Percutaneous Neuroablation for Pancreatic Cancer Pain, Severe Cancer Pain, and Trigeminal Neuralgia

Policy Number: PAIN 025.5
Effective Date: October 1, 2024

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Related Policies

- Outpatient Surgical Procedures – Site of Service
- Sympathetic Blockade

Coverage Rationale

Percutaneous Neuroablation is proven and medically necessary for the treatment of pancreatic cancer pain, severe cancer pain, and Trigeminal Neuralgia.

For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Neuroablation, Percutaneous.

Click here to view the InterQual® criteria.

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the protocol titled Medical Records Documentation Used for Reviews.

Definitions

Percutaneous Neuroablation: Percutaneous Neuroablation is a procedure utilized to destroy neural tissue to relieve pain. These procedures may be performed using one of several mechanisms. Chemical neuroablation involves the percutaneous administration of phenol or alcohol around a nerve to denervate it. Percutaneous application of heat (radiofrequency neuroablation) or cold (cryoneurolysis) to the nerve is called thermal Neuroablation. (InterQual, 2023)

Trigeminal Neuralgia: Trigeminal Neuralgia (TN) is a neuropathic pain syndrome which affects the trigeminal nerve. It is characterized by severe electric shock-like painful episodes in one or more divisions of the trigeminal nerve. The first-line treatment of TN commonly involves medical management with use of analgesic and/or antiepileptic drugs. However, TN can be refractory to pharmacotherapy which necessitates the utilization of various invasive or minimally invasive procedures. (Texakalidis et al., 2019)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and

applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring
64620	Destruction by neurolytic agent, intercostal nerve
64640	Destruction by neurolytic agent; other peripheral nerve or branch

References

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [2024T0629F]

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Texakalidis P, Xenos D, Tora MS, et al. Comparative safety and efficacy of percutaneous approaches for the treatment of trigeminal neuralgia: A systematic review and meta-analysis. Clin Neurol Neurosurg. 2019 Jul;182:112-122.

Policy History/Revision Information

Date	Summary of Changes
10/01/2024	**Related Policies** • Added reference link to the Clinical Policy titled *Sympathetic Blockade* **Medical Records Documentation Used for Reviews** (previously titled *Documentation Requirements*) • Replaced list of *Required Clinical Information* with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews **Supporting Information** • Archived previous policy version PAIN 025.4

Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.