



CLINICAL GUIDELINES

CMM-402: Greater Occipital Nerve Block

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eviCore healthcare Clinical Decision Support Tool Diagnostic Strategies: This tool addresses common symptoms and symptom complexes. Requests for individuals with atypical symptoms or clinical presentations that are not specifically addressed will require physician review. Consultation with the referring physician, specialist and/or individual's Primary Care Physician (PCP) may provide additional insight.

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Clinical guidelines for medical necessity review of Comprehensive Musculoskeletal Management Services.

CMM-402 Greater Occipital Nerve Block

Definitions**General Guidelines****Indications****Non-Indications****Procedure (CPT[®]) Codes****References**

Definitions

- **Behavioral yellow flags:** an active or history of substance abuse, depression, dissatisfaction with work, job disability, or anxiety diagnosis.
- **Clinically Meaningful Improvement:** a global assessment showing at least 50% improvement, or pain relief with a two (2) point drop in VAS pain scale (where 10 is the worst pain imaginable and 0 is no pain at all).
- **Greater Occipital Nerve (GON):** nerve that arises from the medial division of the dorsal ramus of the C2 spinal nerve. It runs backward between the C1 and C2 vertebrae and traverses between the inferior capitis oblique and semispinalis capitis muscles from underneath the suboccipital triangle. The GON innervates the skin of the back of the scalp up to the vertex of the skull, the ear, and the skin just above the parotid gland.
- **Greater Occipital Nerve Block (GONB):** an injection of a small dose of local anesthetic and/or steroid around the greater occipital nerve. The injections may be given unilateral or bilateral. The GONB block aims to help by reducing the level of pain for a period of time
- **Occipital Neuralgia:** a distinct type of headache characterized by piercing, throbbing, or electric-shock-like chronic pain in the upper neck, back of the head, and behind the ears, usually on one side of the head. Typically, the pain of occipital neuralgia begins in the neck and then spreads upwards. Some individuals will also experience pain in the scalp, forehead, and behind the eyes. Their scalp may also be tender to the touch, and their eyes especially sensitive to light. The location of pain is related to the areas supplied by the greater and lesser occipital nerves, which run from the area where the spinal column meets the neck, up to the scalp at the back of the head. The pain is caused by irritation or injury to the nerves, which can be the result of trauma to the back of the head, pinching of the nerves by overly tight neck muscles, compression of the nerve as it leaves the spine due to osteoarthritis, or tumors or other types of lesions in the neck.
 - ◆ A positive response (relief from pain) after an anesthetic and/or steroid nerve block will confirm the diagnosis.
- **Red flags:** comorbidities that require urgent/emergent diagnostic imaging and/or referral for definitive diagnosis and treatment.

General Guidelines

Application of Guideline

- This guideline only applies to greater occipital nerve block used to treat occipital neuralgia and not to other techniques used to treat occipital neuralgia nor to other conditions treated by greater occipital nerve blocks.

Injectates

- This guideline only applies to injections of anesthetic and/or steroid and does not apply to injections of biologics (e.g., platelet rich plasma, stem cells, amniotic fluid, etc.) and/or any other injectates that are not in scope of eviCore's management.

Frequency & Number of Injections/Procedures

- Only one invasive interventional spinal modality or procedure will be performed on the same date of service.
- When criteria in the **Indications** section is met, up to six (6) greater occipital nerve blocks total (whether unilateral or bilateral) are permitted in 12 months
- At least four (4) week duration is required between the last occipital nerve block, cervical trigger point injection, or cervical facet injection/medial branch block

Indications

Initial Greater Occipital Nerve Block

The initial greater occipital nerve block for occipital neuralgia is considered **medically necessary** when **ALL** of the following are met:

- Clinical findings and/or imaging studies suggest no other obvious cause of the headache
- A comprehensive headache evaluation must be performed with consideration of alternative causes such as **ANY** of the following:
 - ◆ Exertional headache
 - ◆ Migraine with or without aura
 - ◆ Medication overuse headache
- Diagnosis of occipital neuralgia as evidenced by **BOTH** of the following:
 - ◆ Paroxysmal stabbing pain, (with or without aching between attacks), in the distribution of the greater occipital nerve
 - ◆ Tenderness over the affected nerve

