Headache and Occipital Neuralgia Treatment

Table of Contents

Coverage Policy .................................................. 1
Overview.............................................................. 2
General Background ........................................... 2
Coding/Billing Information ................................. 10
References .......................................................... 12

Related Coverage Resources

Acupuncture
Biofeedback
Botulinum Therapy
Chiropractic Care
Deep Brain, Motor Cortex and Responsive Cortical Treatment
Electrical Stimulation and Therapy Devices
Hyperbaric Oxygen Therapy, Systemic & Topical
Minimally Invasive Intradiscal/Annular Procedures and Trigger Point Injections
Omnibus Codes
Oxygen for Home Use
Physical Therapy
Transcatheter Closure of Septal Defects
Transcranial Magnetic Stimulation
Vagus Nerve Stimulation (VNS)

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Coverage Policy

Each of the following ablative treatments, electrical stimulation or neurosurgeries is considered experimental, investigational or unproven for the treatment of headache (e.g., chronic migraine, chronic cluster or cervicogenic headache) or occipital neuralgia (this list may not be all-inclusive):

- cervical microdecompression surgery (Jho Procedure)
- cryodenervation
- discectomy and spinal fusion
- electrical stimulation of occipital nerve
• ganglionectomy
• nerve root decompression
• neurectomy
• occipital nerve neurolysis
• pulsed radiofrequency ablation
• radiofrequency ablation
• radiofrequency denervation
• radiofrequency neurotomy
• rhizotomy

Overview

This Coverage Policy addresses ablative treatments, electrical stimulation or neurosurgeries for the treatment of headache (e.g., chronic migraine, chronic cluster or cervicogenic headache) or occipital neuralgia.

General Background

Cervicogenic headache and occipital neuralgia are syndromes whose diagnosis and treatment have been reported as controversial in the medical literature due to lack of expert consensus regarding their etiology and treatment. The terminology refers to specific types of headache thought to arise from impingement or entrapment of the occipital nerves and/or the upper spinal vertebrae (Dinakar, 2016; Evans, 2004; Biondi, 2001; Vincent, et al., 1998; Bogduk, 2001).

The clinical features of cervicogenic headache may mimic those associated with primary headache disorders (e.g., tension-type headache, migraine, or hemicrania continua), making it difficult to distinguish among headache types (Biondi, 2005; Martelletti, 2004).

Numerous treatments or procedures for headaches (e.g., chronic migraine, chronic cluster or cervicogenic headache) and occipital neuralgia have been proposed, with varying levels of success. The consensus on standard treatment does not exist, because of the variability in patient selection and clinical outcomes. Pharmacological treatment with oral analgesics, anti-inflammatory medications, tricyclic antidepressants, and anticonvulsant medications have been used alone or in combination with other treatment modalities. Other methods suggested are: the use of a cervical collar during the acute phase; physical therapy with stretching and strengthening exercises; postural training; relaxation exercises; transcutaneous nerve stimulation (TENS); and manual therapy, including spinal manipulation and spinal mobilization (Bogduk, et al., 2009; Biondi, 2005, 2001; Martelletti, et al., 2004).

In a review of medical textbooks, commonly used treatments for pain relief from cervicogenic headache and occipital neuralgia include the use of local injected anesthetics, with or without the addition of corticosteroid preparation, to block the affected nerve(s). It is noted that these injections can be used as therapeutic treatment measures for pain relief, although the duration of pain relief varies from hours to months. However, the scientific evidence regarding injection therapy or percutaneous nerve block for occipital neuralgia and cervicogenic headache has been limited (Dinakar, 2016; Peters, 2004; Chavin, 2003).

Pharmacological and alternative treatment modalities are not effective for some individuals, and therefore other methods have been proposed, such as local injections of anesthetics and/or steroids and epidural steroid injections. Botulinum Toxin Type A (Botox® A) has been investigated as a treatment of occipital neuralgia and cervicogenic headaches (Kapural, et al., 2007; Freund, et al., 2000).

