

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

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

**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) 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:
    - o Pain in foot and/or toes; AND
    - o 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:
    - o Activity modification
    - o Orthotics/splints/taping
    - o Protective padding
    - o Shoe modification
    - o 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 (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

- 1 evaluation and management elements of the history, examination, and medical  
 2 decision making.
- 3 2. The medical record must contain documentation indicating the reason for the  
 4 procedure, the concentration of the alcohol solution injected (for PAND), and a  
 5 description of the procedure performed – including whether imaging guidance  
 6 was used.
- 7 3. When a specific neuroma is injected, it will be considered one injection service  
 8 regardless of the number of injections administered at that specific anatomical  
 9 location on a single date of service.
- 10 4. The medical necessity for injections of more than two sites at one session is  
 11 considered uncommon. Performance and submitting claims for such injections are  
 12 likely to result in a request for medical records that must clearly document the  
 13 medical necessity of these additional injections.
- 14 5. Failure of injections to achieve long term elimination or clinically significant  
 15 reduction in symptoms precludes the medical necessity for repeated or continued  
 16 injections.
- 17 6. Payment for all substances injected for CPT code 64632 is included in the amount  
 18 paid for the injection and not separately reimbursable.

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 20 **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

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 22 **BACKGROUND**

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

27  
 28 Morton's neuroma, a painful peripheral neuropathy, typically affects the common digital  
 29 nerve and its branches in the third plantar web space. It is a common condition mainly  
 30 affecting middle aged women, and there are many proposed etiological theories involving  
 31 chronic repetitive trauma, ischemia, entrapment, and intermetatarsal bursitis. Histological  
 32 examination reveals the etiology to be perineural fibrosis, inflammatory tissue  
 33 surrounding the nerve.

1 Diagnosis is usually made through history taking and clinical examination (i.e., by  
2 eliciting the Mulder’s sign). Current proposed non-operative treatment strategies include  
3 shoe-wear modifications, activity modification, orthotics/splints/taping, anti-  
4 inflammatory medications (e.g., NSAIDS). More invasive options include injections of  
5 local anesthetic agents, sclerosing agents, neurolytic agents, and steroids. Operative  
6 management options primarily involve either nerve decompression or neurectomy (Jain,  
7 2013).

8  
9 Corticosteroid injections are commonly administered for Morton’s neuroma as a first-line  
10 therapy. Thomson et al. (2013) performed a randomized controlled trial to determine if  
11 either corticosteroid and anesthetic (methylprednisolone and lignocaine) or anesthetic  
12 alone (lignocaine) are effective for the treatment of Morton’s neuroma. Compared with  
13 the control group, global assessment of foot health in the corticosteroid group was  
14 significantly better at three months (mean difference, 14.1 scale points [95% confidence  
15 interval, 5.5 to 22.8 points];  $p = 0.002$ ). Significant and non-significant improvements  
16 associated with the corticosteroid injection were observed for measures of pain, function,  
17 and patient global assessment of general health at one and three months after injection.  
18 The authors concluded that injections for Morton’s neuroma can be of symptomatic  
19 benefit for at least three months. In 2023, Thomas et al. performed a systematic review to  
20 identify the most significant evidence for the non-operative treatment of Morton’s  
21 neuroma. Corticosteroid showed a statistically significant reduction in mean VAS over all  
22 their studies ( $p < 0.01$ ), with 50% success at 12 months. Alcohol injection showed  
23 promising short-term pain-relieving results only.

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

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34 Neurolysis (or destruction of a nerve) can be accomplished by chemical means (alcohol  
35 or phenol) or thermal means (cryoneuroablation or radiofrequency lesioning). Jain et al.  
36 (2013) carried out a review of the literature on the treatment of Morton’s neuroma and  
37 concluded that chemical neurolysis with alcohol is an effective and safe treatment  
38 strategy. Complete symptom resolution has been reported in up to 89% of patients  
39 ( $N=190$ ) in a series of studies. The alcohol injections showed a reduction in lesion size at  
40 6 months after the last injection. The reported complications include periprocedural pain  
41 (16.8%), allergic reaction (1.1%), and failure, with up to 20% progressing to surgery.

1 Hughes et al. (2007) assessed the efficacy of a series of guided alcohol injections for the  
2 treatment of patients (N=101) with symptomatic Morton’s neuroma in a prospective  
3 study. Partial or total symptom improvement was reported by 94% of the patients, with  
4 84% reporting completely pain-free.

5  
6 Pasquali et al. (2014) carried out a retrospective study to determine the efficacy of  
7 alcohol injections for the treatment of Morton’s neuroma. Patients (N=508) with  
8 symptomatic Morton’s neuroma administered alcohol injections (USGAI). A mean  
9 number of 3.0 (range, 1 to 4) injections were performed for each neuroma. Mean local  
10 inflammatory reaction was 0.7 (range, 0 to 2). There were no other local or systemic  
11 complications. The overall mean pre-USGAI visual analogue scale (VAS) score was 8.7  
12 (range, 6 to 10), while the post-USGAI VAS score at 1 year was 3.6 (range, 0 to 9). At 1-  
13 year follow-up 74.5% of patients were satisfied with the procedure.

### 14 15 **PRACTITIONER SCOPE AND TRAINING**

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

21  
22 It is best practice for the practitioner to appropriately render services to a member only if  
23 they are trained, equally skilled, and adequately competent to deliver a service compared  
24 to others trained to perform the same procedure. If the service would be most  
25 competently delivered by another health care practitioner who has more skill and  
26 training, it would be best practice to refer the member to the more expert practitioner.

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28 Best practice can be defined as a clinical, scientific, or professional technique, method, or  
29 process that is typically evidence-based and consensus driven and is recognized by a  
30 majority of professionals in a particular field as more effective at delivering a particular  
31 outcome than any other practice (Joint Commission International Accreditation Standards  
32 for Hospitals, 2020).

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

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