02-61000-29

Original Effective Date: 11/15/00

Reviewed: 01/23/25

Revised: 03/15/25

Subject: Nerve Block Injections

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

Position Statement	Billing/Coding	Reimbursement	Program Exceptions	Definitions	Related Guidelines
Other	References	Updates			

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 vulvodynia." 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 ± 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 ± 2.11 (CI 6.92-7.98) and 14.35 ± 6.62 (CI 12.68 -16.02), respectively. At 3-month follow ups, average VAS and FPPS decreased to 4.12 ± 2.44 (CI 3.50-4.73; $p < 0.001$) and 10.3 ± 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. Thirteern 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, **AND**
- Previous treatment attempted or not indicated

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)

All other nerve blocks:

- Pain in affected area; **AND**
- Failure to respond to conservative management [e.g., physical therapy, NSAIDS (unless contraindicated), activity modification], **AND**
- Repeat blocks will be considered medically necessary when there is at least 50% pain relief for 6-8 weeks

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, 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.**

Imaging (fluoroscopic or ultrasound) for nerve block injections to the foot does not meet 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 blocks, multiple facet joint injections, sacroiliac joint injections, and sympathetic nerve blocks in any and all combinations would be administered to the same individual on the same day. If the first procedure used to treat the presumptive diagnosis fails to produce improvement and rules out that possibility, then it may be appropriate to proceed to the next logical treatment.

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 (**investigational**)
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 **(investigational if performed for treatment of chronic pelvic/perineal pain)**
64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve **(investigational if performed for treatment of chronic pelvic/perineal pain)**
64435	Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve **(investigational if performed for treatment of chronic pelvic/perineal pain)**
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 (**investigational**)
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; sphenopalatine ganglion **(investigational)**
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

ICD-10 Diagnosis Codes That Support Medical Necessity:

G57.60 – G57.62	Lesion of plantar nerve
G89.11	Acute pain due to trauma
G89.12	Acute post-thoracotomy pain
G89.18	Other acute postprocedural pain
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.

Coding notes:

Per CPT guidelines:

- CPT code 64455 is the appropriate code for reporting nerve block injections for Morton's neuroma.
- **Only one unit** of code **64455** should be reported per DOS, per neuroma, regardless of number of sites injected.

  Code **64455** is a unilateral procedure. For bilateral procedures, modifier 50 should be used.

**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.

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.

REFERENCES:

1. AHRQ National Guideline Clearinghouse. Lower extremity injury medical treatment guidelines. NGC:011050. Colorado Division of Workers' Compensation. Denver (CO): Colorado Division of Workers' Compensation; 2016 Mar 16.
2. Akesen S, Akesen B, et al. Comparison of efficacy between the genicular nerve block and the popliteal artery and the capsule of the posterior knee (IPACK) block for total knee replacement surgery: A prospective randomized controlled study. Acta Orthop Traumatol Turc. 2021 Mar;55(2):134-140. doi: 10.5152/j.aott.2021.20187.
3. American Cancer Society Treatment & Topics Resources. Pain Control: A Guide for People with Cancer and Their Families. Updated 11/04/08.
4. American Chronic Pain Association. ACPA Consumer Guide to Pain Medication & Treatment 2009. Epidurals, Nerve & Facet Blocks & Radiofrequency Ablation (Rhizotomy).
5. American Podiatric Medical Association. Treatment by Your Podiatric Physician: Neuromas. ©2010 American Podiatric Medical Association, Inc.
6. American Podiatric Medical Association. Treatment by Your Podiatric Physician: Heel Pain. ©2010 American Podiatric Medical Association, Inc.
7. Ashkenazi A, Blumenfeld A et al. Peripheral Nerve Blocks and Trigger Point Injections in Headache Management – A Systematic Review and Suggestions for Future Research. Headache 2010; 50:943-952.
8. Barad M, Ailani J, Hakim SM, Kissoon NR, Schuster NM. Percutaneous Interventional Strategies for Migraine Prevention: A Systematic Review and Practice Guideline. Pain Med. 2022 Jan 3;23(1):164-188. doi: 10.1093/pm/pnab236.
9. Baron R, Binder A, Wasner G. (2010). Neuropathic pain: diagnosis, pathophysiological mechanisms, and treatment. The Lancet Neurology, 9(8), 807-819.
10. Blue Cross Blue Shield Association Evidence Positioning System®. 2.01.85 – Neural Therapy, 12/24.

