using radiofrequency or chemicals (eg, local anesthetics, alcohol, or glucocorticoids). Systematic reviews indicate that both radiofrequency ablation and chemical ablation are effective, but most studies are small, and direct comparisons between these techniques are not available. A randomized trial of 59 patients with symptomatic knee OA demonstrated that genicular nerve block with bupivacaine and celestone chronodose (versus normal saline injections) led to improvement in pain scores, although the absolute effect was modest and diminished over 12 weeks of follow-up. Studies assessing the efficacy and safety of repeated injections for genicular nerve block are lacking. Shanahan et al (2023) reported on the effectiveness of genicular nerve block (GNB) in participants with longstanding knee osteoarthritis in a 12-week trial with 59 participants. They

concluded that US-guided GNB has shown promise as a treatment in the management of symptomatic knee OA, but its efficacy until now has not been truly established. Limitations of the study included small numbers, that safety could be established on a single study, and possible inadvertent inadequate blinding.

Shrikhande et al (2023) evaluated the efficacy of a multimodal, outpatient neuromuscular protocol in treating remaining sensitization and myofascial pain in endometriosis patients post-surgical excision. A retrospective longitudinal study was conducted for women aged 22 to 78 with a history of surgically excised endometriosis. 60 women with an average duration of pain of  $8.63 \pm 7.65$  years underwent a treatment protocol consisting of ultrasound guided trigger point injections, peripheral nerve blocks, and pelvic floor physical therapy for 6 weeks. Concomitant cognitive behavioral therapy once weekly for a total of 12 weeks was also undertaken. At new patient consults, average VAS and FPPS were  $7.45 \pm 2.11$  (CI 6.92-7.98) and  $14.35 \pm 6.62$  (CI 12.68 -16.02), respectively. At 3-month follow ups, average VAS and FPPS decreased to  $4.12 \pm 2.44$  (CI 3.50-4.73;  $p < 0.001$ ) and  $10.3 \pm 6.55$  (CI 8.64-11.96;  $p < 0.001$ ), respectively. Among FPPS categories, sleeping, intercourse, and working showed the highest statistical significance. The authors concluded “data suggests the multimodal protocol was effective in treating the remaining underlying sensitization and myofascial pain seen in endometriosis patients post-surgical excision, particularly in decreasing pain and improving function during work and intercourse.” The authors noted several study limitations, stating “the retrospective design ... does not allow for randomized control trials. The use of a placebo treatment would infringe the ethics and trust of our patients who are pursuing relief from their long-lasting pain. To gather in-depth insight into the clinical significance and quality-of-life improvements of our patients, a future consideration is to include PROMIS-29 and Female Sexual Function Index questionnaires as part of the outcome measures. Moreover, our follow ups occur 3 months after treatment which implies our outcomes may be short term. A future improvement is to gather data 6 months after treatment also.”

Natarajan et al (2021) conducted a retrospective longitudinal study of 200 female and male patients with <chronic pelvic pain> CPP was performed upon an Institutional Review Board (IRB) approval (IRB# 17-0761). The outpatient protocol consisted of ultrasound-guided trigger point injections to the pelvic floor musculature with peripheral nerve blocks once a week for 6 weeks in an outpatient setting. Pelvic pain and functionality were measured before and after treatment using the Visual Analogue Scale and the Functional Pelvic Pain Scale. Functionality categories assessed were intercourse, bladder, bowel, working, walking, running, lifting, and sleeping. Pretreatment, mean VAS score was 6.44 (standard deviation [SD] = 2.50;  $p < 0.05$ , 95% confidence interval [CI] = 6.09-6.79). Posttreatment mean VAS score was 4.25 (SD = 2.63;  $p < 0.05$ , 95% CI = 3.88-4.61). The mean FPPS score before treatment was 10.77 (SD = 6.39;  $p < 0.05$ , 95% CI = 9.88-11.65). Posttreatment mean FPPS score was 7.42 (SD = 5.87;  $p < 0.05$ , 95% CI = 6.61-8.23). Analysis of subcategories within FPPS indicated statistically significant improvement in the categories of intercourse, working, and sleeping. The authors concluded “findings show the treatment was efficient at decreasing pain in CPP patients. Results show promise for improving overall pelvic functionality, particularly within the categories of intercourse, sleeping, and working. One limitation to our study is its retrospective nature which prevents randomized control groups. The efficacy of our protocol in comparison to a placebo will not be possible as it would violate the ethics and trust of our patients who seek relief from their debilitating pain. Another major challenge is assessing the long-term efficacy of our protocol for the patients who have chronic underlying disease processes such as Endometriosis, Bladder Pain Syndrome/Interstitial Cystitis, and Connective Tissue disorders/Hypermobility because flare-ups can occur in these chronic conditions which require further treatment.”

