National Medical Policy

Subject: **Occipital Nerve Block**

Policy Number: **NMP55**

Effective Date*: **October 2003**

Updated: **July 2016**

This National Medical Policy is subject to the terms in the IMPORTANT NOTICE at the end of this document

For Medicaid Plans: Please refer to the appropriate State's Medicaid manual(s), publication(s), citation(s), and documented guidance for coverage criteria and benefit guidelines prior to applying Health Net Medical Policies guidelines first:

The Centers for Medicare & Medicaid Services (CMS)
For Medicare Advantage members please refer to the following for coverage guidelines first:

Use	Source	Reference/Website Link
	National Coverage Determination (NCD)	
	National Coverage Manual Citation	
X	Local Coverage Determination (LCD)*	Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency: http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx
	Article (Local)*	
	Other	
	None	Use Health Net Policy

Instructions

- Medicare NCDs and National Coverage Manuals apply to ALL Medicare members in ALL regions.
- Medicare LCDs and Articles apply to members in specific regions. To access your specific region, select the link provided under "Reference/Website" and follow the search instructions. Enter the topic and your specific state to find the coverage determinations for your region. *Note: Health Net must follow local coverage determinations (LCDs) of Medicare Administration Contractors (MACs) located

outside their service area when those MACs have exclusive coverage of an item or service. (CMS Manual Chapter 4 Section 90.2)

- If more than one source is checked, you need to access all sources as, on occasion, an LCD or article contains additional coverage information than contained in the NCD or National Coverage Manual.
- If there is no NCD, National Coverage Manual or region specific LCD/Article, follow the Health Net Hierarchy of Medical Resources for guidance.

Current Policy Statement

Health Net, Inc. considers greater occipital nerve block medically necessary when used to diagnose and treat occipital neuralgia.

Codes Related To This Policy

NOTE:
The codes listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit documents and medical necessity criteria. This list of codes may not be all inclusive.

On October 1, 2015, the ICD-9 code sets used to report medical diagnoses and inpatient procedures have been replaced by ICD-10 code sets.

ICD-9 Codes

723.8 Other syndromes affecting cervical region, for occipital neuralgia

ICD-10 Codes

M54.81 Occipital neuralgia

CPT Codes

64405 Injection, anesthetic agent; greater occipital nerve

HCPCS Codes

N/A

Scientific Rationale – Update July 2016

Okmen et al. (2016) completed a study with the goal to evaluate six months of results following repeated greater occipital nerve (GON) blocks. The authors evaluated the results from GON block performed on 60 patients. Briefly, a standard 2mL of 0.5% Bupivacaine GON blockage was applied once a week for 4 weeks. The Visual Analog Scale (VAS) scores were recorded, (i.e., the number of migraine attacks and the Migraine Disability Assessment Questionnaire (MIDAS) scores. The study subjects were not allowed to use medication for prophylaxis, and Ibuprofen (400mg, 1200mg at maximum) was prescribed for any migraine attacks. The initial mean number of attacks per month before starting treatment was 8.33+2.31. After treatment, the initial MIDAS mean was found to be 2.82 per month; this declined to 1.47 in 3rd, and was 1.50 in the 6th month. The individual month values were found to be significant, and were listed respectively as, 1st month: 3.95+2.52, 2nd month: 3.23+1.82, 3rd month: 2.60+1.90, 4th month: 2.68+2.10, 5th month: 2.58+1.90 and 6th month: 2.58+1.90. The mean VAS scores were recorded as follows for each month: 6.28±1.24, 3.13±0.97, 2.55±1.19, 2.35±1.26, 2.38±1.20 and 2.48±1.30, respectively. This difference was noted to be statistically significant. No difference

regarding the efficacy of the treatment was determined when the results were compared across age groups. We assume that GON blockage with 2mL of 0.5% Bupivacaine can be a supportive treatment in migraine treatment, with no serious adverse effects reported.

