



MASSACHUSETTS

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Medical Policy

Minimally Invasive Ablation Procedures for Morton and Other Peripheral Neuromas

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Policy Number: 719

BCBSA Reference Number: 7.01.147 (For Plan internal use only)

Related Policies

None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Minimally invasive ablation procedures, including intralesional alcohol injection, radiofrequency ablation, and cryoablation, are considered **INVESTIGATIONAL** for the treatment of Morton and other peripheral neuromas.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	This is not a covered service.
Commercial PPO and Indemnity	This is not a covered service.

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

According to the policy statement above, the following CPT codes are considered investigational for the conditions listed for **Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:**

CPT Codes

CPT codes:	Code Description
64632	Destruction by neurolytic agent; plantar common digital nerve
64640	Destruction by neurolytic agent; other peripheral nerve or branch

Description

Neuroma

A neuroma is a pathology of a peripheral nerve that develops as part of a normal reparative process. Neuromas may develop after nerve injury or result from chronic irritation, pressure, stretch, poor repair of nerve lesions or previous neuromas, laceration, crush injury, or blunt trauma.¹ Neuromas typically appear 6 to 10 weeks after trauma, with most presenting within 1 to 12 months after injury or surgery. They may gradually enlarge over 2 to 3 years and may or may not be painful. Pain from a neuroma may be secondary to traction on the nerve by scar tissue, compression of the sensitive nerve endings by adjacent soft tissues, ischemia of the nervous tissue, or ectopic foci of ion channels that elicit neuropathic pain. Patients may describe the pain as low-intensity dull pain or intense paroxysmal burning pain, often triggered by external stimuli such as touch or temperature. Neuroma formation has been implicated as a contributor of neuropathic pain in residual limb pain, postthoracotomy, postmastectomy, and postherniorrhaphy pain syndromes. Neuromas may coexist with phantom pain or can predispose to it.

Morton Neuroma

Morton neuroma is a common and painful compression neuropathy of the common digital nerve of the foot that may also be referred to as interdigital neuroma, interdigital neuritis, and interdigital or Morton metatarsalgia.^{1,2,3} It is histologically characterized by perineural fibrosis, endoneurial edema, axonal degeneration, and local vascular proliferation. Thus, some investigators do not consider Morton neuroma to be a true neuroma; instead, they consider it to be an entrapment neuropathy occurring secondary to compression of the common digital nerve under the overlying transverse metatarsal ligament. Morton neuroma appears 10-fold more often in women than in men, with an average age at presentation of around 50 years.⁴

The pain associated with Morton neuroma is usually throbbing, burning, or shooting, and localized to the plantar aspect of the foot. It is typically located between the 3rd and 4th metatarsal heads, although it may appear in other proximal locations.^{1,2} The pain may radiate to the toes and can be associated with paresthesia. The pain can be severe, and the condition may become debilitating to the extent that patients are apprehensive about walking or touching their foot to the ground. It is aggravated by walking in shoes with a narrow toe box or high heels that cause excessive pronation and excessive forefoot pressure; removal of tight shoes typically relieves the pain.

Diagnosis

Although a host of imaging methods are used to diagnosis Morton neuroma, including plain radiographs, magnetic resonance imaging, and ultrasonography, objective findings are unique to this condition and are primarily used to establish a clinical diagnosis.¹ Thus, a patient's toes often show splaying or divergence. Patients may describe the feeling of a "lump" on the foot bottom or a feeling of walking on a rolled-up or wrinkled sock. Clinical examination with medial and lateral compression may reproduce the painful symptoms with a palpable "click" on interspace compression (Mulder sign).⁵

Treatment

Management of patients diagnosed with Morton neuroma typically starts with conservative approaches, such as the use of metatarsal pads in shoes and orthotic devices that alter supination and pronation of the affected foot.³ These approaches try to reduce pressure and irritation of the affected nerve. They may provide relief, but do not alter the underlying pathology. There is scant evidence to support the effectiveness or comparative effectiveness of these practices.^{2,6,7} In a case series, Bennett et al (1995) evaluated a 3-stage protocol of "stepped care" through which private practice patients (N=115) advanced from stage I (education plus footwear modifications, and a metatarsal pad) to stage II (steroid injections with local anesthetic or local anesthetic alone), and into stage III (surgical resection) if stages I and II were not relieved within 3 months.⁸ Overall, 97 (85%) of 115 patients believed that pain had been reduced with the treatment program. However, 24 (21%) patients eventually required surgical excision of the nerve, and 23 (96%) of them had satisfactory results.

