Priority Health	BILLING POLICY No. 146
Nerve Blocks for Peripheral Nerve Neuropathy	
Date of origin: September 2025	**Review dates: 7/2026**

POLICY DESCRIPTION

This policy outlines billing and payment requirements associated with nerve blocks for peripheral nerve neuropathy.

DEFINITION

Nerve blocks cause the temporary interruption of conduction of impulses in peripheral nerves or nerve trunks by the injection of local anesthetic agent(s) and/or steroid.

MEDICAL POLICY

There is currently no related Medical Policy.

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Coding

Priority Health will align with CMS for conditions considered not medically necessary. Peripheral nerve blocks (64450) coded with a diagnosis from the list that CMS considers not medically necessary will be denied.

Subcutaneous injections do not include the structures described by CPT code 64450, direct injection into other peripheral nerves, but rather the injection of tissue surrounding a specific focus. These services should not be coded with CPT code 64450. This code pertains to the additional procedure involving the administration of an anesthetic agent (nerve block) and/or steroid by a qualified healthcare professional acting within their scope of practice.

CPT/HCPCS Codes:

Code	Description
64450	Injection(s), Anesthetic agent(s) and/or Steroid: other peripheral nerve or branch

Use of the following CPT/HCPCS Codes for these treatments is inappropriate:

Code	Description
76881	Ultrasound, Complete Joint (IE, joint space and peri-articular soft-tissue structures), Real-time with image documentation
76882	Ultrasound, Limited, Joint or Focal evaluation of the nonvascular extremity structure (s) (EG, Joint

	space, Peri-articular tendon(s) Muscles (s), Nerve(s), other soft-tissue structure(s), or soft-tissue mass(es), Real- time with image documentation
76942	Ultrasonic guidance for needle placement (EG, Biopsy, Aspiration, Injection, Localization device), Imaging supervision and interpretation
76999	Unlisted ultrasound procedure (EG, Diagnostic, Interventional)
97032	Application of a modality to 1 or more areas; Electrical stimulation (Manual), Each 15 Minutes
97139	Unlisted therapeutic procedure (Specify)
G0282	Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

A57589 Billing and Coding: Nerve Blocks for Peripheral Neuropathy

L35222 Nerve Blocks for Peripheral Neuropathy

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures,

DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
7/2026	Added language that PH align with CMS for conditions not considered medically necessary