



Geisinger Health Plan Policies and Procedure Manual

Policy: MP381

Section: Medical Policy

Subject: Trigeminal Neuralgia

Applicable line of business:

Commercial	x	Medicaid	x
Medicare	x	ACA	x
CHIP	x		

I. Policy: Trigeminal Neuralgia

II. Purpose/Objective: To provide a policy of coverage regarding Trigeminal Neuralgia

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

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.

Commercial

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.

Medicare

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

CHIP

Geisinger Health Plan Kids (GHP Kids) is a Children's Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Medicaid

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

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 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

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- 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.

DESCRIPTION:

Trigeminal neuralgia, also known as tic douloureux, is a neuropathic pain condition affecting the face, characterized by paroxysmal, triggered, pain. Although the pathophysiology remains unclear, evidence suggests that pain occurs because of pressure on the trigeminal nerve root at the entry zone into the pontine region of the brain stem leading to focal demyelination and aberrant neural discharge. Pain usually lasts from seconds to minutes and may recur spontaneously between pain-free intervals. It affects more women than men (3:1 ratio) and is more common in the elderly. The treatment of idiopathic trigeminal neuralgia is often a challenging and conservative management with drug therapy is always the first-line treatment. When pharmacologic therapy is ineffective or intolerable, interventional pain treatment or surgery is considered.

INDICATIONS:

The Plan considers interventional or surgical treatment of trigeminal neuralgia to be medically necessary when the member has tried and failed or is intolerant to pharmacotherapies. The following treatments may be considered:

- Percutaneous radiofrequency rhizotomy/lysis
- Glycerol rhizolysis
- Trigeminal nerve blocks
- Balloon compression
- Microvascular decompression
- CyberKnife/Gamma Knife therapy

EXCLUSIONS:

Treatments not listed under the Indications section of this policy are considered to be **Unproven** and therefore not medically necessary and **NOT COVERED**. This list includes, but is not limited to, the following:

- Deep brain stimulation
- Motor cortex stimulation
- Spinal cord stimulation
- Peripheral / subcutaneous nerve field stimulation
- Transcranial direct current stimulation

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

CODING ASSOCIATED WITH:

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.

- 61450 Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion
- 61458 Craniectomy, suboccipital; for exploration or decompression of cranial nerves
- 61460 for section of one or more cranial nerves
- 61791 Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); trigeminal medullary tract
- 61796 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
- 61797 each additional cranial lesion, simple
- 61798 1 complex cranial lesion
- 61799 each additional cranial lesion, complex
- 64400 Injection, anesthetic agent; trigeminal nerve, any division or branch
- 64600 Destruction by neurolytic agent; trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
- 64605 second and third division branches at foramen ovale
- 64610 second and third division branches at foramen ovale under radiologic monitoring
- 64612 Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg., for blepharospasm, hemifacial spasm)
- 64716 Neuroplasty and/or transposition; cranial nerve (specify)
- 64732 Transection or avulsion of; supraorbital nerve
- 64734 Transection or avulsion of; infraorbital nerve

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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.

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

Devised: 12/24

Revised:

Reviewed:

CMS UM Oversight Committee Approval: 02/25

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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.