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Health Policy Analysis

Local Coverage Determinations for Peripheral Nerve Injections and Procedures for Chronic Pain: Policy Changes, Clinical Limitations, and Health-Equity Implications

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Five Medicare Administrative Contractors (MACs)—CGS, Palmetto GBA, Wellpoint Federal (formerly National Government Services), Wisconsin Physicians Service, and Noridian—participated in a collaborative policy-development process addressing peripheral nerve injections and related procedures for chronic pain. Novitas Solutions and First Coast Service Options did not participate. The September 2025 draft policies would have limited coverage principally to radiofrequency neurolysis for trigeminal neuralgia and corticosteroid injections for carpal tunnel syndrome and Morton neuroma, with lifetime caps on the latter procedures. After public comment and further evidence review, four contractors published materially identical final LCDs, with a notice period from September 10 through October 24, 2026, and an effective date of October 25, 2026. The final policies restored limited, criteria-based coverage for sympathetic blocks in complex regional pain syndrome, genicular nerve blocks and ablation for selected patients with knee osteoarthritis, greater occipital nerve blocks for occipital neuralgia, and selected suprascapular nerve blocks. They also removed the lifetime caps on median-nerve and Morton-neuroma injections. Pudendal, intercostal, ganglion impar, ulnar, and unspecified other peripheral-nerve procedures remain noncovered when performed for chronic pain. This health-policy analysis compares the draft and final policies, distinguishes Noridian's participation in the collaborative process from publication of a final LCD, summarizes coding and documentation requirements, and examines the access and health-equity implications of geographically discordant Medicare coverage.

Key words: Peripheral nerve blocks, local coverage determinations, Medicare Administrative Contractors, patient access, health equity, evidence assessment, Contractor Advisory Committee

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Peripheral nerve injections deliver local anesthetic, with or without corticosteroid, to a named peripheral nerve or ganglion. Percutaneous denervation techniques, including conventional or cooled radiofrequency ablation and cryoneurolysis, are intended to interrupt nociceptive transmission. Growth in utilization, variation in technique, and limitations in the clinical evidence prompted a collaborative review by multiple Medicare Administrative Contractors (MACs), which generally applied a moderate-certainty evidentiary threshold.

The American Society of Interventional Pain Physicians (ASIPP), together with other professional organizations and interested parties, opposed the restrictive draft LCDs and submitted detailed comments to the participating MACs (1). ASIPP emphasized three concerns:

1. Effects on independent practices and access: ASIPP argued that broad withdrawal of coverage could destabilize independent pain practices and reduce beneficiary access, particularly where alternative specialists or facilities are limited. It placed this concern in the context of declining inflation-adjusted

physician payment, citing an estimated 33% reduction for physicians overall and a 41% reduction for interventional pain physicians from 2001 through 2026 (2-9).

2. Interpretation of the evidence: ASIPP contended that the draft policies gave insufficient weight to clinical evidence and real-world experience supporting selected peripheral nerve procedures. The comments also challenged the use of a single evidentiary threshold across clinically distinct nerves, indications, and procedures.
3. Potential substitution toward higher-risk care: ASIPP warned that loss of targeted nonopioid procedures could shift some patients toward opioid therapy, more invasive interventions, or surgery. This concern is clinically plausible but should be evaluated empirically rather than assumed to occur uniformly (10,11).

ASIPP proposed a structured pathway modeled on coverage criteria for facet-joint interventions (13):

1. Diagnostic phase: Permit up to 2 diagnostic blocks per year to identify the pain generator.
2. Response threshold: Require at least 50% improvement in pain and function after the diagnostic blocks.
3. Therapeutic phase: When the response threshold is met, cover up to 2 radiofrequency neurotomy procedures or 4 therapeutic nerve blocks per year.

The final LCDs remain substantially more restrictive than prior practice for many chronic-pain indications, although they restore coverage for several procedures that the drafts would have excluded.

The final policies cover the following procedures subject to nerve-specific indications, documentation requirements, and utilization parameters:

1. Therapeutic peripheral nerve blocks: Restricted to the indications and codes expressly identified in the LCD and associated billing article.
2. Trigeminal neuralgia: Radiofrequency neurolysis limited to 2 procedures in a rolling 12-month period.
3. Carpal tunnel syndrome/Median neuropathy at the wrist: Corticosteroid injections limited to a lifetime maximum of 3 injections per side.
4. Selected procedures: Limited coverage for genicular nerve blocks and radiofrequency ablation, sympathetic blocks for complex regional pain syndrome (CRPS), greater occipital nerve blocks, and suprascapular nerve blocks.
5. Procedures that remain noncovered for chronic-pain management include the following:
   - Occipital denervation and occipital nerve blocks outside the covered criteria.
   - Suprascapular nerve blocks outside the covered criteria.
   - Pudendal nerve blocks or radiofrequency ablation.
   - Ganglion impar blocks.
   - Intercostal nerve blocks or erector spinae plane blocks.
   - Sciatic nerve blocks.
   - Ulnar nerve or digital nerve blocks.
   - Ilioinguinal, iliohypogastric, and genitofemoral nerve blocks.
   - Cluneal and lateral femoral cutaneous nerve blocks.
   - Brachial plexus or interscalene blocks when billed for chronic-pain management rather than covered perioperative indications.