11. Blue Cross Blue Shield Association Evidence Positioning System®. 7.01.159 -- Sphenopalatine Ganglion Block for Headache, 12/24.
12. Boswell MV, Shah RV, Everett CR, Sehgal N, Mckenzie-Brown AM, Abdi S, Bowman RC, Deer TR, Datta S, Colson JD, Spillane WF, Smith HS, Lucas LF, Burton AW, Chopra P, Staats PS, Wasserman RA, Manchikanti L. Interventional techniques in the management of chronic spinal pain: evidence-based practice guidelines. Pain Phys 2005;8(1): 1-47.
13. Callaghan BC, Cheng HT, Stables CL, Smith AL, Feldman EL. (2012). Diabetic neuropathy: clinical manifestations and current treatments. The Lancet Neurology, 11(6), 521-534.
14. Cardaillac C, Ploteau S, Labat JJ, Levesque A, Riant T. Intérêt de l'infiltration du ganglion Impar dans les vulvodynies rebelles : à propos d'une série de 8 cas [Interest of infiltration of Impar node in rebel vulvodynia: About a series of 8 cases]. Prog Urol. 2016 Dec;26(17):1213-1221. French. doi: 10.1016/j.purol.2016.08.004. Epub 2016 Sep 7. PMID: 27614384.
15. Castillo-Álvarez F, Hernando de la Bárcena I, Marzo-Sola ME. Greater occipital nerve block in the treatment of headaches. Review of evidence. Med Clin (Barc). 2023 Aug 11;161(3):113-118. English, Spanish. doi: 10.1016/j.medcli.2023.04.001. Epub 2023 Apr 24. PMID: 37100680.
16. Centers for Medicare and Medicaid (CMS). Local Coverage Determination (LCD): PERIPHERAL NERVE BLOCKs (L33933) (10/01/15) (revised 01/08/19).
17. Cepeda MS, Carr DB, Lau J. Local anesthetic sympathetic blockade for complex regional pain syndrome. Cochrane Database of Systematic Reviews 2005, Issue 4. Art. No.: CD004598. DOI: 10.1002/14651858. CD004598.pub2.
18. Chen J-L, et al. Can the addition of ultrasound-guided genicular nerve block using 5% dextrose water augment the effect of autologous platelet rich plasma in treating elderly patients with knee osteoarthritis? Biomedical Journal, https://doi.org/10.1016/j.bj.2020.08.011.
19. Cho DY, Drover DR, Nekhendzy V, Butwick AJ, Collins J, Hwang PH. The effectiveness of preemptive sphenopalatine ganglion block on postoperative pain and functional outcomes after functional endoscopic sinus surgery. Int Forum Allergy Rhinol. 2011 May-Jun;1(3):212-8.
20. Chou R, Qaseem A, Snow V, Casey D, Cross JT Jr, Shekelle P, Owens DK; Clinical Efficacy Assessment Subcommittee of the American College of Physicians; American College of Physicians; American Pain Society Low Back Pain Guidelines Panel. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. Ann Intern Med. 2007 Oct 2; 147(7): 478-91.
21. Chowdhury D, Mundra A, Datta D, Duggal A, Krishnan A, Koul A. Efficacy and tolerability of combination treatment of topiramate and greater occipital nerve block versus topiramate monotherapy for the preventive treatment of chronic migraine: A randomized controlled trial. Cephalalgia. 2022 Aug;42(9):859-871. doi: 10.1177/03331024221082077. Epub 2022 Mar 8.
22. ClinicalTrials.gov. Botox Injection in Treatment of Cluster Headache, NCT02019017. Last updated January 3, 2014.
23. ClinicalTrials.gov. Sphenopalatine Nerve Block for Headache TX 360, NCT01939314. Last updated September 5, 2013.
24. Cuvillon P, Reubrecht V, Zoric L, Lemoine L, Belin M, Ducombs O, Birenbaum A, Riou B, Langeron O. Comparison of subgluteal sciatic nerve block duration in type 2 diabetic and non-diabetic patients. Br J Anaesth. 2013 May;110(5):823-30.
25. DeMaria S Jr, Govindaraj S, Chinosorvatana N, Kang S, Levine A. Bilateral sphenopalatine ganglion blockade improves postoperative analgesia after endoscopic sinus surgery. Am J Rhinol Allergy. 2012 Jan-Feb;26(1): e23-7.
26. Demlr Y, et al. A Different Approach to the Management of Osteoarthritis in the Knee: Ultrasound Guided Genicular Nerve Block. Pain Medicine, Volume 18, Issue 1, January 2017, Pages 181–183, https://doi.org/10.1093/pm/pnw177.

