

1 **Clinical Practice Guideline: Injection Treatment for Morton’s Neuroma**

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3 **Date of Implementation: August 20, 2015**

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5 **Product: Specialty**

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8 **GUIDELINES**

9 A. American Specialty Health – Specialty (ASH) considers services consisting of CPT  
 10 Code 64455 (Injection(s), anesthetic agent(s) and/or steroid) or 64632 (Percutaneous  
 11 Alcohol (30-100% solution ONLY; no other substances considered medically  
 12 necessary) for Nerve Destruction (PAND) Injections) to be medically necessary for  
 13 the treatment of Morton’s neuroma upon meeting the following indications:

14 1. Up to 2 injections for the following diagnoses:

15

16 **ICD-10 Codes and Descriptions That Support Medical Necessity**

| ICD-10 Code     | ICD-10 Code Description              |
|-----------------|--------------------------------------|
| G57.61 – G57.63 | *Lesion of plantar nerve, lower limb |

17 \*Interdigital neuroma

18

- 19 2. AFTER 2 injections, subject to meeting ALL of the following criteria:
- 20 a. Lesion of plantar nerve (interdigital neuroma) (ICD-10: G57.61 – G57.63) to
- 21 include:
- 22 o Pain in foot and/or toes; AND
- 23 o Morton’s neuroma suspected by exam and history
- 24 o Yes to confirmatory signs- pain in interspace
- 25 b. Continued symptoms after NON-OPERATIVE treatment, including at **least 2**
- 26 of the following:
- 27 o Activity modification
- 28 o Orthotics/splints/taping
- 29 o Protective padding
- 30 o Shoe modification
- 31 o Anti-inflammatory medications (e.g., non-steroidal anti-inflammatory
- 32 drugs [NSAIDS])
- 33 c. Following initial two injections, 50% reduction in pain and symptoms lasting
- 34 a significant duration and documented in medical record

1 B. Policy Guidelines

- 2 1. The medical record must adequately describe the patient's clinical state to include  
 3 history, physical findings, laboratory and other tests (e.g., identification of the  
 4 problem including diagnosis, precipitating events, quantity and quality of pain,  
 5 test results, response to previous conservative treatment, as well as any other  
 6 pertinent evaluation and management elements of the history, examination, and  
 7 medical decision making).
- 8 2. The medical record must contain documentation indicating the reason for the  
 9 procedure, the concentration of the alcohol solution injected (for PAND), and a  
 10 description of the procedure performed – including whether imaging guidance  
 11 was used.
- 12 3. When a specific neuroma is injected, it will be considered one injection service  
 13 regardless of the number of injections administered at that specific anatomical  
 14 location on a single date of service.
- 15 4. The medical necessity for injections of more than two sites at one session is  
 16 considered uncommon. Performance and submitting claims for such injections are  
 17 likely to result in a request for medical records that must clearly document the  
 18 medical necessity of these additional injections.
- 19 5. Failure of injections to achieve long term elimination or clinically significant  
 20 reduction in symptoms precludes the medical necessity for repeated or continued  
 21 injections.
- 22 6. Payment for all substances injected for CPT code 64632 is included in the amount  
 23 paid for the injection and not separately reimbursable.

24 **CPT Codes and Descriptions**

| <b>CPT® Code</b> | <b>CPT® Code Description</b>   |
|------------------|--|
| 64455            | Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (e.g., Morton’s neuroma) |
| 64632            | Destruction by neurolytic agent; plantar common digital nerve  |

26 **BACKGROUND**

27 Neuropathic pain generally develops as a result of lesions or disease affecting the  
 28 somatosensory nervous system either in the periphery or centrally. Clinically, neuropathic  
 29 pain is characterized by spontaneous ongoing or shooting pain and evoked amplified pain  
 30 responses after noxious or non-noxious stimuli.

1 Morton's neuroma, a painful peripheral neuropathy, typically affects the common digital  
2 nerve and its branches in the third plantar web space. It is a common condition mainly  
3 affecting middle aged women, and there are many proposed etiological theories involving  
4 chronic repetitive trauma, ischemia, entrapment, and intermetatarsal bursitis. Histological  
5 examination reveals the etiology to be perineural fibrosis, inflammatory tissue  
6 surrounding the nerve.

7  
8 Diagnosis is usually made through history taking and clinical examination (i.e., by  
9 eliciting the Mulder's sign). Current proposed non-operative treatment strategies include  
10 shoe-wear modifications, activity modification, orthotics/splints/taping, anti-  
11 inflammatory medications (e.g., NSAIDs). More invasive options include injections of  
12 local anesthetic agents, sclerosing agents, neurolytic agents, and steroids. Operative  
13 management options primarily involve either nerve decompression or neurectomy (Jain,  
14 2013).

15  
16 Corticosteroid injections are commonly administered for Morton's neuroma as a first-line  
17 therapy. Thomson et al. (2013) performed a randomized controlled trial to determine if  
18 either corticosteroid and anesthetic (methylprednisolone and lignocaine) or anesthetic  
19 alone (lignocaine) are effective for the treatment of Morton's neuroma. Compared with  
20 the control group, global assessment of foot health in the corticosteroid group was  
21 significantly better at three months (mean difference, 14.1 scale points [95% confidence  
22 interval, 5.5 to 22.8 points];  $p = 0.002$ ). Significant and non-significant improvements  
23 associated with the corticosteroid injection were observed for measures of pain, function,  
24 and patient global assessment of general health at one and three months after injection.  
25 The authors concluded that injections for Morton's neuroma can be of symptomatic  
26 benefit for at least three months. In 2023, Thomas et al. performed a systematic review to  
27 identify the most significant evidence for the non-operative treatment of Morton's  
28 neuroma. Corticosteroid showed a statistically significant reduction in mean VAS over all  
29 their studies ( $p < 0.01$ ), with 50% success at 12 months. Alcohol injection showed  
30 promising short-term pain-relieving results only.