Scientific Rationale – Update July 2015

Palamar et al (2015) compared the effectiveness of ultrasound-guided greater occipital nerve block (GONB) using bupivacaine 0.5% and placebo on clinical improvement in patients with refractory migraine without aura (MWOA) in a randomized, double-blinded clinical trial at a single center. Thirty-two patients with a diagnosis of MWOA according to the International Classification of Headache Disorders-II criteria were included in the study. Twenty-three patients (2 men, 21 women) completed the study. They were randomly assigned to receive either GONB with local anesthetic (bupivacaine 0.5% 1.5 mL) or greater occipital nerve (GON) injection with normal saline (0.9% 1.5 mL). Ultrasound-guided GONB was performed to more accurately locate the nerve. All procedures were performed using a 7 - 13 MHz high-resolution linear ultrasound transducer. The treatment group was comprised of 11 patients and the placebo group was comprised of 12 patients. The primary outcome measure was the change in the headache severity score during the one-month post-intervention period. Headache severity was assessed with a visual analogue scale (VAS) from 0 (no pain) to 10 (intense pain). In both groups, a decrease in headache intensity on the injection side was observed during the first post-injection week and continued until the second week. After the second week, the improvement continued in the treatment group, and the VAS score reached 0.97 at the end of the fourth week. In the placebo group after the second week, the VAS values increased again and nearly reached the pre-injection levels. The decrease in the monthly average pain intensity score on the injected side was statistically significant in the treatment group ($P = 0.003$), but not in the placebo group ($P = 0.110$). No statistically significant difference in the monthly average pain intensity score was observed on the uninjected side in either group (treatment group, $P = 0.994$; placebo group, $P = 0.987$). No serious side effect was observed after the treatment in either group. Only one patient had a self-limited vaso-vagal syncope during the procedure. The authors noted the study was limited by its small and the short follow-up duration. Patients were followed for one month after the injection, thus relatively long-term effects of the injection have not been observed. They concluded ultrasound guided GONB with 1.5 mL of 0.5% bupivacaine for the treatment of migraine patients is a safe, simple, and effective technique without severe adverse effects. To increase the effectiveness of the injection, and to implement the isolated GONB, ultrasonography guidance could be suggested.

Inan et al (2015) assessed the efficacy of greater occipital nerve (GON) blockade at chronic migraine (CM) treatment. Patients with CM were randomly divided into two groups of 42. GON blockade was administered four times (once per week) with saline in group A or bupivacaine in group B. After 4 weeks of treatment, blinding was removed; in group A, GON blockade was achieved using bupivacaine, while group B continued to receive bupivacaine, and blockade was administered once per month, then followed for 2 months. Primary endpoint was the difference in number of headache days, duration of headache, and pain scores. Seventy-two of 84 patients completed the study. After 1 month of treatment, number of headache days had decreased from 16.9 ± 5.7 to 13.2 ± 6.7 in group A ($P = 0.035$) and from 18.1 ± 5.3 to 8.8 ± 4.8 in group B ($P < 0.001$), ($P = 0.004$, between groups); duration of headache (hour) had decreased from 24.2 ± 13.7 to 21.2 ± 13.4 in group A ($P = 0.223$) and from 25.9 ± 16.3 to 19.3 ± 11.5 in group B ($P < 0.001$), ($P = 0.767$,

between groups). VAS score decreased from 8.1 ± 0.9 to 6.7 ± 1.6 in group A (P = 0.002) and from 8.4 ± 1.5 to 5.3 ± 2.1 in group B (P < 0.001), (P = 0.004, between groups). After blinding was removed (in 2nd and 3rd month), group A exhibited similar results like group B in 3rd month. The authors concluded the results suggest that GON blockade with bupivacaine was superior to placebo and was found to be effective, safe, and cost-effective for the treatment of CM.

