October 29, 2025

**Electronic Submission via:** policydraft@noridian.com

Noridian Healthcare Solutions, LLC
4510 13th Ave. S, STE1
Fargo, ND 58103-6646

**RE: Draft Local Coverage Determination for Peripheral Nerve Blocks and Procedures for Chronic Pain (DL40265)**

To Whom It May Concern:

The American Association of Nurse Anesthesiology (AANA) welcomes the opportunity to comment on the draft local coverage determination (LCD) for Peripheral Nerve Blocks (PNBs) and Procedures for Chronic Pain (DL40265). This proposed LCD narrows coverage for PNBs and denervation procedures, which, if finalized as proposed, will risk limiting patient access to proven therapies, exacerbate health disparities, and increase reliance on opioids or more invasive options. Specifically, AANA offers the following recommendations and comments:

- Revise LCD to Expand Exceptions Beyond Malignancy-Related Pain to Include Refractory Neuropathic or Musculoskeletal Pain After Documented Failure of First-Line Therapies.
- Revise the LCD to Eliminate Lifetime Caps and Allow for Additional Injections with Documentation of Greater Than 50 Percent Sustained Improvement from Prior Interventions and With No Viable Alternatives.
- Clarify the Sedation Criteria for PNBs and Provide Templates for Documentation to Reduce Administrative Burden.

AANA is the professional association for Certified Registered Nurse Anesthetists (CRNAs) and student registered nurse anesthetists (SRNAs). AANA membership includes more than 67,000 CRNAs and SRNAs, representing about 88 percent of the nurse anesthetists in the United States. CRNAs are advanced practice registered nurses (APRNs) who personally administer more than 58 million anesthetics to patients each year in the United States.[1] AANA members have previously served as subject matter experts (SME) on the development of draft LCDs related to chronic pain management as part of Multi-jurisdictional Contractor Advisory Committee (CAC)

[1] For further information see: https://www.aana.com/about-us.

meetings. CRNAs are recognized for the vital role in providing patient focused, comprehensive pain care in communities throughout the United States.

**AANA Request: Revise LCD to Expand Exceptions Beyond Malignancy-Related Pain to Include Refractory Neuropathic or Musculoskeletal Pain After Documented Failure of First-Line Therapies**

We request that Noridian Healthcare Solutions revise the LCD to expand exceptions for the use of beyond malignancy-related pain to include refractory neuropathic or musculoskeletal pain after documented failure of first-line therapies (e.g., serotonin-norepinephrine reuptake inhibitors [SNRIs], transcutaneous electrical nerve stimulation [TENS]). AANA is deeply concerned that DL40265 improperly restricts access to essential peripheral nerve blocks (PNBs) and denervation procedures for Medicare beneficiaries with chronic pain, by deeming many interventions "not reasonable and necessary" without sufficient consideration of emerging evidence. This current proposal could disproportionately affect vulnerable populations noted in the LCD's background, such as older adults and minorities who experience higher chronic pain prevalence, and it undermines CRNAs' ability to provide opioid-sparing care in Noridian Healthcare Solutions' jurisdictions. This proposal is also counterproductive given the Administration's current public health emergency related to the opioid crisis affecting the nation.[2]

The proposal's non-coverage list, including genicular nerve blocks (GNBs), occipital nerve blocks, etc. overlooks moderate-to-high quality evidence demonstrating their efficacy for common conditions like knee osteoarthritis (OA) and chronic headaches. For genicular nerve radiofrequency ablation (GNRFA) in knee OA, a 2025 systematic review of 28 studies found that GNRFA provides clinically significant pain reduction in the majority of patients, with pooled analyses showing modest to substantial improvements in pain scores and function, lasting up to 12 months or longer when using large lesion techniques.[3] Another 2024 review of randomized controlled trials (RCTs) and retrospective studies confirmed GNRFA's superiority over genicular nerve blocks alone in long-term pain control and safety, with low complication rates.[4] A 2023 study further demonstrated reduced postoperative opioid use and improved function post-GNRFA.[5] These findings align with American Society of Regional Anesthesia and Pain Medicine (ASRA) guidelines, which support GNRFA for refractory knee OA.