Second and Subsequent Greater Occipital Nerve Block(s)

The second and subsequent greater occipital nerve block(s) for recurrent occipital neuralgia are considered **medically necessary** when **ALL** of the following are met:

- Clinical findings and/or imaging studies suggest no other obvious cause of the headache
- A comprehensive headache evaluation must be performed with consideration of alternative causes such as **ANY** of the following:
 - ◆ Exertional headache
 - ◆ Migraine with or without aura
 - ◆ Medication overuse headache
- Clinically meaningful improvement after each injection (including the initial injection)

- The greater occipital nerve block (GONB) must be combined with a self-care program.
 - ◆ A self-care program may include **ANY** of the following:
 - Anti-inflammatory medications
 - Muscle relaxants
 - Rest
 - Massage
 - Heat
- Confirmed diagnosis of recurrent occipital neuralgia as evidenced by tenderness to palpation over the greater occipital nerve
- Evidence of **BOTH** of the following for patients with chronic pain where there has been continuous opiate usage for 3 months or longer:
 - ◆ Co-management of behavioral health and medical conditions
 - ◆ A plan to address potential opiate overuse or abuse

Non-Indications

Not Medically Necessary

- Greater occipital nerve blocks performed without meeting the requirements listed in the Definitions, the General Guidelines, and the Indications sections are considered **not medically necessary**.

Experimental, Investigational, or Unproven (EIU)

- Occipital nerve ablation by any method is considered **experimental, investigational, or unproven (EIU)**.
- Use of an injectate other than anesthetic and/or steroid is considered **experimental, investigational, or unproven (EIU)**

Procedure (CPT®) Codes

This guideline relates to the CPT® code set below. Codes are displayed for informational purposes only. Any given code's inclusion on this list does not necessarily indicate prior authorization is required. Pre- authorization requirements vary by individual payor.

CPT®	Code Description/Definition
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve

This list may not be all inclusive and is not intended to be used for coding/billing purposes. The final determination of reimbursement for services is the decision of the individual payor (health insurance company, etc.) and is based on the member/patient/client/beneficiary's policy or benefit entitlement structure as well as any third party payor guidelines and/or claims processing rules. Providers are strongly urged to contact each payor for individual requirements if they have not already done so.