Dilli et al (2014) sought to determine the efficacy of occipital nerve block (ONB) with local anesthetic and corticosteroid for the preventive treatment of migraine. Patients between 18 and 75 years old with ICHD-II-defined episodic (> 1 attack per week) or chronic migraine (modified ICHD-II as patients with>10 days with consumption of acute medications were permitted into the study) were randomized to receive either 2.5ml 0.5% bupivacaine plus 0.5ml (20mg) methylprednisolone over the ipsilateral (unilateral headache) or bilateral (bilateral headache) ON or 2.75ml normal saline plus 0.25ml 1% lidocaine without epinephrine (placebo). Patients completed a one-month headache diary prior to and after the double-blind injection. The primary outcome measure was defined as a 50% or greater reduction in the frequency of days with moderate or severe migraine headache in the four-week post-injection compared to the four-week pre-injection baseline period. Thirty-four patients received active and 35 patients received placebo treatment. Because of missing data, the full analysis of 33 patients in the active and 30 patients in the placebo group was analyzed for efficacy. In the active and placebo groups respectively, the mean frequency of at least moderate (mean 9.8 versus 9.5) and severe (3.6 versus 4.3) migraine days and acute medication days (7.9 versus 10.0) were not substantially different at baseline. The percentage of patients with at least a 50% reduction in the frequency of moderate or severe headache days was 30% for both groups (10/30 vs nine of 30, Δ 0.00, 95% CI -0.22 to 0.23). The authors concluded greater ONB does not reduce the frequency of moderate to severe migraine days in patients with episodic or chronic migraine compared to placebo. The study was registered with ClinicalTrial.gov (NCT00915473).

Kashipazha et al (2014) evaluated the therapeutic efficacy of GONB in patients affected by migraine headaches. A randomized double-blinded controlled trial was conducted on 48 patients suffering from migraine headaches. A syringe containing 1.0 mL of lidocaine 2%, 0.5 mL of either saline (control group, N = 24) or triamcinolone 0.5 mL (intervention group, N = 24) was prepared for each patient. Patients were assessed prior to the injection, and also 2 weeks, 1 month, and 2 months thereafter for severity and frequency of pain, times to use analgesics and any appeared side effects. No significant differences were revealed in pain severity, pain frequency, and analgesics use between the two groups at the four study time points including at baseline, and 2, 4, and 8 weeks after the intervention. However, in both groups, the indices of pain severity, pain frequency, and analgesics use were significantly reduced at the three time points after the intervention compared with before the intervention. The authors concluded GONB with triamcinolone in combination with lidocaine or normal saline with lidocaine results in reducing pain severity and frequency as well as use of analgesics up to two months after the intervention, however any difference attributed to the drug regimens by assessing of the trend of pain characteristics changes.

Scientific Rationale – Update July 2014

Lambru et al (2014) prospectively assess the efficacy and consistency of response to greater occipital nerve blockade (GONB) in a large series of chronic cluster headache (CCH) patients. CCH patients who had a unilateral GONB were studied prospectively.

Headache characteristics were collected using headache diaries. Responders were considered to be patients with a complete or partial response lasting at least 7 days. In a subgroup of responders the outcomes of serial GONB performed at 3-monthly intervals were also analyzed. Eighty-three CCH patients were studied. After the first GONB, a positive response was observed in 47 (57%) patients: 35 (42%) were rendered pain free, 12 (15%) had a partial benefit and one patient obtained <50% improvement. The duration of a positive response lasted a median of 21 days (range 7-504 days). There was a transient worsening of condition in 6% of patients. The overall rate and average duration of response remained consistent after the second [n = 37; 31 responders (84%); median duration 21 days], third [n = 28; 20 responders (71%); median duration 25 days] and fourth [n = 14; 10 responders (71%); median duration 23 days] injections. Investigators concluded GONB seems to be an efficacious treatment with reproducible effects in CCH patients. Performed three monthly, GONB may have a useful role in the management of CCH.

