Clinical Practice Guideline: **Nerve Block and Neurolytic Procedures for Foot Pain Excluding Morton's Neuroma**

Date of Implementation: **May 21, 2015**

Product: **Specialty**

GUIDELINES

American Specialty Health – Specialty (ASH) considers services consisting of CPT Code 64450 to be medically necessary for the following indications:

1. Up to 2 injections for the following diagnoses:

ICD-10 Codes and Descriptions That Support Medical Necessity

Code	Description
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy
G57.50 - G57.53	Tarsal tunnel syndrome
G57.90 - G57.93	Unspecified mononeuropathy of lower limb
G58.8 - G58.9	Other specified and unspecified mononeuropathies
G59	Mononeuropathy in diseases classified elsewhere
M79.2	Neuralgia and neuritis, unspecified

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Nerve Block and Neurolytic Procedures for Foot Pain Excluding Morton's Neuroma
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2. After 2 injections, must meet the following criteria:
   Failure of non-operative care to include at least 2 of the following:
   - Activity modification
   - Orthotics/splints/taping
   - Padding
   - Shoe modification, if appropriate based on diagnosis
   - Anti-inflammatory medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDS])

It is expected that adequate diagnostics have occurred to rule out other diagnoses. CPT code 64450 can NOT be used for a diagnosis of Morton's neuroma (lesion of plantar nerve, lower limb, ICD-10 codes G57.60 - G57.63).

Destruction by neurolytic agent; other peripheral nerve or branch as described by CPT code 64640 should not be used for treatment of the above diagnoses, Morton's neuroma, or chronic heel pain (i.e., plantar fascial fibromatosis and fibroplastic disorder, unspecified ICD-10 codes M72.2 and M72.9). Use of cryoablation (for example, cryosurgery, neuroablation) for the treatment of either plantar fasciitis or plantar fibroma is considered investigational and not medically necessary. Additionally, this code is not a viable treatment option for the diagnoses covered within the scope of this clinical practice guideline. Refer to the *Injection Treatments for Morton's Neuroma (CPG 213 – S)* clinical practice guideline for the treatment of Morton's neuroma.

CPT CODES AND DESCRIPTIONS

CPT Code	Description
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch
64640	Destruction by neurolytic agent; other peripheral nerve or branch

BACKGROUND

Neuropathic pain generally develops as a result of lesions or disease affecting the somatosensory nervous system either in the periphery or centrally. Examples of neuropathic pain include painful polyneuropathy, neuralgia, and radiculitis. Clinically, neuropathic pain is characterized by spontaneous ongoing or shooting pain and evoked amplified pain responses after noxious or non-noxious stimuli.

Tarsal Tunnel Syndrome

Tarsal tunnel syndrome (TTS) is an entrapment neuropathy of the posterior tibial nerve or its branches within its fibro-osseous tunnel beneath the flexor retinaculum on the medial

side of the ankle. It is a rare but important condition causing a range of symptoms affecting the plantar aspect of the foot. Clinical diagnosis can be obtained from a detailed history and physical examination such as compressive test at the tarsal tunnel area. Nerve conduction studies can be used to determine compression at the tarsal tunnel site and provide an efficient and rapid method of quantifying nerve conduction velocity and the amplitude of both sensory nerve action potentials (SNAPs) and compound motor action potentials (cMAPs) (Kane et al., 2012). The initial treatments of TTS are conservative management, such as physical therapy, night splint, and steroid injection.

Chronic Heel Pain

Radiofrequency ablation of the plantar fascia as well as radiofrequency nerve ablation and cryoprobe have been advocated more recently as an alternative surgical approach to chronic heel pain. According to the American College of Foot and Ankle Society (ACFAS) consensus statement for adult acquired infracalcaneal heel pain (Schneider et al., 2018), these procedures have very little long-term data or peer-reviewed studies. Further research is needed to determine their effectiveness. The panel reached consensus that the statement "*Other surgical techniques (e.g., ultrasonic debridement with a microtip device, cryosurgery, and bipolar radiofrequency ablation) are safe and effective options for chronic, refractory plantar fasciitis*" was uncertain—neither appropriate nor inappropriate. Thus, radiofrequency therapy for plantar fasciitis and other causes of chronic heel pain is considered investigational.