Ablative treatments (e.g., pulsed radiofrequency ablation, radiofrequency ablation, radiofrequency neurotomy, radiofrequency denervation, neurolysis, cryodenervation, nerve root shizotomy) have been investigated attempt to denervate the occipital and/or upper cervical nerve. Surgical interventions have been investigated as a treatment option to relieve impingement of the nerve root(s) and thereby eliminate symptoms caused by compression and injury to the cervical nerves, including but not limited to, ganglionectomy, nerve root decompression, cervical microdecompression ((Jho Procedure) (Zhang, et al., 2011; Ducic, et al., 2009; Lee, et
Electrical stimulation (e.g., occipital nerve stimulation, peripheral nerve stimulation, and peripheral nerve field stimulation) has been proposed as a treatment for occipital neuralgia and headaches. Electrical stimulation can be delivered transcutaneously, percutaneously and by using an implantable device. Peripherally implanted nerve stimulation entails the placement of electrodes near or on a selected peripheral nerve such as the occipital nerves at the base of the head. Percutaneous or open implantation of a neurostimulator electrode array is a technique being investigated for treatment of chronic pain such as occipital neuralgia. Electrical stimulation is delivered by a pulse generator and an electrode that is placed subcutaneously at the site of maximum pain rather than at the site of the nerve. This technique is also referred to as subcutaneous target stimulation or peripheral nerve field stimulation (May, 2016; Garza, et al., 2017; Garzia, 2014). Occipital or peripheral nerve stimulation for chronic migraines has been referred to as the Omega Procedure or Reed Procedure®.

For information on the coverage of peripheral nerve field stimulation for the treatment of chronic pain, please refer to the Cigna HealthCare Coverage Position, Omnibus Codes.

For information on coverage of the Cefaly Supraorbital Transcutaneous Neurostimulator (Cefaly-Technology, Herstal, Belgium) for the treatment of migraine headache, please refer to the Cigna HealthCare Coverage Position, Electrical Stimulation and Therapy Devices.

**U.S. Food and Drug Administration (FDA)**

Currently, the FDA has not cleared any occipital nerve stimulation device for the treatment of headache or occipital neuralgia.

Radiofrequency ablation (RFA) is a procedure and, therefore, is not subject to regulation by the FDA. However, the devices used to perform RFA are regulated by the FDA premarket approval process. There are numerous devices listed in the FDA 510(k) database approved for RFA. Two product codes are dedicated to these devices, one for radiofrequency lesion generators (GXD) and one for radiofrequency lesion probes (GXI) (FDA, 2016). Currently no electrical or radiofrequency devices are approved to treat headache or occipital neuralgia.

**Literature Review**

**Local Injection Therapy**

There is a lack of well-designed, randomized control studies in the peer-reviewed literature relating to Botox A therapy as an effective treatment for cervicogenic headache or occipital neuralgia. The limited evidence comes primarily from small retrospective case series studies. Long term outcomes have not been reported in the studies. Further controlled studies are required to assess the efficacy of this approach in a large series of patients with cervicogenic headache or occipital neuralgia (Kapurul et al., 2007; Martelleti, et al., 2004; Freund, et al., 2000; Hobson, et al., 1997).

For information on the coverage of Botox A for the treatment of cervicogenic headache and other types of headaches, please refer to the Cigna HealthCare Coverage Position, Botulinum Therapy.

**Neurosurgery**

A number of different surgical procedures have been investigated for the treatment of occipital neuralgia and cervicogenic headache. Several small retrospective case series studies have reported positive effects of various surgical treatments. However, there were recurrences of pain and varying levels of pain relief and duration. No specific characteristics could be identified that were predictive of a positive outcome or sustained response to treatment. Larger studies with longer periods of follow-up are needed to confirm the benefits reported in the available studies.