Scientific Rationale – Update January 2013

Baron et al (2011) investigated the potential role of greater occipital nerve blocks (GON) and trigger point injections (TPI) in patients with cervicogenic headache along with complaints of dizziness, tinnitus, nausea, imbalance, hearing complaints, and ear/eye pain in a retrospective review of 147 patients. Data included chief complaint, secondary symptoms, response to injection, pre-GON/TPI posterior vertex sensation changes to pinprick, cervical spine examination, and response to vibration of cervical and suboccipital musculature. Chief complaints in decreasing frequency: dizziness (93%), tinnitus (4%), headache (3%), and ear discomfort (0.7%). Overall symptoms in decreasing frequency: dizziness (97%), headache (88%), neck pain (63%), tinnitus (23%), and ear discomfort (22%). Improvements after GON/TPI: neck range of motion (71%), headache (57%), neck pain (52%), ear discomfort (47%), dizziness (46%), and tinnitus (30%). Dizziness responders had neck position asymmetries (84%), reproducible dizziness by cervical and suboccipital musculature vibration (75%), and preinjection posterior vertex sensory changes (60%). Reviewers concluded a wider spectrum of cervically mediated symptoms may exist by influence of trigeminocervical and vestibular circuitry through cervical afferent neuromodulation. Certain examination findings may help to predict benefit from GON/TPI.

Scientific Rationale

There are many causes of occipital pain, and they are frequently grouped together as occipital neuralgia. A history of radiating scalp pain in the distribution of the occipital nerves, coupled with exacerbation and reproduction of pain on palpation of these structures at, or proximal to, the nuchal crest should prompt consideration of occipital neuralgia. Occipital neuralgia is a common cause of headaches. Many tension-type headaches in the occipital region or whiplash injuries are related to irritation or compression of these nerves. In any headache evaluation, it is important to rule out cervical causes of headache. Migraine headaches may also be triggered by an occipital neuralgia. Damage to the greater occipital nerve has been reported after halo pin placement for cervical spine or intracranial procedures.

Occipital nerve block is most often used to diagnose and treat pain in the occipital region. When it is used for diagnosis, a careful history and thorough physical examination are necessary to minimize the chance that serious causes of occipital pain will be missed or diagnosis delayed. Some have suggested that, in addition to the neuropathic changes that lead to occipital headaches, the pain characteristic of occipital neuralgia may also be related to arthritis of the cervical spine (cervicogenic

headache) and other rarer but serious conditions. By International Headache Society definition, occipital neuralgia is relieved by local anesthetic blockade of the involved occipital nerve; thus, the principal indication for occipital block is diagnosis. Another indication is the treatment of chronic occipital neuralgia, often with a series of therapeutic blocks combining local anesthetic and corticosteroid. Occipital nerve block also provides scalp anesthesia for surgical procedures when local infiltration techniques alone do not suffice.

Differential diagnostic injections of the greater and lesser occipital nerves definitively diagnose primary occipital neuralgia (C3 and/or C3 dorsal root ganglion involvement). Affected patients generally respond well to steroid injections over the dorsal root ganglia of C2 and/or C3, and in refractory cases, excellent results have been obtained with percutaneous functional stereotactic RF dorsal root ganglion lesioning. Cryoneurolysis is effective in providing long-lasting relief. The location of the nerve as it emerges from the suboccipital musculature allows safe placement of a cryoprobe inserted cephalad over the occiput and directed caudally. Severe, refractory cases have also been managed with open exploration of the occipital nerve just proximal to the nuchal crest and cryolesioning of the greater occipital nerve and its branches under direct vision. Implanted quadripolar occipital nerve stimulation devices have also been effective as a rescue intervention.

Even though there are no published reports of placebo-controlled trials of greater occipital nerve blocks, with or without steroid, it has become a well-established medical procedure for treatment for cervicogenic headache.

Review History

October 16, 2003	Medical Advisory Council
April 2006	Update – no changes
April 2008	Update – no revisions
April 2011	Update. Added Medicare Table with link to LCDs. No revisions.
January 2012	Update – no revisions
January 2013	Update - no revisions. Code updates.
January 2014	Update – no revisions
July 2014	Update – no revisions
July 2015	Update – no revisions
July 2016	Update – no revisions. Code updates.

This policy is based on the following evidence-based guidelines:

1. Hayes. Health Technology Brief. Greater Occipital Nerve Blocks for Treatment of Migraine Headaches. June 30, 2016. Updated May 17, 2016.