References

1. Lennard T., Shin D., Shoulder and chest wall blocks. In: Lennard ed. *Pain procedures in Clinical Practice*. 2nd ed. Hanley & Belfus; 2000:94-95.
2. Silberstein S. Evaluation of the Headache in *Patient. Clinician's Manual on Migraine*. Philadelphia: Current Medicine, Inc.; 2002:Page 9.
3. Balmaceda C., Rossi, J. Detecting Potentially Life-Threatening Headache Syndromes. *J Crit Illn*. 2003;18:23-30.
4. Peters K. S. Secondary headache and head pain emergencies. *Prim Care*. Jun 2004;31(2):381-393, vii.
5. Ashkenazi A., Matro, R., Shaw, J. W., et al. Greater occipital nerve block using local anaesthetics alone or with triamcinolone for transformed migraine: a randomised comparative study. *J Neurol Neurosurg Psychiatry*. Apr 2008;79(4):415-417.
6. Krymchantowski A. V., Silva, M. T., Barbosa, J. S., et al. Amitriptyline versus amitriptyline combined with fluoxetine in the preventative treatment of transformed migraine: a double-blind study. *Headache*. Jun 2002;42(6):510-514.
7. Spira P. J., Beran, R. G. Gabapentin in the prophylaxis of chronic daily headache: a randomized, placebo-controlled study. *Neurology*. Dec 23 2003;61(12):1753-1759.
8. Silberstein S. D., Lipton, R. B., Dodick, D. W., et al. Efficacy and safety of topiramate for the treatment of chronic migraine: a randomized, double-blind, placebo-controlled trial. *Headache*. Feb 2007;47(2):170-180.
9. De Felice M., Porreca, F. Opiate-induced persistent pronociceptive trigeminal neural adaptations: potential relevance to opiate-induced medication overuse headache. *Cephalalgia*. Dec 2009;29(12):1277-1284.
10. Ghiotto N., Sances, G., Galli, F., et al. Medication overuse headache and applicability of the ICHD-II diagnostic criteria: 1-year follow-up study (CARE I protocol). *Cephalalgia*. Feb 2009;29(2):233-243.
11. Pageler L., Savidou, I., Limmroth, V. Medication-overuse headache. *Curr Pain Headache Rep*. Dec 2005;9(6):430-435.
12. Lake A. E., 3rd. Medication overuse headache: biobehavioral issues and solutions. *Headache*. Oct 2006;46 Suppl 3:S88-97.
13. Dubois M. Y., Livovich, J., Fletwood, J., et al. Incompetence, drug diversion or pain management? Trying to draw the line. *Pain Med*. Mar 2002;3(1):73-77.
14. Fishbain D. A., Cutler, R. B., Rosomoff, H. L., et al. Is there a relationship between nonorganic physical findings (Waddell signs) and secondary gain/malingering? *Clin J Pain*. Nov-Dec 2004;20(6):399-408.
15. Giordano J., Schatman, M. E. A crisis in chronic pain care: an ethical analysis. Part three: Toward an integrative, multi-disciplinary pain medicine built around the needs of the patient. *Pain Physician*. Nov-Dec 2008;11(6):775-784.
16. Greater Occipital Nerve (GON) block injections- Injections into the head to prevent migraine. © 2021, *The Migraine Trust*. <https://migrainetrust.org/live-with-migraine/healthcare/treatments/greater-occipital-nerve-gon-block-injections/#page-section-1>.
17. Juškys R., Štuckas G. Effectiveness of treatment of occipital neuralgia using the nerve block technique: a prospective analysis of 44 patients. *Acta Med Lit*. 2018;25(2):53-60. doi: 10.6001/actamedica.v25i2.3757.
18. Kahan M., Srivastava, A., Wilson, L., et al. Misuse of and dependence on opioids: study of chronic pain patients. *Can Fam Physician*. Sep 2006;52(9):1081-1087.
19. Tacci J. A., Webster, B. S., Hashemi, L., et al. Healthcare utilization and referral patterns in the initial management of new-onset, uncomplicated, low back workers' compensation disability claims. *J Occup Environ Med*. Nov 1998;40(11):958-963.
20. Ferrari A., Leone, S., Tacchi, R., et al. The link between pain patient and analgesic medication is greater in migraine than in rheumatic disease patients. *Cephalalgia*. Jan 2009;29(1):31-37.
21. Bovim G., Fredriksen, T. A., Stolt-Nielsen, A., et al. Neurolysis of the greater occipital nerve in cervicogenic headache. A follow up study. *Headache*. Apr 1992;32(4):175-179.
22. Gille O., Lavignolle, B., Vital, J. M. Surgical treatment of greater occipital neuralgia by neurolysis of the greater occipital nerve and sectioning of the inferior oblique muscle. *Spine* (Phila Pa 1976). Apr 1 2004;29(7):828-832.
23. LCD- *Peripheral Nerve Blocks (L3933)* effective 10/01/2015. Revision effective 01/08/2019. <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33933&ver=30&bc=CAAAAAAAAAAAAA>.
24. Occipital Neuralgia. *National Institutes of Health (NIH): National Institute of Neurological Disorders and Stroke*. Last Reviewed 2022 July 25. <https://www.ninds.nih.gov/health-information/disorders/occipital-neuralgia#:~:text=Publications-,Definition,neck%20and%20then%20spreads%20upwards>.
25. Yu M., Wang, S. Anatomy, Head and Neck, Occipital Nerves. In *StatPearls [Internet]*. © 2022, StatPearls Publishing LLC. Last Update 2021 Nov 05. <https://www.ncbi.nlm.nih.gov/books/NBK542213/>.