27. Dworkin RH, et al. (2013). Interventional management of neuropathic pain: NeuPSIG recommendations. PAIN®, 154(11), 2249-2261.

28. Everett C R, Shah R V, Sehgal N, McKenzie-Brown A M. A systematic review of diagnostic utility of selective nerve root blocks. Pain Physician. 2005;8(2): 225-233.

29. Ghai A, Jangra P, Wadhera S, et al. A prospective study to evaluate the efficacy of ultrasound-guided ganglion impar block in patients with chronic perineal pain. Saudi J Anaesth. 2019;13(2):126–130. doi: 10.4103/sja.SJA_667_18.Hashimoto A, Ito H, Sato Y, Fujiwara Y. (2013). The Efficacy and Safety of Continuous Popliteal Sciatic Nerve Block for the Relief of Pain Associated with Critical Limb Ischemia: A Retrospective Study. Open Journal of Anesthesiology, 3, 433.

30. Gharaei H, Gholampoor N. The Role of Interventional Pain Management Strategies for Neuropathic Pelvic Pain in Endometriosis. Pain Physician. 2023 Sep;26(5):E487-E495.

31. González Sotelo V, Maculé F, Minguell J, Bergé R, Franco C, Sala-Blanch X. Ultrasound-guided genicular nerve block for pain control after total knee replacement: Preliminary case series and technical note. Rev Esp Anestesiol Reanim. 2017 Dec;64(10):568-576. English, Spanish. doi: 10.1016/j.redar.2017.04.001. Epub 2017 May 26. PMID: 28554709.

32. Hasırcı Bayır BR, Gürsoy G, Sayman C, Yüksel GA, Çetinkaya Y. Greater occipital nerve block is an effective treatment method for primary headaches? Agri. 2022 Jan;34(1):47-53. English. doi: 10.14744/agri.2021.32848. PMID: 34988960.

33. Hayes Inc. Hayes Medical Technology Directory. Nerve Blocks for the Treatment of Chronic Nonmalignant Pain. Lansdale, PA: Hayes, Inc.; December 2005. Update performed 12/15/06.

34. Health Care Guideline: Assessment and Management of Chronic Pain. INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT. 2009.

35. Hutton D, Mustafa A, Patil S, Rathod S, Shrikhande G, Advincula A, Drummond J, Gregersen P, Hall J, Metz C, Milspaw A, Orbuch IK, Stahl P, Stein A, Shrikhande A. The burden of Chronic Pelvic Pain (CPP): Costs and quality of life of women and men with CPP treated in outpatient referral centers. PLoS One. 2023 Feb 9;18(2):e0269828. doi: 10.1371/journal.pone.0269828.

36. Institute for Clinical Systems Improvement (ICSI). Assessment and management of acute pain. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2006 Mar. 68 p.

37. Ishiyama T, et al. Ultrasound-guided out-of-plane obturator nerve block. Anaesthesia. 2013 Oct;68(10):1074-5.

38. Kakazu C, et al. In the new era of ultrasound guidance is pneumothorax from supraclavicular block a rare complication of the past. Br J Anaesth. 2014 Jul;113(1):190-1.

39. Kim DH, et al. Ultrasound-Guided Genicular Nerve Block for Knee Osteoarthritis: A Double-Blind, Randomized Controlled Trial of Local Anesthetic Alone or in Combination with Corticosteroid. Pain Physician. 2018 Jan;21(1):41-52.