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[2] https://aspr.hhs.gov/legal/PHE/Pages/Opioids-Renewal-18Sept2025.aspx.

[3] Cooper A, Sen H, Thiyagarajan S, Chang KH, Luo H, Conger A, McCormick ZL, Ehsanian R. Effectiveness of Genicular Nerve Radiofrequency Ablation in Osteoarthritis and Post-surgical Knee Pain: Systematic Review. Pain Med. 2025 Aug 26:pnaf115. doi: 10.1093/pm/pnaf115.

[4] Toubasi AYM, Myles A, Singh P, Sun Z, Dua A. Genicular Nerve Block Versus Genicular Nerve Ablation for Knee Osteoarthritis: A Systematic Review of Randomized Controlled Trials and Retrospective Studies. Cureus. 2025 Feb 16;17(2):e79106. doi: 10.7759/cureus.79106.

[5] Caragea M, Woodworth T, Curtis T, Blatt M, Cheney C, Brown T, Carson D, Kuo KT, Randall D, Huang EY, Carefoot A, Teramoto M, Mills M, Cooper A, Burnham T, Conger A, McCormick ZL. Genicular nerve radiofrequency ablation for the treatment of chronic knee joint pain: a real-world cohort study with evaluation of prognostic factors. Pain Med. 2023 Dec 1;24(12):1332-1340. doi: 10.1093/pm/pnad095.

For occipital nerve blocks in chronic headaches, a 2023 systematic review and meta-analysis showed significant reductions in headache severity and frequency following occipital nerve blocks, with sustained benefits in migraine and cluster headache patients.[6] A 2024 RCT confirmed greater occipital nerve block (GONB) efficacy in chronic migraine, reducing pain intensity and improving quality of life.[7] A narrative review highlighted GONB's role as both diagnostic and therapeutic for refractory headaches, with minimal side effects.[8] These procedures are endorsed in ASRA and American Society of Anesthesiologists (ASA) advisories for neurologic pain management.

We, therefore, request that Noridian Healthcare Solutions revise the LCD to expand exceptions beyond malignancy-related pain to include refractory neuropathic or musculoskeletal pain after documented failure of first-line therapies and to tie coverage to outcomes-based criteria rather than blanket exclusions, consistent with evidence-based guidelines.

**AANA Request: Revise the LCD to Eliminate Lifetime Caps and Allow for Additional Injections with Documentation of Greater Than 50 Percent Sustained Improvement from Prior Interventions and With No Viable Alternatives**

We request that Noridian Healthcare Solutions revise the LCD to eliminate lifetime caps and to allow for additional injections with documentation of greater than 50 percent sustained improvement from prior interventions and with no viable alternatives. The proposed lifetime limits of three corticosteroid injections for carpal tunnel syndrome (CTS) per side and two for Morton's neuroma proposed in the LCD are overly restrictive and may not accommodate recurrent or bilateral conditions, potentially denying care to patients with progressive neuropathies. These arbitrary limits contradict Medicare's reasonable and necessary standard.[9]

While the LCD cites moderate evidence for short-term benefits in CTS, it underestimates the value of repeat injections in delaying surgery and managing relapses, which is critical for Medicare beneficiaries who may not be surgical candidates due to comorbidities. On repeat injections for CTS, a long-term study found that 50 percent of patients receiving repeat corticosteroid injections achieved symptomatic relief for one year or more, with many avoiding