In a retrospective study, Gande et al. (2015) reported on the long-term efficacy of cervical dorsal root rhizotomy (CDR) in the management of patients with refractory medical occipital neuralgia (ON). A retrospective chart review of 75 ON patients who underwent cervical dorsal root rhizotomy was performed. Fifty-five patients were included because they met the International Headache Society's (IHS) diagnostic criteria for ON, responded to
CT-guided nerve blocks at the C-2 dorsal nerve root, and had at least one follow-up visit. Telephone interviews were additionally used to obtain data on patient satisfaction. Forty-two patients (76%) were female, and the average age at surgery was 46 years (range 16-80). Average follow up was 67 months (range 5-150). Etiologies of ON included the following: idiopathic (44%), posttraumatic (27%), postsurgical (22%), post-cerebrovascular accident (4%), post-herpetic (2%), and postviral (2%). At last follow-up, 35 patients (64%) reported full pain relief, 11 (20%) partial relief, and 7 (16%) no pain relief. The extent of pain relief after CDR was not significantly associated with ON etiology (p=0.43). Of 37 patients whose satisfaction-related data were obtained, 25 (68%) reported willingness to undergo repeat surgery for similar pain relief, while 11 (30%) reported no such willingness; a single patient (2%) did not answer this question. Twenty-one individuals (57%) reported that their activity level/final functional state improved after surgery, 5 (13%) reported a decline, and 11 (30%) reported no difference. The most common acute postoperative complications were infections in 9% (n=5) and CSF leaks in 5% (n=3); chronic complications included neck pain/stiffness in 16% (n=9) and upper-extremity symptoms in 5% (n=3) such as trapezius weakness, shoulder pain, and arm paresthesias. The study was limited by its size and lack of control group.

In a retrospective chart review, Pisapia et al. (2012) evaluated 29 patients who had undergone C2 nerve root decompression (n=11), C2 dorsal root ganglionectomy (n=10), or decompression followed by ganglionectomy (n=8) for intractable occipital neuralgia. The overall results stated that 19 of 29 patients (66%) experienced a good or excellent outcome at most recent follow-up. A total of 34% of the patients reported poor outcome in that the headache was unchanged or worse at a mean follow-up of 45 months. Of the 19 patients who completed the telephone questionnaire (mean follow-up 5.6 years), patients undergoing decompression, ganglionectomy, or decompression followed by ganglionectomy experienced similar outcomes. Of 19 telephone responders, 68% rated overall operative results as very good or satisfactory and 37% poor rated overall operative results as unchanged or worse. The study was limited by its size and lack of control group.

In a retrospective chart review, Acar et al. (2008) evaluated 20 patients who had undergone C2 and/or C3 ganglionectomies for intractable occipital pain. Patients were interviewed regarding pain relief, pain relief duration, functional status, medication usage and procedure satisfaction, preoperatively, immediately postoperative, and at follow-up (mean 42.5 months). C2, C3 and consecutive ganglionectomies at both levels were performed on 4, 5, and 11 patients, respectively. All patients reported preoperative pain relief following cervical nerve blocks. Average visual analog scale scores were 9.4 preoperatively and 2.6 immediately after procedure. Ninety-five percent of patients reported short-term pain relief (<3 months). In 13 patients (65%), pain returned after an average of 12 months (C2 ganglionectomy) and 8.4 months (C3 ganglionectomy). Long-term results were excellent, moderate and poor in 20, 40 and 40% of patients, respectively. Cervical ganglionectomy offers relief to a majority of patients, immediately after procedure, but the effect is short lived. The authors reported that cervical ganglionectomy offers relief to a majority of patients, immediately after procedure, but the effect is short lived.

In a retrospective study (n=10), Gille et al. (2004) evaluated a new surgical treatment for greater occipital neuralgia consisting of neurolysis of the greater occipital nerve and section of the inferior oblique muscle. All of the patients had pain exacerbated by flexion of the cervical spine. Mean follow-up was 37 months. The results of the treatment were assessed based on: degree of pain on a visual analog scale (VAS) before surgery, at three months, and at last follow-up; consumption of analgesics before surgery and at follow-up; and the degree of patient satisfaction at follow-up. Anatomic anomalies (i.e., hypertrophy of the venous plexus around C2, nerve penetration of the inferior oblique muscle, and degenerative C1–C2 osteoarthritis) were found in three patients. The mean VAS score was 80/100 before surgery and 20/100 at last follow-up. The majority of the patients were satisfied or very satisfied with the operation. Patients reported a decrease in analgesic consumption.

Kapoor et al. (2003) reported in a retrospective study the results of 17 patients with occipital neuralgia who underwent intradural rhizotomies after experiencing positive results from computed tomography (CT) fluoroscopy-guided C2 or C3 nerve root blocks. Immediately after surgery, all patients had complete pain relief. Patients were followed for a mean of 20 months. At follow-up, 11 patients (64.7%) had complete relief of symptoms; two (11.8%) had partial relief, and four (23.5%) had no relief. Of the nine patients who had undergone previous surgery, four reported complete relief (44.4%); four patients (44.4%) reported no relief, and one reported partial relief. Eight out of 16 (50%) reported more activity and function after surgery; however, 25% felt they were either unchanged or less functional than before surgery. There was a trend toward better response
to rhizotomy in patients without prior head or neck surgery. The study was limited by its size and lack of control group.

