Percutaneous Neuroablation for Pancreatic Cancer Pain, Severe Cancer Pain, and Trigeminal Neuralgia

Policy Number: 2025T0629H
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Instructions for Use

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Related Commercial/Individual Exchange Policy

- Outpatient Surgical Procedures - Site of Service
- Sympathetic Blockade

Application

UnitedHealthcare Commercial

This Medical Policy applies to UnitedHealthcare Commercial benefit plans.

UnitedHealthcare Individual Exchange

This Medical Policy applies to Individual Exchange benefit plans.

Coverage Rationale

Percutaneous Neuroablation is proven and medically necessary for the treatment of pancreatic cancer pain, severe cancer pain, and Trigeminal Neuralgia.

For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Neuroablation, Percutaneous.

Click here to view the InterQual® criteria.

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the protocol titled Medical Records Documentation Used for Reviews.

Definitions

Trigeminal Neuralgia: Trigeminal Neuralgia (TN) is a neuropathic pain syndrome which affects the trigeminal nerve. It is characterized by severe electric shock-like painful episodes in one or more divisions of the trigeminal nerve. The first-line treatment of TN commonly involves medical management with use of analgesic and/or antiepileptic drugs. However, TN can be refractory to pharmacotherapy which necessitates the utilization of various invasive or minimally invasive procedures (Texakalidis et al., 2019).

Percutaneous Neuroablation: Percutaneous Neuroablation is a procedure utilized to destroy neural tissue to relieve pain. These procedures may be performed using one of several mechanisms. Chemical neuroablation involves the percutaneous administration of phenol or alcohol around a nerve to denervate it. Percutaneous application of heat (radiofrequency neuroablation) or cold (cryoneurolysis) to the nerve is called thermal neuroablation (InterQual, 2023).

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch
64605	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale
64610	Destruction by neurolytic agent, trigeminal nerve; second and third division branches at foramen ovale under radiologic monitoring
64620	Destruction by neurolytic agent, intercostal nerve
64640	Destruction by neurolytic agent; other peripheral nerve or branch

References

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Texakalidis P, Xenos D, Tora MS, et al. Comparative safety and efficacy of percutaneous approaches for the treatment of trigeminal neuralgia: A systematic review and meta-analysis. Clin Neurol Neurosurg. 2019 Jul;182:112-122.

Policy History/Revision Information

Date	Summary of Changes
05/01/2025	**Template Update** • Created shared policy version to support application to Rocky Mountain Health Plans membership **Application** ***Individual Exchange*** • Removed language indicating this Medical Policy does not apply to the state of Colorado **Supporting Information** • Archived previous policy version 2025T0629G

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.