Medicare peripheral nerve block policy comparison

L40267 compared with L36850 and A57452
Prepared for clinical and IPSIS policy discussions September 16, 2026

The new policy narrows chronic pain coverage to specified procedures and indications, with condition-specific response and frequency rules. The greatest implementation risk is the mismatch between the LCD's protection for one-time diagnostic blocks and its companion article's coding and repeat-block restrictions. CPT 64450 is a central example. [1,4]

Status and scope. L40267 version 6 and A60302 version 5 are future policies effective October 25, 2026. These documents apply to Wellpoint Federal jurisdictions J6 and JK: Illinois, Minnesota, Wisconsin, Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont. This is a local Original Medicare comparison, not a nationwide coverage determination. [1–4]

1 High level differences

Topic	Current policy	New policy
Coverage structure	Broader diagnostic and short-term therapeutic framework, with examples of covered uses.	Specified indications govern; unlisted therapeutic injections and denervation are noncovered. [1,2]
CPT 64450	A57452 Group 2 includes a substantial covered diagnosis list, subject to LCD criteria.	A60302 Group 8 lists 64450 as noncovered for pain management; the diagnostic exception is unresolved. [3,4]
Diagnostic testing	Expressly supports clarification of mononeuritis, unclear pain sources and selected named neuralgias.	Generally excludes one-time diagnostic blocks from scope, but regulates several named diagnostic blocks; article adds KX and repeat limits. [1,2,4]
Repeat treatment	Generally no more than 3 injections per anatomic site in 6 months; sustained relief expected.	Different rules by nerve and condition; some are hard caps and others trigger review. No general annual allowance for all nerves. [1–4]
Denervation	Includes permissive language for selected neurolysis, including occipital procedures.	Restricts coverage principally to qualifying knee OA ablation and trigeminal neuralgia RF neurolysis; occipital and suprascapular RFA are investigational. [1,2]
Surgical and acute pain	Discusses perioperative and postoperative blocks within the LCD.	Acute pain, surgical pain and regional anesthesia are generally outside scope; ordinary Medicare and NCCI rules still apply. [1,2,4]

A diagnosis appearing on a billing list never guarantees payment. Conversely, being outside this LCD's scope does not itself guarantee coverage. The applicable date of service, purpose, coding, documentation and other Medicare rules still matter.

2 Procedures retained for chronic pain

This matrix separates therapeutic coverage from diagnostic testing. “Review” is not an automatic denial, and an annual limit must not be substituted for an unspecified counting period. PNI means peripheral nerve injection; RFA means radiofrequency ablation. Sources: L40267 condition sections and A60302 utilization rules. [1,4]

Procedure	Covered use and required response	Frequency and counting rule
Median nerve Carpal tunnel	Clinical findings consistent with carpal tunnel syndrome. Corticosteroid injection; local anesthetic alone and denervation are noncovered.	LCD rationale supports up to 3 injections to the same median nerve, at least 2 months apart, with documented benefit. More than 3 may trigger review in the article. No reset interval is stated; the final policy says the lifetime limit was removed.
Stellate ganglion or lumbar sympathetic	CRPS meeting detailed diagnostic criteria, failed standard care, no alternative options remaining, and multidisciplinary care. Subsequent blocks require immediate ≥50% pain reduction and evidence of sympathetic blockade.	Beyond 5 blocks per beneficiary per lifetime: document a ≥5-point reduction in CRPS Severity Score sustained ≥3 months. This is a documentation threshold, not an absolute 5-block prohibition.
Morton neuroma	Corticosteroid with or without local anesthetic.	One steroid injection per side; repeat injections require individual medical-necessity review. No annual reset or absolute lifetime prohibition is stated.
Occipital nerve	Refractory, severe, debilitating occipital neuralgia; other headache causes excluded; medication failure or contraindication; diagnostic response >50% for the anesthetic duration.	Maximum 4 injections in 12 months; article specifies rolling 12 months. Scheduled series, other headache types and occipital RFA are not covered. Diagnostic and bilateral counting need clarification.
Suprascapular nerve	Adhesive capsulitis or degenerative/inflammatory shoulder arthritis; severe pain or restricted function; ≥12 weeks of failed conservative care; ≥50% diagnostic improvement.	Repeat requires ≥50% benefit sustained ≥2 months; adjacent language permits one repeat after ≥50% initial improvement. More than 2 therapeutic injections in 12 months may trigger review. The provisions are not fully reconciled.
Genicular ablation	Qualifying knee OA, positive diagnostic response, and poor surgical candidacy or refusal. See the detailed diagnostic criteria on the next page.	Up to 2 RFA sessions per knee per rolling 12 months. Cryoneurolysis is named, but the temperature restriction and article coding leave the payable cryotherapy pathway unclear.
Trigeminal RF neurolysis	Trigeminal neuralgia ≥6 months; medication failure or intolerance; poor surgical candidacy or refusal; ≥50% response to a diagnostic block.	Up to 2 radiofrequency treatments per rolling 12 months. Other diagnoses are excluded from denervation coverage. A separate therapeutic injection pathway is not clearly established; wording needs clarification.