Jansen (2000) reported in a retrospective study the results of three different surgical treatments in 102 patients with cervicogenic headache that had been nonresponsive to physical or drug therapy. A group of 38 patients were treated with C2 ganglionectomy, and 64 patients with demonstrable spinal structural abnormalities were treated with dorsal or ventral spinal decompression and fusion. Complete relief of pain was reported by 80% of the entire group, and 60–80% relief was experienced by approximately 15% of patients; 6% of patients experienced no relief of pain. Mean duration of pain relief varied: five months for dorsal decompression, 14 months for ventral decompression and 44 months for C2 ganglionectomy.

Pikus et al. (1996) reported in a retrospective study a total of 39 microsurgical decompression procedures of the C2 root and ganglion in 35 patients who met diagnostic criteria for cervicogenic headache. Long-term, pain-free outcome (assessed after a mean of 21 months) was achieved by 33% of patients. Another 46% of patients reported adequate relief, while 21% had recurrence of pain at an average of 18 months after surgery. No specific prognostic characteristics were discernible from the analysis performed on the patient population.

Bovim et al. (1992b) investigated the immediate and long-term results of surgical release of the greater occipital nerve within the trapezius for treatment of patients who previously had relief of the symptoms of cervicogenic headache with nerve blockade. Of 50 patients responding to a questionnaire sent to 58 patients, 46% reported immediate relief, and 36% reported some immediate improvement. However, after a mean follow-up of 14.5 months, only 56% of patients felt that the procedure had been beneficial. The authors recommended further investigation into the efficacy of alternative procedures.

Other Treatment Modalities

A variety of other therapeutic modalities (e.g., ablative treatments and electrical stimulation of the occipital nerve) have been studied for the treatment of occipital neuralgia and headaches that do not respond to pharmacological and/or physical therapy. Larger studies with longer periods of follow-up are needed to confirm the benefits reported in the available studies.

Ablative: In a retrospective study, Huang et al. (2012) reported on pulsed radiofrequency (PRF) for occipital neuralgia to determine whether any demographic, clinical, or treatment characteristics are associated with success. A total of 102 patients with a primary diagnosis of occipital neuralgia were treated with PRF of the greater and/or lesser occipital nerve. A positive primary outcome was predefined as ≥ 50% pain relief lasting at least three months. The secondary outcome measure was procedural satisfaction. A total of 51% of the patients experienced ≥ 50% pain relief and satisfaction with treatment lasting at least three months. This study was limited by design and lack of long-term outcomes.

In a prospective study, Vanedleren et al. (2010) reported on the results of six months of follow-up in which patients presenting with clinical findings suggestive of occipital neuralgia and a positive test block of the occipital nerves underwent a pulsed radiofrequency procedure of the nerves. Mean scores for pain, quality of life, and medication intake were measured one, two, and six months after the procedure. Pain was measured by the visual analog and Likert scales, quality of life was measured by a modified brief pain questionnaire, and medication intake was measured by a Medication Quantification Scale. Approximately 52.6% of patients reported a score of six (pain improved substantially) or higher on the Likert scale after six months. No complications were reported. This study was limited by design of the study and lack of long-term outcomes.

In a prospective study, Halime et al. (2010) reported on 86 patients who had undergone lateral C1-2 joint pulsed radiofrequency application, for cervicogenic headache in a single pain center. The percentage of patients who had 350% pain relief at two months, six months, and one year were 50% (43/86), 50% (43/86), and 44.2% (38/86), respectively. Longterm pain relief at six months and one year were predicted reliably by ≥50% pain relief at two months (p<0.001). One patient complained of increased severity of occipital headache lasting several hours. This study was limited by design of the study and lack of long-term outcomes.