Mustafa et al (2020)

evaluated the effectiveness of treatment of women with Chronic Pelvic Pain Syndrome (CPPS) using a combination of external ultrasound-guided trigger point injections to the pelvic floor musculature with peripheral nerve hydrodissection. A retrospective study of 73 women with CPPS who were treated with external ultrasound-guided trigger point injections to the pelvic floor musculature with pelvic peripheral nerve hydrodissection once a week for six weeks in an outpatient setting. Pelvic pain intensity as measured pretreatment and post treatment using the Visual Analogue Scale and Functional Pelvic Pain Scale. Categories of function evaluated were bladder, bowel, intercourse, walking, sleeping, working, running, and lifting. Pretreatment, the mean VAS score was 6.8 (Standard deviation [SD] 2.38);  $P < .05$ , 95% confidence interval (CI) 6.25 to 7.35. Post treatment, the mean VAS score was 5.08, (SD 2.67);  $P < .05$ , 95% confidence interval (CI) 4.46 to 5.70. The mean total FPPS score before treatment was 11.53 (SD6.50);  $P < .05$ , 95% confidence interval (CI) 10.02 to 13.03. Post treatment, the mean FPPS score was 8.69, (SD 6.38);  $P < .05$ , 95% confidence interval (CI) 7.21 to 10.17. Analysis of the subcategories within the FPPS indicated that the improvement was statistically significant in the categories of intercourse and working. The authors stated their findings “suggest that the treatment was effective at ameliorating pain in women with CPPS. It showed promise in improving overall pelvic function in women with CPPS, specifically in the categories of intercourse and working. Some limitations of our study include a short follow up time and a lack of a control group. In addition, the retrospective nature of this study is limiting but sets the stage for a prospective trial in the future.

Castillo-Alvarez et al (2023) states that peripheral nerve blocks have been a common treatment for multiple headaches. By far, the greater occipital nerve block is the most used and with the stronger body of evidence in routine clinical practice. The authors searched Pubmed Meta-Analysis/Systematic Review, in the last 10 years. Of these results, meta-analyses, and in the absence of these systematic reviews, assessing Greater Occipital Nerve Block in headache was selected for review. Thirteen studies met the inclusion criteria. Following their review, the authors concluded “greater occipital block is an effective and safe technique, easy to perform and which has shown its usefulness in migraine, cluster headache, cervicogenic headache and post-dural puncture headache.” They further states “however, more studies are needed to clarify its long-term efficacy, its place in clinical treatment, the possible difference between different anaesthetics, the most convenient dosage and the role of concomitant use of corticosteroids.” Chowdhury et al (2022) reported on the efficacy and tolerability of combined chronic migraine treatment with greater occipital nerve block (GONB) with topiramate compared to monotherapy with topiramate. 125 participants were randomized to 3 arms: (1) topiramate monotherapy once per day; (2) topiramate plus GONB with 40 mg lidocaine (2%) and 80 mg (2 ml) methylprednisolone as the first injection followed by 2 monthly injections of lidocaine; and (3) topiramate plus monthly GONB with 40 mg lidocaine (2%) injections for 3 months. Efficacy assessments were done for 121 participants. There were some mild adverse events reported, including limb paresthesias, dizziness, bleeding, and local site swelling. The study limitations included that the investigators were not blinded and there was no placebo arm. In addition, the authors stated “post-hoc analysis of the impact of coexistent medication overuse headache on GONB resulted in two unequal groups for comparison and hence the results should be viewed with caution. Finally, chronic migraine patients had lesser disease duration than previous studies, and it is uncertain whether chronic migraine patients with a longer duration of illness will have a similar response to the interventions.”

UpToDate review “Overview of peripheral nerve blocks“ (Jeng, Rosenblatt; 2024) states, “ultrasound imaging permits direct visualization of needle location relative to target nerves, blood vessels, and

