

Percutaneous Neuroablation for Severe Cancer Pain and Trigeminal Neuralgia

Policy Number: 2021T0629A
Effective Date: November 1, 2021

[➔ Instructions for Use](#)

Table of Contents	Page
Coverage Rationale	1
Documentation Requirements	1
Definitions	1
Applicable Codes	2
References	2
Policy History/Revision Information	2
Instructions for Use	2

Related Commercial Policy
<ul style="list-style-type: none"> Outpatient Surgical Procedures - Site of Service

Coverage Rationale

Percutaneous Neuroablation is proven and medically necessary for the treatment of severe cancer pain and Trigeminal Neuralgia. For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Apr. 2021 Release, CP: Procedures, Neuroablation, Percutaneous.

Click [here](#) to view the InterQual® criteria.

Documentation Requirements

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Codes*	Required Clinical Information
Percutaneous Neuroablation for Severe Cancer Pain and Trigeminal Neuralgia	
64620 64640	Medical notes documenting the following, when applicable: <ul style="list-style-type: none"> • Diagnosis • History of the medical condition(s) requiring treatment or surgical intervention • Documentation of signs and symptoms; including onset, duration, and frequency • Physical exam • Relevant medical history • Treatments tried, failed, or contraindicated; include the dates and reason for discontinuation

*For code descriptions, see the [Applicable Codes](#) section.

Definitions

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).

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.

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
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

CPT® is a registered trademark of the American Medical Association

References

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
11/01/2021	<ul style="list-style-type: none">New Medical Policy

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare 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 reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical 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.