

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

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

6 **Product:** **Specialty**

9 **GUIDELINES**

10 American Specialty Health – Specialty (ASH) considers services consisting of CPT® Code
 11 64450 to be medically necessary for the following indications:

- 13 1. Up to 2 injections for the following diagnoses:

15 **ICD-10 Codes and Descriptions That Support Medical Necessity**

ICD-10 Code	ICD-10 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

16

- 1 2. After 2 injections, must meet the following criteria:
 2 Failure of non-operative care to include at least 2 of the following:
 3 ○ Activity modification
 4 ○ Orthotics/splints/taping
 5 ○ Padding
 6 ○ Shoe modification, if appropriate based on diagnosis
 7 ○ Anti-inflammatory medications (e.g., non-steroidal anti-inflammatory drugs
 8 [NSAIDS])
 9

10 It is expected that adequate diagnostics have occurred to rule out other diagnoses. CPT
 11 code 64450 can NOT be used for a diagnosis of Morton’s neuroma (lesion of plantar nerve,
 12 lower limb, ICD-10 codes G57.60 - G57.63).
 13

14 Destruction by neurolytic agent; other peripheral nerve or branch as described by CPT®
 15 code 64640 should not be used for treatment of the above diagnoses, Morton’s neuroma,
 16 or chronic heel pain (i.e., plantar fascial fibromatosis and fibroplastic disorder, unspecified
 17 ICD-10 codes M72.2 and M72.9). Use of cryoablation (i.e., cryosurgery, neuroablation)
 18 for the treatment of either plantar fasciitis or plantar fibroma is considered investigational
 19 and not medically necessary. Additionally, this code is not a viable treatment option for the
 20 diagnoses covered within the scope of this clinical practice guideline. Refer to the *Injection*
 21 *Treatments for Morton’s Neuroma (CPG 213 – S)* clinical practice guideline for the
 22 treatment of Morton’s neuroma.
 23

24 **CPT® Codes and Descriptions**

CPT® Code	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

25
 26 **BACKGROUND**
 27 Neuropathic pain generally develops as a result of lesions or disease affecting the
 28 somatosensory nervous system either in the periphery or centrally. Examples of
 29 neuropathic pain include painful polyneuropathy, neuralgia, and radiculitis. Clinically,
 30 neuropathic pain is characterized by spontaneous ongoing or shooting pain and evoked
 31 amplified pain responses after noxious or non-noxious stimuli.
 32

33 **Tarsal Tunnel Syndrome**

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

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

9 **Chronic Heel Pain**

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

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

38 Allen et al. (2007) completed a prospective study testing the efficacy of cryosurgery on
 39 painful plantar fasciitis of the heel on 59 patients who had failed previous conservative care
 40 (61 total heels). Authors reported that pain decreased significantly in patients up to 365
 41 days post-surgically and suggest that these results demonstrate that cryosurgery offers a
 42 highly effective treatment modality after failed conservative treatment without resorting to

1 open invasive outpatient surgery. Stuber and Kristmanson (2006) performed a narrative
2 literature review of randomized controlled trials to ascertain which conservative treatments
3 provide the best results for plantar fasciitis. There were no studies evaluating the use of
4 cryosurgery for plantar fasciitis evaluated within this review.
5

6 Cavazos et al. (2009) investigated the short- and long-term efficacy of cryosurgery in a
7 retrospective case series of individuals with recalcitrant heel pain. Subjects were
8 individuals who had failed 6 months of conservative care prior to cryosurgery. Mean pain
9 decreased from 7.6 to 1.6 ($p < 0.0005$) at 3 weeks and 1.1 ($p < 0.0005$) at 24 weeks post
10 intervention. The authors suggested that cryosurgery was successful in resolving both
11 short- and long-term heel pain; however, many limitations existed which limits
12 interpretation of results. Further investigation is needed to allow for adequate evaluation
13 of its use as an intervention for chronic heel pain that are not published by manufacturers
14 of the instrument used. Without strong peer-reviewed published data, cryoablation cannot
15 be recommended as an intervention for plantar fasciitis or fibroma. Catal, Bilge and Ragip
16 (2020) conducted a prospective randomized study comparing two different surgical
17 techniques used in plantar fasciitis surgery. Forty-eight patients diagnosed as having
18 plantar fasciitis and treated for at least 6 months with no response to conservative
19 modalities were randomly assigned to receive endoscopic plantar fascia release (EPFR) or
20 cryosurgery (CS). Patients were evaluated using the American Orthopaedic Foot and Ankle
21 Society Ankle-Hindfoot Scale (AOFAS-AHS) as a primary outcome measurement at
22 baseline and 3 weeks and 3, 6, and 12 months after surgery. At the final follow-up visit,
23 the Roles-Maudsley score was used to determine patient satisfaction. Although both groups
24 showed significant improvement at the final evaluation, the patients in the EPFR group had
25 significantly better AOFAS-AHS scores at 3 months. The success rate (Roles-Maudsley
26 scores of excellent and good) in the EPFR group at 12 months was 87% and in the CS
27 group was 65%. Both EPFR and CS were associated with statistically significant
28 improvements at 1-year follow-up. At 3-month follow-up, EPFR was associated with better
29 results and a higher patient satisfaction rate compared with CS.

30 31 **PRACTITIONER SCOPE AND TRAINING**

32 Practitioners should practice only in the areas in which they are competent based on their
33 education, training, and experience. Levels of education, experience, and proficiency may
34 vary among individual practitioners. It is ethically and legally incumbent on a practitioner
35 to determine where they have the knowledge and skills necessary to perform such services
36 and whether the services are within their scope of practice.
37

38 It is best practice for the practitioner to appropriately render services to a member only if
39 they are trained, equally skilled, and adequately competent to deliver a service compared
40 to others trained to perform the same procedure. If the service would be most competently
41 delivered by another health care practitioner who has more skill and training, it would be

1 best practice to refer the member to the more expert practitioner. Best practice can be
 2 defined as a clinical, scientific, or professional technique, method, or process that is
 3 typically evidence-based and consensus driven and is recognized by a majority of
 4 professionals in a particular field as more effective at delivering a particular outcome than
 5 any other practice (Joint Commission International Accreditation Standards for Hospitals,
 6 2020).

7
 8 Depending on the practitioner’s scope of practice, training, and experience, a member’s
 9 condition and/or symptoms during examination or the course of treatment may indicate the
 10 need for referral to another practitioner or even emergency care. In such cases it is prudent
 11 for the practitioner to refer the member for appropriate co-management (e.g., to their
 12 primary care physician) or if immediate emergency care is warranted, to contact 911 as
 13 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practice
 14 guideline for information.

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