related structures, as well as observation of the local anesthetic (LA) during and after the injection. Although results differ for different blocks, in general the use of ultrasound guidance (compared with nerve stimulator techniques) improves the success rate of the block; decreases placement time and onset of block; reduces the volume of LA required for successful block; is associated with decreased vascular puncture and local anesthetic systemic toxicity (LAST); and reduces incidence of pneumothorax and phrenic nerve block. In a meta-analysis of 23 trials including over 2000 PNBs, compared with nerve stimulation alone, ultrasound guidance (with or without nerve stimulation) reduced the rate of vascular puncture (relative risk [RR] 0.23), pain during the procedure (RR 0.6), and the need for analgesic or anesthetic rescue (RR 0.4) [18]. There was no difference in the rate of postoperative neurologic complications. In a subsequent retrospective single institution study including approximately 23,800 nerve blocks, ultrasound guidance was associated with a lower incidence of short term nerve injuries (seven days to six months), compared with landmark based blocks (0.2 versus 0.5 percent), but no difference in long term injuries. Patients in whom ultrasound guidance may be particularly advantageous include those with challenging anatomy (ie, scarring from previous surgeries, patients with obesity) and in those for whom improved visualization may improve safety, such as patients with abnormal coagulation status. Ultrasound may also be useful to "rescue" a block that is inadequate or incomplete <as> the nerve remains visible by ultrasound following LA injection, allowing the block to be repeated.

## **POSITION STATEMENT:**

Nerve block injections **meet the definition of medical necessity** for the following indications:

### **Complex regional pain syndrome (CRPS):**

- Continued pain > 4 weeks duration, **AND**
- Failed conservative treatment with **ALL** of the following treatments:
  - Antidepressant **OR** anticonvulsant, **AND**
  - Physical therapy (PT), occupational therapy (OT), or home exercise program >4 weeks

### **Ischemic limb pain:**

- Intractable pain at rest, **OR**
- Non-healing ulcers; **AND**
  - Severe peripheral artery disease, **AND**
  - Patient is not a candidate for revascularization, **OR**
  - Previous revascularization has failed

### **Pancreatic cancer:**

- Severe abdominal or back pain

### **Chronic pancreatitis:**

- Chronic abdominal or back pain, **AND**
- Continued pain after parenteral narcotics for more than 1 week

### **Morton's neuroma:**

- Pain in foot and/or toes, **AND**
- Morton's neuroma suspected by exam and history

### **Plantar fasciitis and other neuritis of the foot:**

- Pain in foot, **AND**
- Plantar fasciitis or other [neuritis](#) of the foot is suspected by exam and history, **AND**
- Continued symptoms after conservative management for 3 weeks or more, including at least **ONE** of the following:
  - Activity modification, **OR**
  - Orthotics/splints/taping, **OR**
  - Anti-inflammatory medications (e.g., NSAIDS)

### **Meralgia paresthetica:**

- Lateral femoral cutaneous nerve block for meralgia paresthetica (lateral femoral cutaneous nerve entrapment) when symptoms continue after 4 or more weeks of conservative management (e.g., non-opioid analgesics or anticonvulsants).

The following nerve blocks are considered **experimental or investigational**:

- Ganglion impar block for treatment of any condition, including chronic pelvic pain or chronic perineal pain
- Sphenopalatine nerve block for treatment of any condition, including occipital neuralgia and headache
- Genicular nerve block for treatment of chronic knee pain
- Pedicle screw block/hardware/instrumentation block
- Any nerve block for treatment of chronic pelvic pain or chronic perineal pain [including but not limited to ilioinguinal, iliohypogastric, pudendal, posterior femoral cutaneous, paracervical (uterine)]
- Nerve block of any occipital nerve or cranial nerve for treatment of occipital neuralgia or headache
- Any nerve block for treatment of diabetic neuropathy

The available scientific evidence is insufficient to permit conclusions concerning the effect of these procedures on net health outcomes.

### **Imaging guidance for nerve block injections**

Fluoroscopic or ultrasound imaging guidance performed in conjunction with nerve block injections to isolate the target anatomic site **meets the definition of medical necessity**.

**NOTE:** PT, OT or home exercise programs would be continued in addition to nerve block injections as part of a combined treatment plan. It is not expected that epidural injection, facet joint injection, or sacroiliac joint injection would be administered to the same individual on the same day.

Nerve block injections **do not meet the definition of medical necessity** when medical documentation indicates the injection procedures are not effective.

## BILLING/CODING INFORMATION:

### CPT Coding:

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 <b>(investigational)</b>
64408	Injection(s), anesthetic agent(s) and/or steroid; vagus 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 <b>(investigational if performed for treatment of chronic pelvic/perineal pain)</b>
64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve <b>(investigational if performed for treatment of chronic pelvic/perineal pain)</b>
64435	Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve <b>(investigational if performed for treatment of chronic pelvic/perineal pain)</b>
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
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed ( <b>investigational</b> )
64455	Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)
64461	Paravertebral block (PVB) (paravertebral block), thoracic single injection site (including imaging guidance, when performed)
64462	Paravertebral block (PVB) (paravertebral block), second and any additional injection site(s) (including imaging guidance, when performed) (List separately in addition to code for primary procedure)
64505	Injection, anesthetic agent; <u>sphenopalatine ganglion</u> ( <b>investigational</b> )
64510	Injection, anesthetic agent; <u>stellate ganglion</u> (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