General restrictions. Routine scheduled long-term injections are excluded unless specifically permitted. The policy excludes nonstandard injectates and systemic polyneuropathy or widespread diffuse pain treatment; requires informed consent and appropriate training; and requires separate medical necessity for same-day additional pain procedures. Necessary imaging can be covered only with a covered procedure, subject to coding and bundling rules. Sedation instructions conflict across the documents. [1, general limitations; 4]

Diagnostic blocks and procedures excluded from coverage

Diagnostic pathways

Diagnostic use	What the policy says
General one-time block	L40267 excludes a necessary one-time diagnostic block from scope unless specifically addressed. A60302 requires KX for initial diagnostic injections and states one session per peripheral nerve, unilateral or bilateral, without defining a reset period. [1,4]
Genicular block	Up to 2 diagnostic sessions per covered knee. Requires function-limiting moderate/severe OA; pain ≥3 months despite tolerated conservative care; radiographic Kellgren–Lawrence grade 3–4. Recent knee surgery or intra-articular injection within 3 months, inflammatory arthropathy and high injectate volumes are limitations. [1, section E]
Occipital block	Used to establish occipital neuralgia; >50% relief for the expected anesthetic duration is required before therapeutic treatment. Whether it counts toward the 4-injection total is not stated. [1, section G; 4]
Pudendal block	One diagnostic block for suspected pudendal neuralgia meeting Nantes criteria; a second is allowed in rare cases where the pain generator may have been missed. The article's repeat-billing language conflicts with this exception. [1, section I; 4]
Suprascapular block	One diagnostic injection when needed for diagnosis or surgical planning. The broader diagnostic indications do not neatly match the article's therapeutic diagnosis list. [1, section J; 4, Group 6]
Trigeminal block	Diagnostic confirmation is permitted for symptoms consistent with trigeminal neuralgia; ≥50% improvement is required before covered RF neurolysis. [1, section K]

Chronic pain procedures expressly excluded

Procedure or use	Coverage result
Digital nerve blocks	Therapeutic treatment of chronic pain from rheumatoid arthritis or other causes is noncovered. Acute or surgical use is outside the chronic pain scope. [1, section C]
Ganglion impar	Therapeutic blocks and denervation are noncovered. [1, section D]
Genicular procedures	Therapeutic injections are unsupported/noncovered; ablation for chronic pain after total knee replacement beyond the perioperative period is noncovered. [1, section E]
Posterior tibial and pudendal	Tarsal tunnel blocks for chronic foot pain and therapeutic pudendal blocks/injections or RFA are noncovered. Diagnostic pudendal use has a specific exception. [1, sections H and I]
Thoracic and other unlisted therapy	Intercostal and erector spinae plane blocks for chronic pain are noncovered. Other therapeutic PNIs or denervation not listed as covered are also noncovered. [1, section L and general limitation 7]

