Clinical Practice Guideline: **Injection Treatment for Morton's Neuroma**

Date of Implementation: **August 20, 2015**

Effective Date: **February 19, 2026**

Product: **Specialty**

GUIDELINES

A. American Specialty Health – Specialty (ASH) considers services consisting of CPT Code 64455 (Injection(s), anesthetic agent(s) and/or steroid) or 64632 (Percutaneous Alcohol (30-100% solution ONLY; no other substances considered medically necessary) for Nerve Destruction (PAND) Injections) to be medically necessary for the treatment of Morton's neuroma upon meeting the following indications:

1. Up to 2 injections for the following diagnoses:

ICD-10 Codes and Descriptions That Support Medical Necessity

ICD-10 Code	ICD-10 Code Description
G57.61 – G57.63	*Lesion of plantar nerve, lower limb

*Interdigital neuroma

2. AFTER 2 injections, subject to meeting ALL of the following criteria:
   a. Lesion of plantar nerve (interdigital neuroma) (ICD-10: G57.61 – G57.63) to include:
      - Pain in foot and/or toes; AND
      - Morton's neuroma suspected by exam and history
        - Yes to confirmatory signs- pain in interspace
   b. Continued symptoms after NON-OPERATIVE treatment, including at **least 2** of the following:
      - Activity modification
      - Orthotics/splints/taping
      - Protective padding
      - Shoe modification
      - Anti-inflammatory medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDS])
   c. Following initial two injections, 50% reduction in pain and symptoms lasting a significant duration and documented in medical record.

B. Policy Guidelines

1. The medical record must adequately describe the patient's clinical state to include history, physical findings, laboratory, and other tests (e.g., identification of the problem including diagnosis, precipitating events, quantity and quality of pain, test results, response to previous conservative treatment, as well as any other pertinent evaluation and management elements of the history, examination, and medical decision making).
2. The medical record must contain documentation indicating the reason for the procedure, the concentration of the alcohol solution injected (for PAND), and a description of the procedure performed – including whether imaging guidance was used.
3. When a specific neuroma is injected, it will be considered one injection service regardless of the number of injections administered at that specific anatomical location on a single date of service.
4. The medical necessity for injections of more than two sites at one session is considered uncommon. Performance and submitting claims for such injections are likely to result in a request for medical records that must clearly document the medical necessity of these additional injections.
5. Failure of injections to achieve long term elimination or clinically significant reduction in symptoms precludes the medical necessity for repeated or continued injections.
6. Payment for all substances injected for CPT code 64632 is included in the amount paid for the injection and not separately reimbursable.

CPT Codes and Descriptions

CPT® Code	CPT® Code Description
64455	Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (e.g., Morton's neuroma)
64632	Destruction by neurolytic agent; plantar common digital nerve

BACKGROUND

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

Morton's neuroma, a painful peripheral neuropathy, typically affects the common digital nerve and its branches in the third plantar web space. It is a common condition mainly affecting middle aged women, and there are many proposed etiological theories involving chronic repetitive trauma, ischemia, entrapment, and intermetatarsal bursitis. Histological examination reveals the etiology to be perineural fibrosis, inflammatory tissue surrounding the nerve.

Diagnosis is usually made through history taking and clinical examination (i.e., by eliciting the Mulder's sign). Current proposed non-operative treatment strategies include shoe-wear modifications, activity modification, orthotics/splints/taping, anti-inflammatory medications (e.g., NSAIDS). More invasive options include injections of local anesthetic agents, sclerosing agents, neurolytic agents, and steroids. Operative management options primarily involve either nerve decompression or neurectomy (Jain, 2013).

Corticosteroid injections are commonly administered for Morton's neuroma as a first-line therapy. Thomson et al. (2013) performed a randomized controlled trial to determine if either corticosteroid and anesthetic (methylprednisolone and lignocaine) or anesthetic alone (lignocaine) are effective for the treatment of Morton's neuroma. Compared with the control group, global assessment of foot health in the corticosteroid group was significantly better at three months (mean difference, 14.1 scale points [95% confidence interval, 5.5 to 22.8 points]; $p = 0.002$). Significant and non-significant improvements associated with the corticosteroid injection were observed for measures of pain, function, and patient global assessment of general health at one and three months after injection. The authors concluded that injections for Morton's neuroma can be of symptomatic benefit for at least three months. In 2023, Thomas et al. performed a systematic review to identify the most significant evidence for the non-operative treatment of Morton's neuroma. Corticosteroid showed a statistically significant reduction in mean VAS over all their studies ($p < 0.01$), with 50% success at 12 months. Alcohol injection showed promising short-term pain-relieving results only.