40. Lee JE, Kwak KH, Hong SW, Jung H, Chung SY, Park JM. Treatment of radiation-induced cystitis and vulvodynia via a ganglion impar block using a lateral approach under computed tomography guidance: a case report. Korean J Anesthesiol. 2017 Feb;70(1):81-85. doi: 10.4097/kjae.2017.70.1.81. Epub 2017 Jan 26.

41. Lee SH, Kim Y, Lim TY. Efficacy of sphenopalatine ganglion block in nasal mucosal headache presenting as facial pain. Cranio. 2020;38(2):128–130. doi:10.1080/08869634.2018.14758. PMID: 29882504.

42. Lin CS, MD, Cheng JK et al. Ultrasound-Guided Ganglion Impar Block: A Technical Report. Pain Medicine 2010; 11: 390–394.

43. Machado FC, Carone Neto G, Carone RSD. Sphenopalatine ganglion block for refractory COVID-19 headache: a descriptive case series. Braz J Anesthesiol. 2021 Nov-Dec;71(6):667-669. doi: 10.1016/j.bjane.2021.04.024. Epub 2021 Apr 28.

44. Mailis A, Taenzer P. (2012). Evidence-based guideline for neuropathic pain interventional treatments: Spinal cord stimulation, intravenous infusions, epidural injections and nerve blocks. Pain Research & Management: The Journal of the Canadian Pain Society, 17(3), 150.

45. Manchikanti L, Staats PS, Singh V, Schultz DM, Vilims BD, Jasper JF, Kloth DS, Trescot AM, Hansen HC, Falasca TD, Racz GB, Deer TR, Burton AW, Helm S, Lou L, Bakhit CE, Dunbar EE, Atluri SL, Calodney AK, et al. Evidence-based practice guidelines for interventional techniques in the management of chronic spinal pain. Pain Phys 2003; 6: 3-81.

46. Manchikanti, L., Singh, V., Kloth, D. Interventional Pain Management Practice Policies; Sympathetic Blocks. American Society of Interventional Pain Physicians.

47. McCormick ZL, Reddy R, et al. A Prospective Randomized Trial of Prognostic Genicular Nerve Blocks to Determine the Predictive Value for the Outcome of Cooled Radiofrequency Ablation for Chronic Knee Pain Due to Osteoarthritis. Pain Med. 2018 Aug 1;19(8):1628-1638. doi: 10.1093/pm/pnx286. PMID: 29300971.

48. Morgan A, Romanello G. Use of the Sphenopalatine Ganglion Block to Treat Migraine Headaches in the Emergency Department. Cureus. 2022 Jan 19;14(1): e21428. doi: 10.7759/cureus.21428.

49. Morse J, et al. Comparison of success rates, learning curves, and inter-subject performance variability of robot-assisted and manual ultrasound-guided nerve block needle guidance in simulation. Br J Anaesth. 2014 Jun;112(6):1092-7.

50. Mustafa A, Brooks B, Leishear K, Aronson R, Shrikhande A. A novel treatment approach for women with chronic pelvic pain syndrome leading to increased pelvic functionality. J Womens Health Gyn. 2020;7:1-0.

51. National Institute for Health and Clinical Excellence (NICE). Clinical Guideline 150: Headaches: Diagnosis and management of headaches in young people and adults. September 2012.

52. National Institute of Neurological Disorders and Stroke. Complex Regional Pain Syndrome Fact Sheet; last updated 02/03/09.

53. National Podiatric Medical Association. Foot Health Topics. Neuromas. ©2008 National Podiatric Medical Association.

54. Nowakowski P, Bierylo A. Ultrasound guided axillary brachial plexus block. Part 2 - technical issues. Anaesthesiol Intensive Ther. 2015;47(4):417-24.

55. Natarajan J, Ahmed T, Patil S, Mamsaang M, Kapadia R, Tailor Y, Shrikhande A. Pain and functionality improved when underlying neuromuscular dysfunction addressed in chronic pelvic pain patients. Neurourol Urodyn. 2021 Aug;40(6):1609-1615. doi: 10.1002/nau.24726. Epub 2021 Jun 3.

