MEDICAL POLICY	Occipital Nerve Ablation (All Lines of Business Except Medicare)
Effective Date: 9/1/2022  9/1/2022 Medical Officer Date	Medical Policy Number: 155 Technology Assessment Committee Approved Date: 8/06; 9/08; 10/10; 8/11 Medical Policy Committee Approved Date: 1/13; 3/14; 8/15; 5/16; 7/17; 1/18; 2/18; 12/18; 11/19; 1/2021; 11/2021; 2/2022

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

All Lines of Business except Medicare

BENEFIT APPLICATION

Medicaid Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

POLICY CRITERIA

Note: For Medicare members, please see the Medical Policy: "Back: Facet Joint Interventions for Pain Management (Medicare Only)" for ablation procedures of the occipital nerve.

Ablation (e.g. cryoablation, pulsed radiofrequency ablation) of the occipital nerve (Greater, Lesser or Third) is considered **investigational and is not covered** for all indications, including but not limited to occipital neuralgia, cluster headaches or refractory migraine headache.

Link to Policy Summary

CPT/HCPCS CODES

All Lines of Business Except Medicare	
Prior Authorization Required Note: When billed for occipital nerve ablation, the following two codes are considered investigational and are not covered.	
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)

DESCRIPTION

Occipital Nerves

The occipital nerves are a group of nerves that arise from the C2 and C3 spinal nerves, innervating the posterior scalp up as far as the vertex. There are three major occipital nerves in the human body: the greater occipital nerve, the lesser (or small) occipital nerve, and the third (or least) occipital nerve.[1]

Cluster Headache

According to ECRI, "cluster headaches are a primary neurovascular disorder that patients experience as severe to very sever, one-sided head pain. Chronic CHs typically occur every other day, daily, or even several times daily with pain lasting from 15 minutes to a few hours."[2]

Migraine Headache

Migraine headache is defined as recurring headache attacks lasting 4 to 72 hours. "Typical characteristics of the headache are unilateral location, pulsating quality, moderate-to-severe intensity, aggravated by routine physical activity, associated with nausea, and/or photophobia and phonophobia." Migraines can also include an aura or perceptual disturbance. Common treatments of migraines include nonsteroidal anti-inflammatory drugs (NSAIDs), steroids, and triptans (e.g., sumatriptan). Preventative therapies are also available, including calcium channel blockers and corticosteroids.

Occipital Neuralgia

Occipital neuralgia is a rare neurological disorder characterized by piercing, throbbing, or electric-shock-like pain in the upper neck, back of the head, and behind the ears, usually on one side of the head. Commonly, the cause of occipital neuralgia is unknown; however, it can occur due to irritation or injury to the occipital nerve. Therapies for occipital neuralgia may include pain medications, anesthetic injection, and steroids to reduce inflammation and block the transmission of pain signals.

Ablation of the Occipital Nerve

Ablative procedures (e.g. cryoablation, radiofrequency ablation, rhizotomy) are performed in the attempt to denervate the occipital nerve (greater or lesser), upper cervical nerve (eg, second cervical nerve, also known as C2), supraorbital, supratrochlear or sphenopalatine ganglion. The proposed goal of denervation is to disrupt pain signals sent from the nerves to the brain without causing excessive sensory loss, motor dysfunction or other complications.

Occipital Nerve Stimulation (ONS)

ONS involves the implantation of subcutaneous electrodes at the base of the skull over the greater, lesser, or third occipital nerves. The electrodes are connected to leads which are tunneled together in a caudal direction to an impulse generator implanted in the chest wall, low back, buttocks, or abdomen. The generators can be controlled by the physician or patient and can provide continuous or intermittent stimulation. Additionally, the generators can be non-rechargeable with a 2 to 5 year lifespan or rechargeable.

REVIEW OF EVIDENCE

A review of the ECRI, Hayes, Cochrane, and PubMed databases was conducted regarding the use of occipital nerve ablation as a treatment for refractory migraine headache or occipital neuralgia. Below is a summary of the available evidence identified through April 2022.

Ablation of the Occipital Nerve

Several systematic reviews investigating the use of radiofrequency ablation (RFA) and pulsed radiofrequency ablation (PRFA) for the management of cervicogenic headache (CHA) were identified.[8-10] While numerous studies demonstrated benefit, investigators from each publication concluded that there was a lack of high-quality RCTs and/or strong non-RCTs to support the use of RFA and PRFA in the management of CHA. Limitations included studies' small sample sizes, lack of long-term follow-up, heterogenous treatment parameters, and lack of randomized comparator groups.

CLINICAL PRACTICE GUIDELINES

No clinical practice guidelines addressing ablation of the occipital nerve were identified.

POLICY SUMMARY

There is insufficient evidence to support the safety and efficacy of occipital nerve ablation for refractory migraine headaches or occipital neuralgia. Evidence addressing ablation of the occipital nerve is limited, with no demonstrated clinical utility reported in high-quality studies. Furthermore, no clinical practice guidelines recommend ablation for treating migraines or neuralgia. Therefore, ablation of the occipital nerve is considered investigational.

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days' notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and PHP and PHA Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

MEDICAL POLICY CROSS REFERENCES

- Back: Ablative Procedures to Treat Back and Neck Pain (All LOB Except Medicare)
- Back: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (Medicare Only)

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