Outside scope is distinct from noncoverage. The LCD excludes regional surgical anesthesia, acute pain and acute nerve injury, surgical/perioperative pain, medically refractory malignancy-related pain, joint impingement and surgical neurotomy. Subacute pain and chronic postsurgical pain boundaries remain incompletely explained. [1, Issue and definitions]

3 Inconsistencies and gaps requiring correction

The first group below identifies direct conflicts or missing operational rules. These are stronger grounds for clarification than a general claim that every restriction is unsupported. Policy-based access risks are prospective; the cited documents do not establish actual post-implementation denial rates or patient outcomes.

Diagnostic access and payment

1. Diagnostic carve-out versus diagnostic restrictions. The LCD generally excludes one-time diagnostic blocks; A60512 response 19 says diagnostic blocks needed for diagnosis and selection for procedures or surgery were not intended to be restricted. Yet A60302 imposes a one-session-per-nerve rule and prohibits most repeat diagnostic billing. The LCD's "unless stated" qualification explains some named exceptions, but the article's general reach remains unclear. Correction: specify which diagnostic services are regulated and preserve a usable payment route for those outside scope. [1, Issue; 4, Utilization and KX; 5, response 19]

2. CPT 64450 has no explicit diagnostic coding exception. A60302 Group 8 lists 64450 as noncovered for pain management. Its asterisked single-diagnostic exception is attached to 64430 and 64632, not 64450. The general KX paragraph does not expressly resolve that omission. Correction: identify payable diagnostic 64450 claims, acceptable diagnoses and edits, and how diagnostic purpose is recognized. The inclusion of the neurolytic procedure code 64632 in a diagnostic-exception footnote also needs correction or explanation. [4, KX and Group 8]

3. No definition of a new diagnostic episode. The article supplies no time interval, new-condition exception, lookback period, pre-effective-date counting rule, or transfer-of-care instructions for its per-nerve diagnostic restriction. A new doctor or a new calendar year does not have a stated reset. Correction: define episode, named nerve, branch, side and materially changed diagnosis, with a safe method for clinicians to establish prior use. [4, Utilization and KX]

4. Pudendal repeat exception disappears in the article. L40267 permits a second diagnostic pudendal block in a rare missed-generator situation. A60302's KX section permits repeated diagnostic billing only for genicular blocks; Group 8 warns that subsequent starred-code injections are subject to denial. Correction: carry the LCD's pudendal exception into billing instructions and edits. [1, section I; 4, KX and Group 8]

Knee treatment and denervation

5. Diagnostic knee response is assigned a therapeutic duration. Genicular ablation eligibility includes ≥50% pain improvement and language calling for consistent pain relief or function for at least 3 months after a diagnostic injection. The same section requires low injectate volumes to improve diagnostic accuracy and does not support therapeutic genicular injections. Elsewhere, diagnostic success tracks the expected anesthetic duration. It is unclear whether the 3 months modifies the diagnostic response, another treatment response or follow-up. Correction: separate the short diagnostic response from any therapeutic-duration requirement. Otherwise a patient with a convincingly positive short block may be unable to reach ablation. [1, section E and sections G/J]

6. The article contradicts genicular RFA coverage. A60302 allows 2 RFA sessions per knee per rolling year, then says therapeutic radiofrequency neurolysis may not be billed for conditions other than trigeminal neuralgia. A subsequent 2-treatment limit is not explicitly confined to trigeminal procedures. Correction: state separate code-specific rules for knee and trigeminal treatment. Cryoneurolysis also needs a coherent covered technique, temperature, code and frequency pathway; naming it in coverage while restricting approximately −88°C treatment and listing cryo codes as noncovered is insufficient. [1, section E; 4, Utilization and Group 8]

