Minimally invasive ablation procedures, radiofrequency ablation, and cryoablation, are considered investigative for the treatment of peripheral neuromas.

Coding
One of the following CPT codes would be used to report these procedures:
- 64632: Destruction by neurolytic agent; plantar common digital nerve
- 64640: Destruction by neurolytic agent; other peripheral nerve or branch

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

Benefit Application
Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates [e.g., Federal Employee Program (FEP)] prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status
Although radiofrequency ablation probes and generators and cryoablation equipment have been cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process, none appear to be specifically indicated for treatment of Morton neuroma or any other specific peripheral neuroma.

Rationale
Background
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
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 a 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 posthemiomopathy pain syndromes. They may coexist with phantom pain or can predispose to it.

**Morton Neuroma**

Morton intermetatarsal 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. Morton neuroma is usually associated with a throbbing, burning, or shooting pain 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. 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.

**Diagnosis of Morton Neuroma**

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. 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).

**Treatment of Morton Neuroma**

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. 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. In 1 case series (1995), investigators 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. 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.

**Surgical Techniques**

Surgical intervention is considered the definitive therapy. The most common procedure is open excision of the interdigital nerve pathology through a dorsal or plantar approach. A second procedure, referred to as nerve decompression with neurolysis or translocation of the affected part of the interdigital nerve, has been used to treat Morton neuroma. Although this second approach uses smaller incisions and seems to have more rapid recovery than open excision, it is reported to be a more demanding surgical procedure that requires specialist training and equipment and is less common in practice. No randomized controlled trials have been reported comparing the effectiveness of different management approaches for Morton neuroma.
A 2004 Cochrane systematic review found evidence insufficient to assess the effectiveness of surgical and nonsurgical interventions for Morton neuroma. A 2013 literature review summarized the results of surgical excision studies that included 250 patients. In general, these series were poorly reported and highly heterogeneous, used disparate outcome measures, had short follow-up periods (average, 2-10 years), and could not be directly compared. In the only prospective comparative study (1997) of surgical methods, the dorsal approach resulted in earlier weight bearing (mean, 16 days vs 23 days, respectively) and return to work (mean, 22 days vs 37 days, respectively) compared with a plantar approach in 52 cases at an average follow-up of 3 years. Painful scars were more common with the plantar approach (n=5) than with the dorsal approach (n=2), with only 1 patient in each group experiencing symptom recurrence. Other case series of primary neurectomy have shown reductions in pain in 50% to 100% of patients, with self-reported satisfaction rates ranging from 52% to 86%, at mean follow-up of 24 to 126 months. Common complications included paresthesia (range, 51%-82%), scar tenderness or hypersensitivity (range, 6%-32%), and wound infection (range, 1.4%-9.7%).

Long-term outcomes of surgical resection were reported in 2 additional series that involved a total of 159 cases refractory to conservative management. One 2010 series (N=78) reported a mean follow-up of 4.6 years (range, 0.8-8.1 years). With a dorsal approach, 82% of patients with long-standing symptoms (mean duration, 33 months) reported excellent or good results, 10% had a fair result with restriction of activities or pain, while 8% had no improvement postsurgery. Complications included wound infections in 8 cases that resolved with antibiotics, 5 with persistent hypersensitive scars, and 4 developing local keloid formations. Eight (10%) cases required revision due to neuroma recurrence at a mean of 2 years after index surgery. The second long-term series (N=81), published in 2013, reported a mean follow-up of 15.3 years (range, 10-20 years). With a mostly dorsal approach (97% of cases), outcomes were reported as excellent in 45%, good in 32%, and fair in 15%. 8% reported poor results postsurgery and were referred for revision. Paresthesia in the supplying area of the resected nerve was reported in 72% of cases, while normal sensation was reported in 26%. Other surgical complications were not reported in this series.

Ablation Techniques
Several minimally invasive procedures to treat refractory Morton neuroma are aimed at in situ destruction of the pathology: radiofrequency ablation (RFA) and cryoablation (also known as cryoneurelysis, cryolysis, cryoanalgesia). 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. Cryoablation uses a 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.

This review primarily focuses on evidence for the use of 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.