Use of cryoablation (for example, cryosurgery, neuroablation) for the treatment of either plantar fasciitis or plantar fibroma is also considered investigational and not medically necessary. Cryoablation has also been proposed as an alternative treatment for individuals who have failed previous conservative therapies for plantar fasciitis and plantar fibroma. It is a minimally invasive outpatient procedure typically performed on the proximal plantar area of the foot. After administration of a local anesthetic, a small incision is made adjacent to the area of primary discomfort. A specialized probe is inserted into the area of pain and is then treated with a series of cooling then thawing cold applications. This process will destroy nerve tissue by causing extensive vascular damage to the endoneural capillaries or blood vessels supplying the nerves. The hypothesis is that freezing the specific areas of pain caused by plantar fasciitis creates a block that stops the conduction of pain. No sutures are necessary, and a small dressing is applied to the surgical area. There is minimal need for post-operative pain medication and most individuals promptly resume normal activities. Well-designed published literature to support this intervention is lacking.

Allen et al. (2007) completed a prospective study testing the efficacy of cryosurgery on painful plantar fasciitis of the heel on 59 patients who had failed previous conservative care (61 total heels). Authors reported that pain decreased significantly in patients up to 365 days post-surgically and suggest that these results demonstrate that cryosurgery

offers a highly effective treatment modality after failed conservative treatment without resorting to open invasive outpatient surgery. Stuber and Kristmanson (2006) performed a narrative literature review of randomized controlled trials to ascertain which conservative treatments provide the best results for plantar fasciitis. There were no studies evaluating the use of cryosurgery for plantar fasciitis evaluated within this review.

Cavazos et al. (2009) investigated the short- and long-term efficacy of cryosurgery in a retrospective case series of individuals with recalcitrant heel pain. Subjects were individuals who had failed 6 months of conservative care prior to cryosurgery. Mean pain decreased from 7.6 to 1.6 ($p<0.0005$) at 3 weeks and 1.1 ($p<0.0005$) at 24 weeks post intervention. The authors suggested that cryosurgery was successful in resolving both short- and long-term heel pain; however, many limitations existed which limits interpretation of results. Further investigation is needed to allow for adequate evaluation of its use as an intervention for chronic heel pain that are not published by manufacturers of the instrument used. Without strong peer-reviewed published data, cryoablation cannot be recommended as an intervention for plantar fasciitis or fibroma.

PRACTITIONER SCOPE AND TRAINING

Practitioners should practice only in the areas in which they are competent based on their education, training and experience. Levels of education, experience, and proficiency may vary among individual practitioners. It is ethically and legally incumbent on a practitioner to determine where they have the knowledge and skills necessary to perform such services and whether the services are within their scope of practice.

It is best practice for the practitioner to appropriately render services to a member only if they are trained, equally skilled, and adequately competent to deliver a service compared to others trained to perform the same procedure. If the service would be most competently delivered by another health care practitioner who has more skill and training, it would be best practice to refer the member to the more expert practitioner. Best practice can be defined as a clinical, scientific, or professional technique, method, or process that is typically evidence-based and consensus driven and is recognized by a majority of professionals in a particular field as more effective at delivering a particular outcome than any other practice (Joint Commission International Accreditation Standards for Hospitals, 2020).

Depending on the practitioner's scope of practice, training, and experience, a member's condition and/or symptoms during examination or the course of treatment may indicate the need for referral to another practitioner or even emergency care. In such cases it is prudent for the practitioner to refer the member for appropriate co-management (e.g., to their primary care physician) or if immediate emergency care is warranted, to contact 911 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice guideline for information.

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