Additional gaps affecting patients and practices

7. Sedation instructions disagree. The LCD allows exceptional, documented need for sedation during injections; its anesthesia discussion recognizes that some RFA cases may require moderate sedation or an anesthesia team. A60512 response 48 says the policy does not deny anesthesia for denervation. A60302 instead says moderate/deep sedation, general anesthesia and monitored anesthesia care should not be billed except for operative/perioperative blocks. Correction: align the article with documented exceptions and the distinction between injections and ablation. [1, general limitation 3 and Anesthesia; 4, Utilization; 5, response 48]

8. Median nerve counting lacks a time period. The final LCD expressly says the lifetime limit was removed, but its rationale still supports up to 3 injections to the same median nerve, at least 2 months apart. The article says more than 3 may trigger review. Correction: state the counting interval, whether a later recurrence starts a new course, and review criteria. This cannot responsibly be summarized as either "3 per year" or "3 for life." [1, proposed-to-final explanation and section A rationale; 4, Utilization]

9. Shoulder repeat criteria are not reconciled. One sentence allows repeats after ≥50% improvement sustained for ≥2 months; the next allows one repeat after ≥50% improvement without repeating the duration requirement. More than 2 therapeutic injections in 12 months triggers possible review rather than a categorical prohibition. Correction: publish one consistent repeat rule, specify how diagnostic injections are counted, and define criteria for an exceptional additional treatment. [1, section J; 4, Utilization]

10. Injection and session counting are ambiguous. The occipital cap does not say whether a diagnostic block is included, whether bilateral treatment counts once or twice, or how greater, lesser and third occipital nerves are counted. Morton neuroma has one injection per side and individualized repeat review but no reset or repeat-response standard. Correction: define counting units, laterality, nerve branches and acceptable documentation. A60302's generic bilateral instruction to use modifier 50 "plus add-on code" also needs procedure-specific clarification. [1, sections F/G; 4, Bilateral Procedures and Utilization]

11. CRPS restrictions lack a complete continuation pathway. After 5 lifetime sympathetic blocks, a 5-point CSS improvement lasting ≥3 months is required, but the policy does not clearly explain aggregation across limbs and sympathetic targets, access to previous clinicians' treatment history, or management of a new episode. The requirement that no alternative options remain also needs a practical definition when rehabilitation and other treatments continue. Correction: define counting, refractory status and a response-based exception process. Five blocks is not an absolute lifetime cap. [1, section B; 4, Utilization]

12. Scope and diagnosis lists do not align. The article excludes pain due to sympathetic neuropathies while providing CRPS sympathetic-block codes. The LCD defines subacute pain without a clear pathway and excludes surgical pain while restricting certain chronic postsurgical procedures. Therapeutic diagnosis lists may be narrower than permitted diagnostic evaluations. The trigeminal noncoverage sentence is grammatically ambiguous about whether the diagnosis qualification applies to both injections and denervation; only diagnostic blocks and RF neurolysis have clear affirmative pathways. Correction: map indications and exclusions to specific billing rules. [1, Issue and sections B/E/J/K; 4, scope and diagnosis groups]

13. Transition and patient exceptions are not explained. The new materials do not provide an explicit continuity rule for beneficiaries already benefiting from treatment, clarify whether earlier diagnostic blocks exhaust future eligibility, or show the operational relationship to the still-current L36850/A57452 pages. Correction: publish transition dates, history counting, claim examples and a route for individualized review before implementation. [1–4]

4 CPT 64450 and later blocks by another clinician

Are single blocks still allowed

A single therapeutic 64450 block for chronic pain is not preserved merely because it is performed once. The LCD excludes therapeutic PNIs not specifically covered, and A60302 lists 64450 as noncovered for pain management. Changing clinician, diagnosis wording or calendar year does not override that restriction. [1, limitation 7; 4, Group 8]