Literature Review
Assessment of the efficacy of therapeutic interventions involves a determination whether an intervention improves health outcomes. The optimal study design for this purpose is a randomized controlled trial that includes clinically relevant measures of health outcomes. Intermediate outcome measures may also be adequate if there is an established link between the intermediate outcome and true health outcomes. Nonrandomized comparative studies and uncontrolled studies can sometimes provide useful information on health outcomes but are prone to biases such as noncomparability of treatment groups, placebo effect, and variable natural history of the condition.
Radiofrequency Ablation for Morton Neuroma
Our literature review identified 3 case series that reported outcomes with radiofrequency ablation (RFA) for treating Morton neuroma.

Genon et al (2010) reported on a retrospective review of a single center's experience with RFA to treat Morton neuroma according to a clinical algorithm that proceeds from nonoperative interventions to RFA and to open neurectomy if initial approaches failed.32 Thirty-seven patients who had failed conservative management (not described) and had symptoms for at least 12 months in duration were treated with RFA using a NeuroTherm NT1000 (NeuroTherm) radiofrequency generator. At an average follow-up of 11 months (range, 3-21 months), among the 37 patients (38 neuromas) treated, 7 (19%) reported complete relief of symptoms, 21 (58%) reported partial relief, and 10 (27%) reported no relief. Among those with no relief, 8 (22%) of patients had open surgical revision, with 6 of 8 reporting complete relief, 3 reporting partial relief, and 1 was unchanged. No complications due to RFA were reported.

Moore et al (2012) reported on a second retrospective series of RFA management of Morton neuroma.33 This series included 29 patients (22 women; age range, 23-73 years) who had not responded to conservative management (primarily steroid and alcohol injections) over 1 to 2 months. Patients were treated with RFA (Smith & Nephew) under monitored anesthesia using an electrode inserted dorsally with fluoroscopic guidance. Among the 29 cases, 24 (83%) expressed complete relief of symptoms 1 month following RFA; none reported more pain. The remaining 5 (17%) had minimal to no relief. Of them, 1 patient had open revision, and the others had no additional treatment or were lost to follow-up. One patient reported recurrence 9 months following RFA, and another had superficial cellulitis that responded to antibiotic therapy. All patients returned to normal shoe gear and activities within 2 days of RFA.

Chuter et al (2013) reported on a third retrospective series of RFA to treat Morton neuroma.34 This series included 25 patients (21 women) with a mean age of 55 years (range, 33-73 years) who had mean symptom duration of 3.8 years (range, 6 months to 15 years). All failed conservative management. Before RFA, patients had an average pain score of 6.0 (range, 3.0-9.0) on a 10-point visual analog scale (VAS). Four weeks after RFA, the average VAS pain score was 1.7 (range, 0-8.0; p<0.001), an average symptom improvement of 76%. The only complication reported involved a patient who experienced irritation of the posterior tibial nerve following the procedure. Three (10%) patients proceeded to open surgical excision within 6 months of RFA due to incomplete pain relief or recurrence.

Section Summary: Radiofrequency Ablation for Morton Neuroma
Three case series have reported outcomes of RFA to treat Morton neuroma. The body of evidence is highly heterogeneous regarding RFA protocols used, prior conservative management, patient characteristics, follow-up durations, outcome measures, and the reporting of outcomes (e.g., using denominators of “feet,” “neuromas,” or “patients,” which required conversion to “patients”). Although favorable outcomes were achieved in substantial proportions in each study, the outcome measures were unclear as to their clinical meaning, except the VAS used in the Chuter report. Furthermore, in all 3 series, a variable proportion of patients required further surgical excision, making the value of prior RFA uncertain.

Cryoablation for Morton Neuroma
Two retrospective case series on the use of cryoablation to treat peripheral nerve pain have been identified.