Contractor Jurisdictions and Policy Status

The participating contractors and policy status summarized:

Final LCD	Contractor	Proposed ID	Jurisdiction notes
L40261	CGS	DL40261	KY, OH
L40263	Palmetto GBA	DL40263	Palmetto A/B states
L40267	NGS	DL40267	NGS A/B states
L40300	WPS	DL40300	Later draft comment close (11/22/2025)
DL40265No final LCD posted as of manuscript review	Noridian JE and JF	DL40265	Current active: L35456 / L35457

Companion documents of practical importance include billing and coding article A60302 (14), effective October 25, 2026, and the WPS response-to-comments article A60522 (15). Pain-management article A52863 (16) was revised to remove carpal- and tarsal-tunnel language and direct readers to the new policy framework. Novitas and First Coast did not participate; their existing policies remain controlling in their jurisdictions unless they later adopt or issue comparable guidance.

Draft Policy Versus Final Policy

September 2025 Draft Policies

Open-meeting and draft-article language limited reasonable-and-necessary coverage to three categories: (1) radiofrequency neurolysis for trigeminal neuralgia meeting duration, medication-failure, surgical, and ≥75% diagnostic-block criteria, with a maximum of two radiofrequency treatments per rolling 12 months; (2) corticosteroid ± local anesthetic for median neuropathy at the wrist, with a maximum of three injections per lifetime per side; and (3) corticosteroid ± local anesthetic for Morton neuroma, with a maximum of two injections per lifetime per side. Local-anesthetic-only median blocks and median denervation were noncovered. A long list of procedures, including occipital, stellate, trigeminal block (as therapy), suprascapular, thoracic block and denervation, genicular block/cryo/ablation, pudendal, digital, posterior tibial at the tarsal tunnel, ulnar, trigeminal denervation for diagnoses other than trigeminal neuralgia, and "any other" PNB or denervation, was considered not reasonable and necessary.

Final Policy Changes

A60522 reports that hundreds of comments and submitted peer-reviewed articles led to a substantial expansion of coverage for indications the contractors determined had sufficient evidence (15). The final LCD was retitled "Peripheral Nerve Injections and Procedures for Chronic Pain," reorganized by target nerve, and supplemented with definitions of acute (≤4 weeks), subacute (4-12 weeks), and chronic (≥12 weeks) pain. Each nerve-specific section includes an evidence analysis. The final policy removed lifetime limits for median-nerve and Morton-neuroma injections and added limited coverage for stellate and lumbar sympathetic blocks for CRPS, genicular diagnostic blocks and radiofrequency ablation for selected knee osteoarthritis, greater occipital nerve blocks after a positive diagnostic block, and selected suprascapular nerve blocks. It did not add coverage for pudendal procedures or for interventions directed at long COVID or posttraumatic stress disorder as syndromic indications.

Target	Draft (2025)	Final (effective 10/25/2026)
Median / CTS	3 steroid injections lifetime/side; LA-only and denervation non-covered	Lifetime cap removed; >3 same-nerve steroid injections may trigger review; LA-only and denervation still non-covered
Morton neuroma	2 steroid injections lifetime/side	Lifetime cap removed
Trigeminal RF	Covered with 4 criteria; 2 RF / 12 mo	Covered; 2 therapeutic RF codes / rolling 12 mo; RF not billable for other diagnoses
Sympathetic / CRPS	Explicitly non-covered	Limited coverage; >5 lifetime blocks need CSS documentation
Genicular	GNB, cryo, ablation non-covered	Limited dx block + RFA for selected KOA; ≤2 dx sessions; ≤2 RFA/knee/12 mo
Greater occipital	Non-covered	Limited for occipital neuralgia after positive dx block; ≤4 / 12 mo
Suprascapular	Non-covered	1 diagnostic allowed; >2 therapeutic / 12 mo may trigger review
Pudendal, digital, ganglion impar, tarsal tunnel, thoracic, ulnar, and CPT 64450 other	Non-covered	Noncovered for chronic pain, subject to the policy's single diagnostic pudendal-injection allowance

Utilization Rules In Final Article A60302

The following billing rules will govern claims under the participating contractors' final policies for dates of service on or after October 25, 2026.