A true one-time diagnostic 64450 block has a stronger clinical coverage argument, but payment is unresolved. The LCD's diagnostic carve-out and the contractor's stated intent support access. The article's noncoverage list, missing 64450 asterisk and per-nerve repeat prohibition prevent a reliable promise that 64450-KX will pay. KX identifies an initial diagnostic injection under the article; it is not an override of medical necessity or an explicit guarantee against the Group 8 edit. [1, Issue; 4, KX/Group 8; 5, response 19]

Acute, surgical or perioperative use must be assessed separately. These indications are generally outside this chronic pain LCD. That does not eliminate NCCI bundling, anesthesia rules, correct-code requirements or other coverage conditions. Use a more specific nerve code when applicable; 64450 should not substitute for a named procedure to avoid a restriction. [1, Issue; 4, Coding Guidance and perioperative instructions]

Your two clinician scenario

Later procedure	Best reading and payment implication
Different named nerve for a different problem	This is not a repeat of the same nerve merely because both services use 64450. For example, a cluneal diagnostic block and a later lateral femoral cutaneous diagnostic block address different targets, assuming 64450 correctly describes each service. The per-nerve text supports the distinction, even within the same year. The unresolved 64450 coding exclusion still creates denial risk.
Same nerve for a genuinely new condition	There may be a valid clinical reason to reassess, but no new-episode exception is stated. Documenting a new diagnosis alone does not establish eligibility under the article's repeat prohibition. Written contractor clarification or an applicable named exception is needed; payment cannot be predicted.
Same nerve and same problem a year later	No annual reset is specified for general diagnostic blocks. A new year or rendering NPI does not establish a new allowance. This is at substantial denial risk under the plain repeat language, subject to specific exceptions.
Other side of the same named nerve	The article refers to one unilateral or bilateral session per peripheral nerve without explaining sequential opposite-side treatment. Do not assume the untouched side is automatically exhausted, or automatically eligible; this needs clarification.
Any later therapeutic 64450 chronic pain block	It faces the therapeutic noncoverage rule independently of whether it is a first or repeat block. A different reason does not itself create a covered indication.

These are interpretations of the published language, not tested claim outcomes. The future policy is not yet in effect as of this review. No published nerve-level claims-edit specification or case-specific payment determination was available in the reviewed materials. [1,4]

How Medicare can distinguish the services

Medicare can associate claims through the beneficiary identifier and see service dates, CPT/HCPCS codes, diagnosis links, modifiers and rendering clinicians. Those fields do not necessarily identify the exact nerve represented by a generic 64450 claim. A different NPI establishes a different clinician, not a different nerve or a new clinical episode. Distinguishing the services may therefore require the medical record and review rather than automatic claim recognition. This is an inference from the claim structure, not a description of a confirmed edit algorithm. [6; 4, Documentation Requirements]

A practical documentation and billing approach

- Retrieve the earlier procedure note when reasonably available. Record its date, named nerve and branch, side, indication, diagnostic or therapeutic intent, injectate and response. If history is incomplete, document that limitation rather than asserting that this is the first block ever.
- For the new service, name the exact target and side, symptoms and diagnosis under evaluation, examination findings, reason the prior block does not answer today's question, and how the result will change treatment or surgical planning. A merely different diagnosis code is not a substitute for this clinical distinction.
- Document diagnostic response with a standardized pain scale before and after the procedure over the expected anesthetic duration, as A60302 requires. Include relevant function, activity testing, injectate and volume, and subsequent decision making when applicable. Do not relabel a therapeutic injection as diagnostic solely to obtain payment.
- Use the correct procedure and diagnosis codes, required KX for an eligible initial diagnostic injection, and appropriate laterality or bilateral reporting for the setting. KX, RT/LT, modifier 50, or 59/XU cannot create coverage for a noncovered service. In particular, 59/XU is not a general solution to a prior-year repeat limitation.
- Ask the MAC for written instructions addressing diagnostic 64450, different nerves sharing the code, new conditions of the same nerve, and cross-provider history. Follow its accepted narrative or documentation-submission process; do not assume a free-text note will automatically bypass an edit.
- If a covered distinct service is denied, first distinguish a correctable claim error from a medical-necessity determination. For an appeal, provide the prior and current notes, target/side comparison, diagnostic purpose and relevant LCD carve-out or exception. CMS generally allows 120 days after receipt of the initial determination to request redetermination. [7]