Minimally Invasive Ablation Procedures

Several minimally invasive procedures to treat refractory Morton and other peripheral neuromas are aimed at in situ destruction of the pathology, including intralesional alcohol injection, radiofrequency ablation (RFA) and cryoablation (also known as cryoneurolysis, cryolysis, and cryoanalgesia).²

Dehydrated ethanol has been shown to inhibit nerve function in vitro, has high affinity for nerve tissue, and causes direct damage to nerve cells via dehydration, cell necrosis, and precipitation of protoplasm, leading to neuritis and a pattern of Wallerian degeneration.² Technically, ethanol is a sclerosant that causes chemical neurolysis of the nerve pathology but is considered an ablative procedure for this evidence review. The use of ultrasound guidance during this procedure has been shown to increase surgical accuracy, improve outcomes, and shorten procedure duration. RFA uses heat generated by an electrode that conducts electromagnetic energy into a tissue or lesion to denature proteins and destroy cells. RFA is used to ablate a wide range of tissues or lesions, including osteoid osteoma; cardiovascular system pathologies; cervical pain syndromes; liver, lung, and other cancers; and varicosities.^{9,10,11,12,13,14,15,16,17,18,19,20} Cryoablation uses coolant to chill a cryoprobe to temperatures below -75°C, which when inserted into a lesion, freezes and kills the tissue. It has been used to treat Morton neuroma, other chronic nerve pain syndromes, and conditions for which RFA has been used.^{21,22,23,24,25,26,27,28}

This review primarily focuses on evidence for the use of intralesional alcohol injection, RFA, and cryoablation on painful neuromas, with emphasis on Morton neuroma and the comparative effectiveness of these less invasive therapies with open surgical resection of the nerve pathology.

Summary

Description

Morton neuroma is a common and painful compression neuropathy of the dorsal foot that is also referred to as intermetatarsal neuroma, interdigital neuroma, interdigital neuritis, and Morton metatarsalgia. Morton neuroma has been treated with conservative measures (pads, orthotics, drugs) or surgery. Minimally invasive procedures, including intralesional alcohol injection, radiofrequency ablation (RFA) and cryoablation, have been investigated as alternatives to open surgery. These methods have also been used to treat other peripheral neuromas.

Summary of Evidence

For individuals who have Morton neuroma who receive intralesional alcohol injection(s), the evidence includes retrospective case series. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. The body of evidence is limited, consisting of case series reporting on the treatment response of patients with refractory Morton neuroma. The available case series have generally reported that some patients experience pain relief and express satisfaction with the procedure. Some evidence has suggested that surgery after failed cases of alcohol injections is more complex and challenging than in untreated patients due to the presence of fibrosis. There is a lack of controlled trials comparing alcohol injections with alternative therapies, and there are no controlled studies comparing outcomes for alcohol injections with those for surgery in surgical candidates. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have Morton neuroma who receive RFA, the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. Four case series identified reported outcomes for radiofrequency ablation (RFA) to treat Morton neuroma. The body of evidence is highly heterogeneous regarding RFA protocols, descriptions of prior conservative management, patient characteristics, follow-up durations, outcome measures, and reporting of outcomes. Variable proportions of patients require surgery after RFA, making the benefit of RFA for avoiding more invasive treatment uncertain. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have Morton neuroma who receive cryoablation, the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. Only 2 retrospective case series on the use of cryoablation to treat peripheral nerve pain were identified in a literature review. The case series were heterogeneous regarding cryoablation protocols and length of follow-up. Outcome measures did not provide information on functional endpoints. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have peripheral neuroma(s) other than Morton neuroma who receive ablation no published literature was identified. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
8/2024	Annual policy review. Policy updated with literature review through April 25, 2024; no references added. Policy statements unchanged.
8/2023	Annual policy review. Policy statement unchanged.
1/2023	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
8/2022	Annual policy review. Ongoing intralesional alcohol ablation added to investigational policy statement. Transferred from MP #642 Alcohol Injections for Treatment of Peripheral Morton Neuromas. Policy title changed to "Minimally Invasive Ablation Procedures for Morton and Other Peripheral Neuromas."
8/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
8/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
8/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
7/2018	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
7/2017	Annual policy review. New references added.
5/2015	New medical policy describing investigational indications. Effective 5/1/2015.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

[Clinical Exception Process](#)

[Medical Technology Assessment Guidelines](#)

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