[6] Evans AG, Joseph KS, Samouil MM, Hill DS, Ibrahim MM, Assi PE, Joseph JT, Kassis SA. Nerve blocks for occipital headaches: A systematic review and meta-analysis. J Anaesthesiol Clin Pharmacol. 2023 Apr-Jun;39(2):170-180. doi: 10.4103/joacp.JOACP_62_21. Epub 2023 Apr 25.
[7] Ertilav E, Aydın ON. Comparison of the efficacy of repeated greater occipital nerve block and pulsed radiofrequency therapy in chronic migraine patients: a randomized controlled study. J Oral Facial Pain Headache. 2024 Sep;38(3):100-107. doi: 10.22514/jofph.2024.031.
[8] William H. Arata, Rajiv K. Midha, Giustino Varrassi, Kelly Sala, Michael J. Plessala, Jared Brodtmann, Kylie Dufrene, Zachary Palowsky, Patricia Griffin, Shahab Ahmadzadeh, Sahar Shekoohi, Alan D. Kaye. Occipital nerve block for headaches: a narrative review. Journal of Oral & Facial Pain and Headache. 2024. 38(2);1-10.
[9] https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/coverage/medicare-coverage-items-and-services

surgery altogether.[10] Another analysis showed that only 33 percent of patients progressed to carpal tunnel release within 5 years post-injection, indicating that injections, including repeats, effectively extend non-surgical management.[11] The American Academy of Orthopaedic Surgeons (AAOS) 2024 Clinical Practice Guideline acknowledges strong evidence against long-term improvement but supports short-term use, noting that local injections outperform splinting in nocturnal paresthesia remission (84.6 percent vs. 43.8 percent at one month). For recurrent CTS, evidence suggests that oral corticosteroids are less effective than injections, and repeats may be necessary every 6-12 weeks in select cases.

**AANA Request: Clarify the Sedation Criteria for PNBs and Provide Templates for Documentation to Reduce Administrative Burden**

We request that Noridian Healthcare Solutions clarify the sedation criteria for PNBs and provide templates for documentation to reduce administrative burden. The draft LCD's near-prohibition on moderate or deep sedation, general anesthesia, or monitored anesthesia care (MAC) for PNBs is overly prescriptive and may compromise safety for patients with severe anxiety, needle phobia, or complex medical histories. While AANA supports minimizing unnecessary sedation, the draft LCD's stance that oral anxiolytics typically suffice ignores evidence-based guidelines allowing sedation in exceptional cases. ASRA's 2024 advisory on nerve blocks under anesthesia highlights that while nerve injury risk is a concern, benefits like improved patient tolerance often outweigh risks in select populations, with recommendations for careful monitoring. The Second ASRA Practice Advisory on Neurologic Complications (2015, updated guidance ongoing) advises against routine deep sedation but permits it with informed consent and sterile technique, noting low complication rates. ASA guidelines echo this, supporting MAC for anxious patients during regional anesthesia. A StatPearls review confirms PNBs are generally well-tolerated but notes sedation enhances feasibility in high-anxiety cases. We therefore request that this criteria align with ASRA/ASA guidelines by allowing sedation in "exceptional and unique cases" without presuming it is "rarely indicated," ensuring patient-centered care.

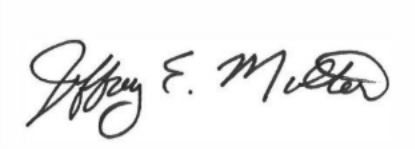
The laborious documentation requirements for exceptions and same-day procedures could impose undue administrative burdens on CRNAs and other pain providers, delaying care and increasing costs. Therefore, we also request that Noridian Healthcare Solutions provide templates for documentation to reduce this administrative burden.

We thank you for the opportunity to comment on this draft local coverage determination. Should you have any questions regarding these matters, please feel free to contact Romy Gelb-Zimmer, AANA Director of Regulatory Affairs at rgelb-zimmer@aana.com.

[10] Dardas AZ, VandenBerg J, Shen T, Gelberman RH, Calfee RP. Long-Term Effectiveness of Repeat Corticosteroid Injections for Trigger Finger. J Hand Surg Am. 2017 Apr;42(4):227-235. doi: 10.1016/j.jhsa.2017.02.001.

[11] Jenkins PJ, Duckworth AD, Watts AC, et al. Corticosteroid injection for carpal tunnel syndrome: a 5-year survivorship analysis. Hand (N Y) 2012;7:151–156. doi: 10.1007/s11552-012-9390-8.

Sincerely,



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AANA President

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Ingrida Lusis, AANA Chief Advocacy Officer