Illustrative chart language, only when factually accurate: "This is the initial diagnostic evaluation of the right lateral femoral cutaneous nerve for the current thigh symptoms. The earlier procedure treated the left cluneal nerve for a separate pain distribution. The present result will determine [specific management decision]. Prior records and current examination support distinct nerve targets." This helps establish the facts; it does not resolve the article's 64450 noncoverage conflict.

What to tell the patient about payment

There is no defensible unconditional assurance that a diagnostic 64450 claim will be paid under the new text. When noncoverage is reasonably anticipated, use the applicable advance beneficiary notice and liability rules before service; an ABN does not make the service covered. Do not assume an LCD medical-necessity exclusion is a statutory exclusion. A60302 distinguishes the relevant noncoverage modifiers. [4, ABN Modifier Guidelines]

The priority request to the contractor is a written, code-specific diagnostic pathway plus an episode definition that protects evaluation of a distinct nerve or a materially changed condition. That would reduce both inappropriate duplicate billing and wrongful denials for new clinical problems.

Source references and implementation requests

Source review date September 16, 2026. The three requested CMS documents are the core comparison. The new companion billing article and contractor responses are necessary to assess implementation, diagnostic access and payment. Bracketed references throughout identify the numbered source and, where useful, its section.

1 New LCD L40267 version 6

Issue; general limitations; condition sections A through L; anesthesia discussion. Effective October 25, 2026.

2 Current LCD L36850 version 25

Coverage Guidance and Limitations. CMS displays this version as currently in effect; revision effective April 1, 2026.

3 Current billing article A57452

Article Guidance; Documentation Requirements; Utilization Guidelines; diagnosis Groups 1 through 3, especially Group 2 for CPT 64450.

4 New billing article A60302 version 5

Article Guidance; Utilization Parameters; KX Modifier; Documentation Requirements; diagnosis Groups 1 through 8. Effective October 25, 2026.

5 Response to comments A60512 version 3

Responses 8, 19, 20, 48, 49 and 52 distinguish contractor intent, evidence judgments and changes from the proposed policy.

6 CMS Medicare Claims Processing Manual Chapter 26

Section 10.4, CMS 1500 items 21 and 24A through 24J: diagnosis, procedure, modifier, service date and rendering provider fields.

7 CMS first level appeal guidance

Redetermination process and the usual 120 day filing period after receipt of the initial determination.

Questions of evidence and policy judgment

The LCD cites evidence limitations; it does not prove that every excluded procedure is ineffective. A challenge should identify the exact indication, evidence and proposed exception. The six-month trigeminal threshold warrants clinical reconsideration, but disagreement with a threshold is distinct from a contradiction. Predicted increases in opioid use, surgery or emergency visits are risks, not established outcomes. This report does not independently re-grade every study. [1; 5, responses 8 and 52]

Priority written clarifications for the MAC

- Confirm the payable claim and diagnosis combinations for single diagnostic 64450, including whether KX overcomes the Group 8 omission and how excluded-from-scope services are protected.
- Define diagnostic episode, nerve, branch, side, time window and treatment-history lookback; address different doctors, different indications, pre-effective-date services and bilateral care.
- Reconcile the genicular three-month response language, pudendal second diagnostic exception, knee versus trigeminal radiofrequency rules and sedation provisions.
- Clarify median, Morton, occipital and shoulder counting; publish case-review standards, transition protection and representative claim examples.