Service	CPT family	Limit	Key modifier
Diagnostic PNB	Nerve-specific	Generally 1 session per nerve, unilateral or bilateral; genicular allows 2	KX on diagnostic line
Median steroid	20526	>3 same nerve may trigger review	Not 64450
Morton steroid	64455	No lifetime cap in final LCD	Laterality LT/RT
TN radiofrequency	64600 / 64605 / 64610	No more than 2 therapeutic RF procedures per rolling 12 months	TN diagnoses only
Genicular block	64454	≤2 diagnostic sessions	52 if not all 3 branches
Genicular RFA	64624	≤2 sessions per knee / rolling 12 months	Do not pair same-day with 64454
Occipital block	64405	≤4 / rolling 12 months	ICD M54.81 only

Service	CPT family	Limit	Key modifier
Suprascapular	64418	>2 therapeutic / 12 mo may trigger review	Shoulder OA / frozen shoulder ICDs
Sympathetic / CRPS	64510 / 64520	After 5 lifetime services, document the required CRPS Severity Score response	CRPS / causalgia ICDs only

Same-day performance with an epidural steroid injection, facet procedure, or trigger-point injection is considered not routinely necessary and requires documentation establishing the independent medical necessity of each service. Imaging included in the descriptors for CPT 64454 and 64624 must not be separately billed with CPT 77002 or 77003 and modifier 59. For bilateral facility claims, the article directs reporting on 2 lines with LT and RT modifiers and 1 unit per line; professional claims should use modifier 50. Sedation is not separately payable for these chronic-pain peripheral nerve procedures.

CPT and ICD 10 Starter Crosswalk

For chronic-pain services governed by A60302, coverage generally requires a CPT code in Groups 1-7 and a corresponding listed ICD-10-CM code. Group 8 identifies codes that are noncovered for pain management. This table is a reference aid and does not replace the controlling LCD, billing article, or current code-set instructions.

Group / CPT	Indication	ICD-10-CM codes supporting medical necessity
1. 20526	Median injection for CTS	G56.01, G56.02, G56.03
2. 64510, 64520, 64505	Sympathetic block for CRPS / causalgia	G90.511–513, G90.521–523, G90.50; G56.41–43; G57.7x
3. 64454, 64624	Genicular block / RFA for knee OA	M17.0, M17.11, M17.12, M17.2, M17.31, M17.32 (and unspecified M17.10 / M17.30)
4. 64455	Morton neuroma	G57.61, G57.62
5. 64405	Greater occipital neuralgia	M54.81 only; excludes G43.x and G44.x
6. 64418	Suprascapular, selected shoulder disease	M19.011/012, M19.111/112, M19.211/212; M75.01/02; selected RA M05.711/712, M06.811/812
7. 64400, 64600, 64605, 64610	Trigeminal neuralgia block / neurolysis	G50.0; B02.22

Group 8 includes CPT 64450; 64420, 64421, and 64620 for intercostal procedures; 64430 and 64632 for pudendal procedures; 64640; 64999 when used for unnamed peripheral nerve blocks; and 0440T-0442T. These codes are noncovered for chronic-pain management under the article, subject to the narrow allowance for a single diagnostic pudendal injection described in the policy. Therapeutic nerve blocks not listed in Groups 1-7 are likewise noncovered for pain management. Perioperative regional anesthesia is outside this chronic-pain noncoverage when the service satisfies applicable National Correct Coding Initiative requirements; the record and claim should support any modifier used.

Documentation That Will Be Requested

A60302 requires a signed and dated record that supports the reported CPT and ICD-10-CM codes and establishes the indication and medical necessity for the specific nerve treated on the date of service (14). For diagnostic blocks, the record should include preprocedure and postprocedure pain scores measured with a standardized scale over the expected duration of the local anesthetic. Required imaging documentation includes at least 1 stored ultrasound image at the target; fluoroscopic ablation documentation should include appropriate views, contrast confirmation, sensory and motor testing, fluoroscopy time and dose, temperature, and lesion duration. When required by the article, the claim comments should identify the ablation device. Sympathetic blocks beyond 5 lifetime services require longitudinal CRPS Severity Score documentation. An incomplete genicular procedure should be reported with CPT 64454 and modifier 52 rather than recoded as CPT 64450.

Implications for Interventional Pain Practice

Compared with community practice in 2024 and 2025, the final LCDs withdraw coverage for many commonly performed peripheral nerve procedures. Compared with the 2025 drafts, however, they restore limited coverage for sympathetic blocks for CRPS, genicular interventions for knee osteoarthritis, greater occipital nerve blocks for occipital neuralgia, and selected suprascapular injections. Coverage remains subject to frequency limits, documentation requirements, and narrow diagnosis-code lists. Practices that historically used CPT 64450 as a general peripheral-nerve code should anticipate denials when it is reported for chronic-pain services governed by these policies. Carpal-tunnel injections should be reported with CPT 20526 when applicable, rather than CPT 64450 or tendon-injection

codes. The revised tendon and ligament article removes tarsal-tunnel language, but the new LCD does not restore chronic-pain coverage for that procedure.