Destruction by neurolytic agent is performed to treat chronic pain by destroying specific sites along a nerve. The interdigital spaces of the foot are common sites for the development of neuromas (e.g., Morton's neuroma). These occur most often between the third and fourth digits of the foot where the medial and lateral plantar nerves combine, usually from repetitive trauma or stress. Pain occurs when the metatarsal heads of the foot are squeezed together. Peripheral nerve blocks, anti-inflammatory injections and local anesthetic injections for pain relief into the soft tissue surrounding the nerve do not represent neurolysis.

Neurolysis (or destruction of a nerve) can be accomplished by chemical means (alcohol or phenol) or thermal means (cryoneuroblation or radiofrequency lesioning). Jain et al.

(2013) carried out a review of the literature on the treatment of Morton's neuroma and concluded that chemical neurolysis with alcohol is an effective and safe treatment strategy. Complete symptom resolution has been reported in up to 89% of patients (*N*=190) in a series of studies. The alcohol injections showed a reduction in lesion size at 6 months after the last injection. The reported complications include periprocedural pain (16.8%), allergic reaction (1.1%), and failure, with up to 20% progressing to surgery.

Hughes et al. (2007) assessed the efficacy of a series of guided alcohol injections for the treatment of patients (*N*=101) with symptomatic Morton's neuroma in a prospective study. Partial or total symptom improvement was reported by 94% of the patients, with 84% reporting completely pain-free.

Pasquali et al. (2014) carried out a retrospective study to determine the efficacy of alcohol injections for the treatment of Morton's neuroma. Patients (*N*=508) with symptomatic Morton's neuroma administered alcohol injections (USGAI). A mean number of 3.0 (range, 1 to 4) injections were performed for each neuroma. Mean local inflammatory reaction was 0.7 (range, 0 to 2). There were no other local or systemic complications. The overall mean pre-USGAI visual analogue scale (VAS) score was 8.7 (range, 6 to 10), while the post-USGAI VAS score at 1 year was 3.6 (range, 0 to 9). At 1-year follow-up 74.5% of patients were satisfied with the procedure.

Millan-Silva et al (2024) completed a systematic review of injection treatments for Morton's neuromas. Six RCTs and six longitudinal observational studies without a comparison group for a total of 1438 patients were included in the review. Factors studied included pain levels before and after treatments on various scales, patient satisfaction, and adverse effects. Five of the six RCTs reported on the injection of triamcinolone (52.6 % pain reduction compared with 33% in placebo group) and one on the injection of capsaicin (58.1% pain reduction compared to placebo). Relief of pain with triamcinolone was higher when ultrasound guidance was used. According to prior studies, a change of 9 mm or more on the 100 mm VAS was considered significant. Injection of neuromas with corticosteroids was the front runner using this measure, followed by hyaluronic acid, capsaicin and alcohol. Adverse effects associated with corticosteroid injections included very low incidences of skin depigmentation and atrophy of the plantar fat pad suggesting a high level of safety. Side effects related to alcohol injection included mild local injection site reactions that resolved in a few hours. The author's take home points included:

- Triamcinolone and methylprednisolone are effective in reducing the pain associated with Morton's neuroma
- Corticosteroids have low risk of complications, such as skin depigmentation and atrophy of the plantar fat pad
- Sclerosant injections, hyaluronic acid, and capsaicin still lack sufficient evidence of effectiveness, although none was associated with severe adverse effects

Matthews et al. (2024) performed a systematic review including 6 randomized controlled trials of treatment of Morton's neuromas with a total of 373 participants. The primary outcome was pain severity (Visual Analog Scale) and secondary outcomes included function (American Orthopaedic Foot and Ankle Society Lesser Toe Metatarsophalangeal-lnterphalangeal Scale – AOFAS; and Manchester Foot Pain and Disability Schedule-MFPDS) and satisfaction, health-related quality of life and adverse events. Two studies compared treatment with injection of a local anesthetic/corticosteroid combination vs. local anesthetic alone. The combination injection resulted in little to no difference in function when compared to local anesthetic injections (low certainty evidence) and may not increase satisfaction. There were no adverse events with local anesthesia. The combination injection resulted in adverse events including mild skin atrophy, plantar fat pad atrophy, and skin hypopigmentation. Two studies showed that ultrasound injections probably reduce pain more effectively than non-ultrasound injections and increase satisfaction 6 months after the procedure but may not reduce adverse events.

Pitcher et al. (2025) completed a systematic review of diagnosis and examination of Morton's neuroma to determine accuracy of these methods. Nine studies were included. Subjective clicking reported by patients was highly specific as was the modified webspace tenderness test. Patient-reported sensations of walking on pebbles and burning had sensitivities and specificities in the 40's-50's%. The authors concluded that lack of a patient report of clicking or negative modified tenderness test would preclude a diagnosis of Morton's neuroma.

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)* policy for information.