References – Update July 2016

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References – Update January 2013

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References – Update January 2012

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References Update – April 2011

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Important Notice

General Purpose.
Health Net's National Medical Policies (the "Policies") are developed to assist Health Net in administering plan benefits and determining whether a particular procedure, drug, service or supply is medically necessary. The Policies are based upon a review of the available clinical information including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the drug or device, evidence-based guidelines of governmental bodies, and evidence-based guidelines and positions of select national health professional organizations. Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract, including medical necessity requirements. Health Net may use the Policies to determine whether under the facts and circumstances of a particular case, the proposed procedure, drug, service or supply is medically necessary. The conclusion that a procedure, drug, service or supply is medically necessary does not constitute coverage. The member's contract defines which procedure, drug, service or supply is covered, excluded, limited, or subject to dollar caps. The policy provides for clearly written, reasonable and current criteria that have been approved by Health Net's National Medical Advisory Council (MAC). The clinical criteria and medical policies provide guidelines for determining the medical necessity criteria for specific procedures, equipment, and services. In order to be eligible, all services must be medically necessary and otherwise defined in the member's benefits contract as described this "Important Notice" disclaimer. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to practice medicine.

Policy Effective Date and Defined Terms.
The date of posting is not the effective date of the Policy. The Policy is effective as of the date determined by Health Net. All policies are subject to applicable legal and regulatory mandates and requirements for prior notification. If there is a discrepancy between the policy effective date and legal mandates and regulatory requirements, the requirements of law and regulation shall govern. * In some states, prior notice or posting on the website is required before a policy is deemed effective. For information regarding the effective dates of Policies, contact your provider representative. The Policies do not include definitions. All terms are defined by Health Net. For information regarding the definitions of terms used in the Policies, contact your provider representative.

Policy Amendment without Notice.
Health Net reserves the right to amend the Policies without notice to providers or Members. In some states, prior notice or website posting is required before an amendment is deemed effective.

No Medical Advice.
The Policies do not constitute medical advice. Health Net does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

No Authorization or Guarantee of Coverage.
The Policies do not constitute authorization or guarantee of coverage of particular procedure, drug, service or supply. Members and providers should refer to the Member contract to determine if exclusions, limitations, and dollar caps apply to a particular procedure, drug, service or supply.

Policy Limitation: Member's Contract Controls Coverage Determinations.
Statutory Notice to Members: The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. The determination of coverage for a particular procedure, drug, service or supply is not based upon the Policies, but rather is subject to the facts of the individual clinical case, terms and conditions of the member's contract, and requirements of applicable laws and regulations. The contract language contains specific terms and conditions, including pre-existing conditions, limitations, exclusions, benefit maximums, eligibility, and other relevant terms and conditions of coverage. In the event the Member's contract (also known as the benefit contract, coverage document, or evidence of coverage) conflicts with the Policies, the Member's contract shall govern. The Policies do not replace or amend the Member's contract.

Policy Limitation: Legal and Regulatory Mandates and Requirements

The determinations of coverage for a particular procedure, drug, service or supply is subject to applicable legal and regulatory mandates and requirements. If there is a discrepancy between the Policies and legal mandates and regulatory requirements, the requirements of law and regulation shall govern.

Reconstructive Surgery
CA Health and Safety Code 1367.63 requires health care service plans to cover reconstructive surgery. "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

(1) To improve function or

(2) To create a normal appearance, to the extent possible.

Reconstructive surgery does not mean "cosmetic surgery," which is surgery performed to alter or reshape normal structures of the body in order to improve appearance.

Requests for reconstructive surgery may be denied, if the proposed procedure offers only a minimal improvement in the appearance of the enrollee, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery.

Reconstructive Surgery after Mastectomy
California Health and Safety Code 1367.6 requires treatment for breast cancer to cover prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the co-payment, or deductible and coinsurance conditions, that are applicable to the mastectomy and all other terms and conditions applicable to other benefits. "Mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Policy Limitations: Medicare and Medicaid
Policies specifically developed to assist Health Net in administering Medicare or Medicaid plan benefits and determining coverage for a particular procedure, drug, service or supply for Medicare or Medicaid members shall not be construed to apply to any other Health Net plans and members. The Policies shall not be interpreted to limit the benefits afforded Medicare and Medicaid members by law and regulation.