Material geographic variation will remain on October 25, 2026, because the final LCDs apply only in the issuing contractors' jurisdictions. Beneficiaries in Novitas and First Coast jurisdictions will continue under different local policies, and Noridian's participation in the draft process should not be equated with publication of a final LCD. The contractors declined to treat practice patterns or procedure volume as substitutes for moderate-certainty outcome evidence and did not adopt coverage with evidence development through the LCD. Publication of new peer-reviewed evidence and a formal reconsideration request remain potential pathways for future policy revision.

Geographic Variation and Health Equity

Geographically discordant coverage raises a health-equity concern because Medicare beneficiaries with comparable clinical conditions may have different access to the same intervention based on the MAC jurisdiction in which care is furnished. Medicare permits local coverage determinations when no controlling national coverage determination applies, but the resulting decentralization can produce differences in covered indications, documentation burdens, and effective access. Prior health-policy research has identified access, equity, and quality as central concerns in Medicare's local coverage system and has documented substantial variation among contractor policies (18-21). In an empirical study of stereotactic body radiotherapy for prostate cancer, use was nearly 3 times higher in areas with favorable rather than unfavorable LCDs, illustrating that local coverage policy can influence treatment utilization (22). That evidence does not establish the magnitude of any disparity for peripheral nerve procedures, but it supports prospective evaluation rather than assuming that geographic policy differences are clinically neutral.

The equity concern is especially important for older adults, people with disabilities, rural beneficiaries, and patients with limited financial or transportation resources. A beneficiary in a noncovering jurisdiction may face self-payment, an Advance Beneficiary Notice, travel to another jurisdiction, or substitution toward medications or more invasive care, whereas a similarly situated beneficiary elsewhere may receive Medicare-covered treatment. Equal entitlement to Medicare does not guarantee identical local coverage in the absence of a national policy, and geographic variation is not by itself proof of unlawful discrimination. Nevertheless, CMS's requirement that LCDs be based on the reasonable-and-necessary standard and supported by an evidence analysis provides a framework for comparing whether materially different local policies remain justified (23). CMS and the MACs should therefore publish jurisdiction-level utilization and denial data, assess differential effects by rurality, disability, race and ethnicity, dual-eligibility status, and socioeconomic disadvantage, and consider national review when persistent variation lacks a clinically persuasive rationale.

Limitations

This analysis describes policies and companion articles available as of the manuscript's review date. LCDs, billing articles, code lists, and contractor assignments may change; readers should verify the controlling documents for the date and place of service. The article does not estimate the number of affected beneficiaries, quantify changes in utilization or outcomes, or determine whether the final policies will cause disparities. Its health-equity conclusions identify a plausible policy risk supported by prior Medicare research, not a causal effect established for these peripheral nerve procedures. The CPT and ICD-10-CM tables are therefore operational summaries rather than substitutes for the complete LCDs, billing articles, National Correct Coding Initiative edits, or professional coding advice.

Conclusions

The four posted final LCDs establish a materially identical policy across four contractor jurisdictions and partially restore coverage that the September 2025 drafts would have eliminated. Noridian participated in the collaborative draft process, but clinicians in Jurisdictions E and F should rely on Noridian's published active policies rather than assume that another contractor's final LCD applies. Practices in the issuing jurisdictions should retire draft guidance that retains the former lifetime caps for carpal-tunnel and Morton-neuroma injections and should not treat CPT 64450 as a generally covered chronic-pain code. Operational implementation should use the applicable nerve-specific LCD, the contractor's billing and coding article, and an Advance Beneficiary Notice process when a beneficiary elects a service Medicare is expected to deny. CMS and the MACs should also monitor whether geographic differences in these policies produce measurable disparities in access, utilization, travel burden, opioid exposure, or outcomes.

Conflicts of Interest

Dr. Soin holds patents related to nonopioid pain therapeutics, spinal cord stimulation, peripheral nerve stimulation, and artificial intelligence. He serves as chief executive officer of the Ohio Society of Interventional Pain Physicians and as a director of the American Society of Interventional Pain Physicians; holds stock options in Neuros Medical; has received equipment, materials, drugs, medical-writing support, gifts, or other services from Avanos in connection with research; and reports other financial or nonfinancial interests involving Alyea Therapeutics, Neuros Medical, Neuronoff, BIOTRONIK Neuro, and Avanos.

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