31  
32 Destruction by neurolytic agent is performed to treat chronic pain by destroying specific  
33 sites along a nerve. The interdigital spaces of the foot are common sites for the  
34 development of neuromas (e.g., Morton's neuroma). These occur most often between the  
35 third and fourth digits of the foot where the medial and lateral plantar nerves combine,  
36 usually from repetitive trauma or stress. Pain occurs when the metatarsal heads of the  
37 foot are squeezed together. Peripheral nerve blocks, anti-inflammatory injections and  
38 local anesthetic injections for pain relief into the soft tissue surrounding the nerve do not  
39 represent neurolysis.

40  
41 Neurolysis (or destruction of a nerve) can be accomplished by chemical means (alcohol  
42 or phenol) or thermal means (cryoneuroablation or radiofrequency lesioning). Jain et al.

1 (2013) carried out a review of the literature on the treatment of Morton’s neuroma and  
 2 concluded that chemical neurolysis with alcohol is an effective and safe treatment  
 3 strategy. Complete symptom resolution has been reported in up to 89% of patients  
 4 ( $N=190$ ) in a series of studies. The alcohol injections showed a reduction in lesion size at  
 5 6 months after the last injection. The reported complications include periprocedural pain  
 6 (16.8%), allergic reaction (1.1%), and failure, with up to 20% progressing to surgery.

7  
 8 Hughes et al. (2007) assessed the efficacy of a series of guided alcohol injections for the  
 9 treatment of patients ( $N=101$ ) with symptomatic Morton’s neuroma in a prospective  
 10 study. Partial or total symptom improvement was reported by 94% of the patients, with  
 11 84% reporting completely pain-free.

12  
 13 Pasquali et al. (2014) carried out a retrospective study to determine the efficacy of  
 14 alcohol injections for the treatment of Morton’s neuroma. Patients ( $N=508$ ) with  
 15 symptomatic Morton’s neuroma administered alcohol injections (USGAI). A mean  
 16 number of 3.0 (range, 1 to 4) injections were performed for each neuroma. Mean local  
 17 inflammatory reaction was 0.7 (range, 0 to 2). There were no other local or systemic  
 18 complications. The overall mean pre-USGAI visual analogue scale (VAS) score was 8.7  
 19 (range, 6 to 10), while the post-USGAI VAS score at 1 year was 3.6 (range, 0 to 9). At 1-  
 20 year follow-up 74.5% of patients were satisfied with the procedure.

21  
 22 Millan-Silva et al (2024) completed a systematic review of injection treatments for  
 23 Morton’s neuromas. Six RCTs and six longitudinal observational studies without a  
 24 comparison group for a total of 1438 patients were included in the review. Factors  
 25 studied included pain levels before and after treatments on various scales, patient  
 26 satisfaction, and adverse effects. Five of the six RCTs reported on the injection of  
 27 triamcinolone (52.6 % pain reduction compared with 33% in placebo group) and one on  
 28 the injection of capsaicin (58.1% pain reduction compared to placebo). Relief of pain  
 29 with triamcinolone was higher when ultrasound guidance was used. According to prior  
 30 studies, a change of 9 mm or more on the 100 mm VAS was considered significant.  
 31 Injection of neuromas with corticosteroids was the front runner using this measure,  
 32 followed by hyaluronic acid, capsaicin and alcohol. Adverse effects associated with  
 33 corticosteroid injections included very low incidences of skin depigmentation and  
 34 atrophy of the plantar fat pad suggesting a high level of safety. Side effects related to  
 35 alcohol injection included mild local injection site reactions that resolved in a few hours.  
 36 The author’s take home points included:

- 37 • Triamcinolone and methylprednisolone are effective in reducing the pain  
 38 associated with Morton’s neuroma
- 39 • Corticosteroids have low risk of complications, such as skin depigmentation and  
 40 atrophy of the plantar fat pad
- 41 • Sclerosant injections, hyaluronic acid, and capsaicin still lack sufficient evidence  
 42 of effectiveness, although none was associated with severe adverse effects

## 1 PRACTITIONER SCOPE AND TRAINING

2 Practitioners should practice only in the areas in which they are competent based on their  
3 education, training and experience. Levels of education, experience, and proficiency may  
4 vary among individual practitioners. It is ethically and legally incumbent on a practitioner  
5 to determine where they have the knowledge and skills necessary to perform such  
6 services and whether the services are within their scope of practice.

7  
8 It is best practice for the practitioner to appropriately render services to a member only if  
9 they are trained, equally skilled, and adequately competent to deliver a service compared  
10 to others trained to perform the same procedure. If the service would be most  
11 competently delivered by another health care practitioner who has more skill and  
12 training, it would be best practice to refer the member to the more expert practitioner.

13  
14 Best practice can be defined as a clinical, scientific, or professional technique, method, or  
15 process that is typically evidence-based and consensus driven and is recognized by a  
16 majority of professionals in a particular field as more effective at delivering a particular  
17 outcome than any other practice (Joint Commission International Accreditation Standards  
18 for Hospitals, 2020).

19  
20 Depending on the practitioner’s scope of practice, training, and experience, a member’s  
21 condition and/or symptoms during examination or the course of treatment may indicate  
22 the need for referral to another practitioner or even emergency care. In such cases it is  
23 prudent for the practitioner to refer the member for appropriate co-management (e.g., to  
24 their primary care physician) or if immediate emergency care is warranted, to contact 911  
25 as appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* policy for  
26 information.

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