### ICD-10 Diagnosis Codes That Support Medical Necessity:

G57.10 – G57.13	Meralgia paresthetica
G57.60 – G57.62	Lesion of plantar nerve
G89.11	Acute pain due to trauma
M25.511 – M25.519	Pain in shoulder
M25.521 – M25.529	Pain in elbow
M25.531 – M25.539	Pain in wrist
M25.541, M25.542, M25.549	Pain in joints of hand
M25.551 – M25.559	Pain in hip
M25.561 – M25.569	Pain in knee
M25.571 – M25.579	Pain in ankle
M25.751 – M25.759	Osteophyte, hip
M46.1	Sacroiliitis, not elsewhere classified
M54.10 – M54.18	Radiculopathy
M54.2	Cervicalgia
M54.50, M54.51, M54.59	Low back pain, including vertebrogenic low back pain
M54.6	Pain in thoracic spine
M70.60 – M70.62	Trochanteric bursitis, hip
M70.70 – M70.72	Other bursitis of hip
M72.2	Plantar fascial fibromatosis

M75.00 – M75.02	Adhesive capsulitis of shoulder
M76.01 – M76.32	Psoas tendinitis; Iliac crest spur; Iliotibial band syndrome
M79.2	Neuralgia and neuritis, unspecified
M79.621 – M79.622	Pain in upper arm
M79.631 – M79.632	Pain in forearm
M79.641 – M79.646	Pain in hand and fingers
M79.661 – M79.662	Pain in lower leg
M79.671, 672 – M79.674, 675	Pain in foot and toes
Q85.00 – Q85.09	Neurofibromatosis or schwannomatosis
R07.1	Chest pain on breathing
R07.81	Pleurodynia
T87.30 – T87.34	Neuroma of amputation stump

### REIMBURSEMENT INFORMATION:

**\*\*64400:** Total number of injections is limited to four (4) injections in six (6) months.

**\*\*64408-64451:** Total number of injections is limited to four (4) injections in six (6) months.

**\*\*64455:** Total number of injections is limited to three (3) injections in twelve (12) months, per neuroma.

**\*\*64461-64462:** Total number of injections is limited to four (4) injections in six (6) months.

**\*\*64510-64530:** Total number of injections is limited to three (3) injections in twelve (12) months.

**\*\*NOTE:** Services in excess of the limitations shown above are subject to medical review of documentation for determination of medical necessity. The following information may be required documentation to support medical necessity: physician history and physical, physician progress notes including documentation of conservative treatment, treatment plan, radiology study reports, and operative report.

### LOINC Codes:

Documentation Table	LOINC Codes	LOINC Time Frame Modifier Code	LOINC Time Frame Modifier Codes Narrative
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Attending physician visit note	18733-6	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Treatment plan	18776-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.

Radiology report	18726-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Surgical report	28573-4	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.

**PROGRAM EXCEPTIONS:**

**Federal Employee Program (FEP):** Follow FEP guidelines.

**State Account Organization (SAO):** Follow SAO guidelines.

**Medicare Advantage:** The following Local Coverage Determination (LCD) was reviewed on the last guideline reviewed date: Peripheral Nerve Blocks (L33933), located at cms.gov.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at [Coverage Protocol Exemption Request](#).

**DEFINITIONS:**

**Cervical plexus:** a network of nerves made up of the C1, C2, C3, and C4 spinal nerves; innervates the skin and muscles of the head, neck, and shoulders. A nerve block can be performed with a single injection at the C4 transverse process with the local anesthetic spreading to the C2 and C3 nerves.

**Genicular nerve:** a sensory nerve that surrounds the knee and provides innervation for the joint.

**Meralgia paresthetica:** compression of the lateral femoral cutaneous nerve.

**Morton’s neuroma:** a swelling of the nerve present in the space between the third and fourth toes.

**Neuritis:** Inflammation of a nerve.

**Plantar fasciitis:** inflammation of the band of tissue that connects the heel bone to the toes.

**Sphenopalatine ganglion:** located in a fossa behind the middle turbinate at the root of the nose and consists of somatosensory, sympathetic, and parasympathetic fibers.

**Stellate ganglion:** collection of sympathetic nerves in the upper neck on either side of the larynx and is the nerve center for the hand, arms, and shoulders.

**RELATED GUIDELINES:**

[Neurolysis/Ablation, 02-61000-34](#)

**OTHER:**

None applicable.

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## COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 01/22/26.

