

Policy: MP294

Section: Medical Benefit Policy

Subject: Intercostal Nerve Block

I. Policy: Intercostal Nerve Block

II. Purpose/Objective:

To provide a policy of coverage regarding Intercostal Nerve Block

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definition

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

INDICATIONS: REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE

Intercostal Nerve Block may be considered medically necessary when **one of the following criteria is met:**

1. Rib Fracture; **or**
2. Thorcotomy incision; **or**
3. Post-herpetic neuralgia

LIMITATIONS:

If the medical necessity for intercostal nerve block is met, no more than two (2) injections may be performed at a single level. No more than 3 procedures will be approved in a 12-week period of time per region, with at least 14 days between injections in the initial therapeutic phase. If there is greater than 50% reduction in symptoms or physical and functional improvement for at least 2 months, the provider may request repeat injections performed at intervals of at least 2 months, and limited to a maximum total of 4 therapeutic procedures per region per 12 months.

If special circumstances are documented, then repeat injections are limited to a maximum of 6 procedures in 12 months.

For GHP Family: The Benefit Limit Exception (BLE) process will apply to requests for more than six (6) injections per calendar year.

CODING ASSOCIATED WITH: Intercostal Nerve Block

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

64420 Introduction/injection of anesthetic agent (nerve block), diagnostic or therapeutic, intercostal nerve, single

64421 Introduction/injection of anesthetic agent (nerve block), diagnostic or therapeutic, intercostal nerve, multiple, regional block

64620 Destruction by neurolytic agent; intercostal nerve

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

Chaudhary V, Chauhan S, Choudhury M, et al. Parasternal intercostal block with ropivacaine for postoperative analgesia in pediatric patients undergoing cardiac surgery: a double-blind, randomized, controlled study. J Cardiothorac Vasc Anesth. 2012 Jun;26(3):439-42.

Truitt MS, Murry J, Amos J, et al. Continuous intercostal nerve blockade for rib fractures: ready for primetime? J Trauma. 2011 Dec;71(6):1548-52

Ho AM, Karmakar MK, Critchley LA. Acute pain management of patients with multiple fractured ribs: a focus on regional techniques. Curr Opin Crit Care. 2011 Aug;17(4):323-7

Takamori S, Yoshida S, Hayashi A, et al. Intraoperative intercostal nerve blockade for post thoracotomy pain. Ann Thorac Surg. 2002 Aug;74(2):338-41.

Savage C, McQuitty C, Wang D, Zwischenberger JB. Post thoracotomy pain management. Chest Surg Clin N Am. 2002 May;12(2):251-63.

This policy will be revised as necessary and reviewed no less than annually.

Devised: 1/15

Revised: 9/15, 4/17 (revised criteria), 8/21 (revise frequency limitations)

Reviewed: 11/16, 4/18, 4/19, 4/20, 4/21

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.