References

American College of Foot and Ankle (ACFAS) Cosmetic Surgery Position Statement (2020). Retrieved on December 29, 2025 from: https://www.acfas.org/policypositionstatements/

Centers for Medicare and Medicaid Services (CMS). CMS Manual System, Pub. 100-03, Chapter 1, Part 2, Section 160.1

Centers for Medicare and Medicaid Services (CMS). Local Coverage Article: Billing and Coding: Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (A57079). Retrieved on December 29, 2025 from https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=57079&ver=3&LCDId=34218&CntrctrSelected=363*1&Cntrctr=363&DocType=Active&bc=AAAAAAABAAAA&

Centers for Medicare and Medicaid Services (CMS). Local Coverage Determination (LCD): Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (L 34218). Retrieved on December 29, 2025 from https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34218&ver=22&CntrctrSelected=363*1&Cntrctr=363&DocType=Active&bc=AAAAAAABIAAA&

Chuter, G. J., Chua, Y., Connell, D., & Blackney, M. (2013). Ultrasound-guided radiofrequency ablation in the management of interdigital (Morton's) neuroma. *Skeletal Radiology, 42*(1), 107-111

Drăghici NC, Bolchis R, Popa LL, Văcăraș V, Iluț S, Bashimov A, Domnița DM, Dragoș HM, Vlad I, Mureșanu DF. Rare entrapment neuropathies of the lower extremity: A narrative review. Medicine (Baltimore). 2024 Aug 30;103(35):e39486. doi: 10.1097/MD.0000000000039486. PMID: 39213217; PMCID: PMC11365641.

Gurdezi, S., White, T., & Ramesh, P. (2013). Alcohol injection for Morton's neuroma: a five-year follow-up. *Foot Ankle Int, 34*(8), 1064-1067

Hughes, R. J., Ali, K., Jones, H., Kendall, S., & Connell, D. A. (2007). Treatment of Morton's Neuroma with Alcohol Injection Under Sonographic Guidance: Follow-Up of 101 Cases. *American Journal of Roentgenology, 188*(6), 1535-1539

Jain, S., & Mannan, K. (2013). The diagnosis and management of Morton's neuroma: a literature review. Foot & ankle specialist, 6(4), 307-317

Joint Commission International. (2020). Joint Commission International Accreditation Standards for Hospitals (7th ed.): Joint Commission Resources

Matthews BG, Thomson CE, Harding MP, McKinley JC, Ware RS. Treatments for Morton's neuroma. Cochrane Database Syst Rev. 2024 Feb 9;2(2):CD014687. doi: 10.1002/14651858.CD014687.pub2. PMID: 38334217; PMCID: PMC10853972.

Millán-Silva MO, Munuera-Martínez PV, Távara-Vidalón P. Infiltrative Treatment of Morton's Neuroma: A Systematic Review. Pain Manag Nurs. 2024 Jul 1:S1524-9042(24)00190-5. doi: 10.1016/j.pmn.2024.06.005. Epub ahead of print. PMID: 38955553.

Moore, J. L., Rosen, R., Cohen, J., & Rosen, B. (2012). Radiofrequency thermoneurolysis for the treatment of Morton's neuroma. *J Foot Ankle Surg, 51*(1), 20-22. doi: 10.1053/j.jfas.2011.10.007

Mozena, J. D., & Clifford, J. T. (2007). Efficacy of chemical neurolysis for the treatment of interdigital nerve compression of the foot: a retrospective study. *J Am Podiatr Med Assoc, 97*(3), 203-206

Pasquali, C., Vulcano, E., Novario, R., Varotto, D., Montoli, C., & Volpe, A. (2015). Ultrasound-Guided Alcohol Injection for Morton’s Neuroma. *Foot & ankle nternational, 36*(1), 55-59

Pitcher M, Moulson A, Pitcher D, Herbland A, Cert G, Cairns MC. Diagnostic Accuracy of Subjective Features and Physical Examination Tests for Morton Neuroma: A Systematic Review. Foot Ankle Orthop. 2024 Nov 19;9(4):24730114241291055. doi: 10.1177/24730114241291055. PMID: 39564390; PMCID: PMC11574893.Summers, A. (2010). Diagnosis and treatment of Morton's neuroma. *Emergency Nurse, 18*(5), 16-17

Thomson, C. E., Beggs, I., Martin, D. J., McMillan, D., Edwards, R. T., Russell, D., . . . Gibson, J. N. (2013). Methylprednisolone injections for the treatment of Morton neuroma: a patient-blinded randomized trial. *J Bone Joint Surg Am, 95*(9), 790-798

Thomson L, Aujla RS, Divall P, Bhatia M. Non-surgical treatments for Morton's neuroma: A systematic review. Foot Ankle Surg. 2020 Oct;26(7):736-743. doi: 10.1016/j.fas.2019.09.009. Epub 2019 Nov 2. PMID: 31718949