## GUIDELINE UPDATE INFORMATION:

11/15/00	Outpatient Pain Management MCG #02-61000-01 approved by MPCC.
12/15/03	Separate MCG created for Nerve Block Injections.
01/01/04	Annual HCPCS coding update.
01/01/06	Scheduled review and revision of guideline consisting of updated references.
11/15/07	Review and revision of guideline consisting of updated references and addition of diagnosis codes.
01/01/09	Annual HCPCS coding update: revised descriptor for codes 64416, 64446, 64448 and 64449.
05/15/09	Scheduled review; update description section to include medical necessity management statement, update position statement to include coverage criteria, update reimbursement statement and references.
11/15/10	Revision; added coverage criteria for peripheral nerve block injections for conditions of the foot; added CPT code 64455; added ICD-9 codes 355.5, 355.79 and 728.71; added related

	ICD-10 codes; revised reimbursement section; added coding notes; updated definitions section; updated references; reformatted guideline.
07/15/11	Revision; formatting changes.
08/15/11	Scheduled review; revised description, added coverage criteria for pre-emptive analgesia to position statement, revised ICD9 and ICD10 coding sections; added Medicare program exception; updated references; reformatted guideline.
02/15/12	Revision. Added coverage statement for CPT 64405, occipital nerve blocks (E/I). Added coverage statement for ganglion impar blocks of the sacrococcygeal joint (E/I). Added criteria for "other peripheral nerve blocks". Updated references and reformatted guideline. Deleted CPT code 64405. Deleted ICD9 codes 307.81, 564.6, 569.42 and 784.0; deleted ICD10 codes G44.00—G44.89, G44.201-G44.229, K59.4, K62.81-K62.82 and R51.
04/01/12	Revision; updated ICD10 coding with new and revised codes.
06/01/12	Revision; added CPT code 64405 back to the guideline with an investigational tag (designated as investigational on 02/15/12). Revised Position Statement verbiage regarding greater occipital nerve blocks. Revised Reimbursement Information section.
04/15/14	Revision; revised description statement and position statement (designated sphenopalantine ganglion block as E/I). Updated program exceptions section and references. Reformatted guideline.
11/15/14	Revision; added coverage statement for nerve block injections for the treatment of diabetic neuropathy (E/I). Reformatted guideline.
10/01/15	Revision; updated ICD9 and ICD10 coding sections.
11/01/15	Revision: ICD-9 Codes deleted.
01/01/16	Annual CPT/HCPCS coding update. Added codes 64461, 64462. Deleted code 64412. Revised Reimbursement Information section and Programs Exception section.
03/01/16	Revision: Update to Position Statement and ICD-10 codes.
10/01/16	ICD-10 coding update: added codes M25.541, M25.542, M25.549.
11/17/16	Revision: Update to Reimbursement Information section.
04/15/18	Scheduled review. Revised description section. Added coverage statement for imaging guidance for nerve block injections; added coverage statement for genicular nerve blocks (E/I). Revised Medicare Advantage program exception. Updated references.
01/01/20	Annual CPT/HCPCS coding update. Added 64454. Revised descriptors for codes 64400, 64405, 64408, 64415, 64416, 64417, 64418, 64420, 64421, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, 64450. Deleted 64402, 64410, 64413.
04/15/20	Scheduled review. Maintained position statement and updated references.
10/01/20	Revision. Updated peripheral nerve block injections, occipital neuralgia section.
12/15/20	Unscheduled review. Maintained position statement, revised definitions, and updated references.
01/01/21	Annual CPT/HCPCS coding update. Revised 64455.
10/01/21	Quarterly CPT/HCPCS coding update: added codes M54.50, M54.51, M54.59; deleted code M54.5.
03/15/22	Scheduled review. Added coverage statement for hardware blocks. Updated references.
09/15/22	Added codes 64451 and M46.1.
10/15/22	Revision: updated Reimbursement Information section.

01/01/23	Annual CPT/HCPCS coding update. Revised 64415, 64416, 64417, 64445, 64446, 64447, 64448.
08/21/23	Update to Program Exceptions section.
02/15/24	Scheduled review. Revised description, maintained position statement and updated references.
03/15/25	Scheduled review. Revised description and ICD10 coding table. Revised position statement to include coverage statement for nerve blocks performed for treatment of chronic pelvic/perineal pain. Updated references.
10/15/25	Revision. Revise criteria for pancreatic cancer; delete criteria subsection titled "all other nerve blocks"; delete (non)coverage statement for imaging performed with nerve blocks for the foot. Revise ICD10 coding and reimbursement information. Update references.
02/15/26	Scheduled review. Position statements, coding, and references updated.