56. Parker MJ, Griffiths R, Appadu BN. Nerve blocks (subcostal, lateral cutaneous, femoral, triple, psoas) for hip fractures. Cochrane Database of Systematic Reviews 2002, Issue 1. Art. No.: CD001159. DOI: 10.1002/14651858. CD001159.

57. Patijn J, Janssen M. et al. Coccygodynia. Pain Practice, Volume 10, Issue 6, 2010 554–559.

58. Patil S, Daniel G, Vyas R, Tailor Y, Howell M, Ahmed T, Reutter C, Shrikhande A. Neuromuscular treatment approach for women with chronic pelvic pain syndrome improving pelvic pain and functionality. Neurourol Urodyn. 2022 Jan;41(1):220-228. doi: 10.1002/nau.24799. Epub 2021 Sep 16.

59. Perez RS, Zollinger PE, Dijkstra PU, Thomassen-Hilgersom IL, Zuurmond WW, Rosenbrand KCJ, Geertzen JH. Evidence based guidelines for complex regional pain syndrome type 1. BMC Neurology 2010, 10:20.

60. 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.

61. Qudsi-Sinclair S, Borrás-Rubio E, Abellan-Guillén JF, Padilla Del Rey ML, Ruiz-Merino G. A Comparison of Genicular Nerve Treatment Using Either Radiofrequency or Analgesic Block with Corticosteroid for Pain after a Total Knee Arthroplasty: A Double-Blind, Randomized Clinical Study. Pain Pract. 2017 Jun;17(5):578-588. doi: 10.1111/papr.12481. Epub 2016 Sep 19. PMID: 27641918.

62. Rodman R, Dutton J. Endoscopic neural blockade for rhinogenic headache and facial pain: 2011 update. Int Forum Allergy Rhinol. 2012 Jul-Aug;2(4):325-30.

63. Rogério LSR, Chung MK, Butrick CW, Antolak SJ Jr, Bevilaqua DR, Kureishy S, Conforto MEC. A Pain Desensitization Algorithm for Phenotyping and Treating Chronic Pelvic Pain. JSLS. 2024 Apr-Jun;28(2):e2024.00009. doi: 10.4293/JSLS.2024.00009.

64. Sahai-Srivastava S, Subhani D. Adverse effect profile of Lidocaine injections for occipital nerve block in occipital neuralgia. J Headache Pain (2010) 11:519–523.

65. Sahin L, et al. Ultrasound-guided single-injection femoral nerve block provides effective analgesia after total knee arthroplasty up to 48 hours. Agri. 2014;26(3):113-8. doi: 10.5505/agri.2014.83788.

66. Schytz HW, Barløse M, Guo S, Selb J, Caparso A, Jensen R, Ashina M. Experimental activation of the sphenopalatine ganglion provokes cluster-like attacks in humans. Cephalalgia 0(0) 1–11. ©International Headache Society 2013.

67. Shanahan EM, Robinson L, Lyne S, Woodman R, Cai F, Dissanayake K, Paddick K, Cheung G, Voyvodic F. Genicular Nerve Block for Pain Management in Patients with Knee Osteoarthritis: A Randomized Placebo-Controlled Trial. Arthritis Rheumatol. 2023 Feb;75(2):201-209. doi: 10.1002/art.42384. Epub 2022 Nov 11.

68. Shrikhande A, Patil S, Subhan M, Moody E, Natarajan J, Tailor Y, Mamsaang M, James N, Leishear K, Vyas R, Sandhu S, Ahmed T, Filart R, Daniel G, Kerin Orbuch I, Larish Y, Liu L. A Comprehensive Treatment Protocol for Endometriosis Patients Decreases Pain and Improves Function. Int J Womens Health. 2023 Jan 23;15:91-101. doi: 10.2147/IJWH.S365637.

69. Shrikhande A, Ullger C, Seko K, Patil S, Natarajan J, Tailor Y, Thompson-Chudy C. A physiatrist's understanding and application of the current literature on chronic pelvic pain: a narrative review. Pain Rep. 2021 Aug 30;6(3):e949. doi: 10.1097/PR9.0000000000000949.