One case series by Friedman et al (2012) reported on a series of patients who had undergone sonographically guided cryoneurolysis.35 Among a cohort of 20 patients, 5 had Morton neuroma (all women; mean age, 55 years). Cryotherapy was administered with a Frigitronics CE 2000 (Cooper Surgical) device using nitrous oxide coolant. A cryoprobe was inserted into the Morton neuroma and the probe temperature was decreased to -75°C and left in place until a continuous series of ice balls was created (one or two 3-minute cycles of cooling). Patients were
scheduled for follow-up at 4 to 6 weeks. However, actual follow-up varied due to patient discretion. Among the 5 Morton neuroma patients, 3 had “marked relief,” 1 had “moderate relief,” and 1 had no relief, at a mean follow-up of 14 weeks (range, 6 weeks to 14 months). Complications of cryoablation were not reported.

The second case series, by Cazzato et al (2016), retrospectively described 20 patients (24 lesions) with Morton neuroma who underwent magnetic resonance–guided cryoablation. All patients were previously treated with ultrasound-guided corticosteroid injections and had not reported relief. While positioned in the magnetic resonance unit, a cryoprobe (Ice-Seed; Galil Medical) was inserted into the center of the lesion. A single freezing cycle of 150 seconds was performed. Mean procedural time was 41 minutes (range, 35-60 minutes). Patients were followed with a telephone survey. The number of months between procedure and last follow-up ranged from 1 to 50 months. Results were reported by lesion, with data available for 18 of the 24 lesions treated. Patients with 14 (78%) of the 18 lesions were “completely satisfied,” 17% were “satisfied with minor reservations,” and 6% were “satisfied with major reservations.” Mean local pain score was 3.0 on a 0-to-10 VAS. Post-VAS scores were not available.

**Section Summary: Cryoablation for Morton Neuroma**

Two retrospective case series have investigated cryoablation to treat Morton neuroma. The body of evidence is heterogeneous regarding cryoablation protocols used, prior conservative management, and length of follow-up. Although large proportions of patients reported satisfaction with the procedure in both studies, daily functioning did not clearly improve after the procedure. The weakness in the body of evidence precludes conclusions on the efficacy of cryoablation for Morton neuroma.

**Other Painful Neuromas**

The literature review for this update did not identify any controlled studies on the use of ablative techniques to treat painful peripheral neuromas other than Morton neuroma. Two recent review articles reported little evidence for any other sites.

**Summary of Evidence**

For individuals who have Morton neuroma who receive radiofrequency ablation (RFA), the evidence includes case series. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. Three case series identified reported outcomes for RFA to treat Morton neuroma. The body of evidence is highly heterogeneous regarding RFA protocols, 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 the effects of the technology on health outcomes.

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 our literature review. The case series were heterogeneous regarding cryoablation protocols and length of follow-up. Outcome measures did not provide information on functional end points. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have peripheral neuroma(s) other than Morton neuroma who receive ablation, the evidence is very limited: no published literature was identified. Relevant outcomes are symptoms, functional outcomes, and treatment-related morbidity. The evidence is insufficient to determine the effects of the technology on health outcomes.
Supplemental Information

Practice Guidelines and Position Statements

The Association of Extremity Nerve Surgeons published clinical practice guidelines in 2014 relevant to this evidence review.37 The guidelines stated that “We do not recommend ablation in the primary treatment of intermetatarsal Entrapment (Morton’s Neuroma).” The guidelines warned that cryoablation should be used with extreme caution, and, if used, should be performed in an open technique, not percutaneously. The guidelines also warned that radiofrequency ablation may cause thermal necrosis of adjacent tissues.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

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<th>Trial Name</th>
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<td>A 3-Arm Randomized Controlled Study Comparing Ultrasound-Guided Cryoablation, Ultrasound-Guided Perineural Lidocaine, and Ultrasound-Guided Perineural Saline to Treat Intrametatarsal Neuroma</td>
<td>66</td>
<td>Dec 2020</td>
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References


**Documentation for Clinical Review**

- No records required

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.

**IE**

The following services may be considered investigational.

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<th>Type</th>
<th>Code</th>
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<td>64640</td>
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**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
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<th>Effective Date</th>
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<td>08/01/2016</td>
<td>BC BSA Medical Policy Adoption</td>
<td>Medical Policy Committee</td>
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<tr>
<td>08/01/2017</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure, or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state government is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department. Please call (800) 541-6652 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.