70. Sutaria RG, et al. Localization of the Lateral Retinacular Nerve for Diagnostic and Therapeutic Nerve Block for Lateral Knee Pain: A Cadaveric Study. PM R. 2017 Feb;9(2):149-153.

71. Szucs S, et al. A comparison of three techniques (local anesthetic deposited circumferential to vs. above vs. below the nerve) for ultrasound guided femoral nerve block. BMC Anesthesiol. 2014 Jan 25; 14:6.

72. Tepper SJ, Stillman MJ (2013). Cluster Headache: Potential Options for Medically Refractory Patients (When All Else Fails). Headache Currents, © 2013 American Headache Society.

73. Thavaneswaran P. Paravertebral blocks for anaesthesia and analgesia: a systematic review. Stepney, SA: Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S). 2006:268. Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S).

74. Tobin J, Flitman S. Treatment of Migraine with Occipital Nerve Blocks Using Only Corticosteroids. Headache 2011; 51:1 55-162.

75. Toshniwal GR, Dureja GP, Prashanth SM. Transsacrococcygeal Approach to Ganglion Impar Block for Management of Chronic Perineal Pain: A Prospective Observational Study. Pain Physician 2007; 10:661-666.

76. Tran J, Giron Arango L, Peng P, Sinha SK, Agur A, Chan V. Evaluation of the iPACK block injectate spread: a cadaveric study [published online ahead of print, 2019 May 6]. Reg Anesth Pain Med. 2019; rapm-2018-100355. doi:10.1136/rapm-2018-100355.

77. UpToDate. Abdominal nerve block techniques. 2024. Accessed at uptodate.com.

78. UpToDate. Acute treatment of migraine in adults. 2024. Accessed at uptodate.com.
79. UpToDate. Cancer pain management: Interventional therapies. 2023. Accessed at uptodate.com.
80. UpToDate. Cervicogenic headache. 2024. Accessed at uptodate.com.
81. UpToDate. Chronic pelvic pain in adult females: Treatment. 2024. Accessed at uptodate.com.
82. UpToDate. Complex regional pain syndrome in adults: Treatment, prognosis, and prevention. 2024. Accessed at uptodate.com.
83. UpToDate. Lower extremity nerve blocks: Techniques. 2024. Accessed at uptodate.com.
84. UpToDate. Management of knee osteoarthritis. 2024. Accessed at uptodate.com.
85. UpToDate. Management of moderate to severe knee osteoarthritis. 2024. Accessed at uptodate.com.
86. UpToDate. Myofascial pelvic pain syndrome in females: Treatment. 2024. Accessed at uptodate.com.
87. UpToDate. Occipital neuralgia. 2024. Accessed at uptodate.com.
88. UpToDate. Overview of peripheral nerve blocks. 2024. Accessed at uptodate.com.
89. UpToDate. Pudendal and paracervical block. 2024. Accessed at uptodate.com.
90. UpToDate. Ultrasound for peripheral nerve blocks. 2024. Accessed at uptodate.com.
91. Weiner, R. (2002). Pain Management A Practical Guide for Clinicians (6th ed). Boca Raton. CRC Press.
92. Yang IY, Oraee S. A Novel Approach to Transnasal Sphenopalatine Ganglion Injection. Pain Physician 2006;9: 131-134, ISSN 1533-3159.
93. Yasar E, et al. Accuracy of Ultrasound-Guided Genicular Nerve Block: A Cadaveric Study. Pain Physician. 2015 Sep-Oct;18(5): E899-904.
94. Yilmaz V, Umay E, Gundogdu I, Aras B. The comparison of efficacy of single intraarticular steroid injection versus the combination of genicular nerve block and intraarticular steroid injection in patients with knee osteoarthritis: a randomised study [published online ahead of print, 2019 Dec 11]. PMID: 31828590.
95. Zarembinski C, Graff-Radford S. An Unusual Challenge in Performing Sphenopalatine Ganglion Block with Enlarged Coronoid Process: Jacob's Disease. Pain Med. 2014 Feb;15(2):329-32.

COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 01/23/25.

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.