In a retrospective study, Lee et al. (2007) studied the clinical efficacy of radiofrequency cervical zygapophyseal joint neurotomy in patients with cervicogenic headache. A total of thirty patients suffering from chronic
cervicogenic headaches for longer than six months and showing a pain relief by greater than 50% from diagnostic/prognostic blocks were included in the study. These patients were treated with radiofrequency neurotomy of the cervical zygapophyseal joints and were subsequently assessed at one week, one month, six months, and at 12 months following the treatment. The results of this study showed that radiofrequency neurotomy of the cervical zygapophysial joints significantly reduced the headache severity in 22 patients (73.3%) at 12 months after the treatment. The limitations of this study include the lack of a control group and small sample size.

In a randomized controlled study, Haspeslagh et al. (2006) compared the efficacy of a radiofrequency treatment with treatment by local injection of the greater occipital nerve in patients with cervicogenic headache (n=30). Fifteen patients received a sequence of radiofrequency treatments (cervical facet joint denervation, followed by cervical dorsal root ganglion lesions when necessary), and the other 15 patients underwent local injections with steroid and anesthetic at the greater occipital nerve, followed by TENS when necessary. Visual analogue scores for pain, global perceived effects scores, quality of life scores were assessed at 8, 16, 24 and 48 weeks. Patients also kept a headache diary. There were no statistically significant differences between the two treatment groups at any time point in the trial. The authors reported that they did not find evidence that radiofrequency treatment of cervical facet joints and dorsal root ganglion is an effective treatment for patients fulfilling the clinical criteria of cervicogenic headache. The authors reported that many patients in clinical practice are treated with neurotomies despite the lack of evidence for positive outcomes.

In a randomized, double-blind, placebo-controlled study, Stovner et al. (2004) studied radiofrequency denervation of facet joints C2 through C6 in cervicogenic headache (n=12). The patients had some improvement three months after treatment, but there were no marked differences between the two groups, concluding that the procedure is probably not beneficial for cervicogenic headaches.

Govind et al. (2003) studied 49 patients with occipital headaches who underwent percutaneous radiofrequency neurotomy. Eighty-eight percent of the patients achieved a successful outcome (complete relief of pain for at least 90 days). The median duration of relief in these patients was 297 days. While the results were promising in this study, it lacked a control group which leads to difficulties in interpretation of the findings.

Nagar et al. (2015) conducted a systematic review to investigate the clinical utility of radiofrequency (RF) neurotomy, and PRF ablation for the management of cervicogenic headache. The primary outcome measures were headache relief and improved quality of life. A total of nine studies met inclusion criteria. In the selected studies there were inconsistencies between randomized trials, flaws in trial design, and gaps in the chain of evidence. The authors reported that there is limited evidence to support RF and pulsed RFA therapies for management of cervicogenic headache. There is a need for high quality randomized controlled trials (RCTs) and/or multiple consistent non-RCTs without methodological flaws to evaluate the efficacy of RF and pulsed RFA therapies for cervicogenic headache.

Electrical Stimulation: In a randomized, multicenter controlled study, Dodick et al. (2015) reported the 52 week results of the efficacy and safety of peripheral nerve stimulation (PNS) of the occipital nerves for managing intractable chronic migraine (ICM). A total of 157 participants were initially implanted with a neurostimulation system, randomized 2:1 to an active treatment or sham treatment control group for 12 weeks. After the initial 12 week study period, there was no difference in the percentage of subjects with a 50% reduction in their visual analog score for pain, although pain intensity, headache days and migraine-related disability improved. Participants subsequently received open-label treatment for an additional 40 weeks. Outcomes collected included number of headache days, pain intensity, migraine disability assessment (MIDAS), Zung Pain and Distress (PAD), direct patient reports of headache pain relief, quality of life, satisfaction and adverse events. Statistical tests assessed change from baseline to 52 weeks using paired t-tests. Intent-to-treat (ITT) analyses of all patients (n=157) and analyses of only patients who met criteria for ICM (n=125) were performed. A total of 46 (29%) individuals were excluded from ITT analysis and 36 (29%) from the ICM group, due to loss to follow-up or explantation of the system. Headache days data at baseline and 52-week were available for 111 patients in the ITT population and for 89 patients in the ICM population. At 52 weeks, mean headache days at baseline were 21.6 for the ITT population and 24.2 for a subset of subjects with ICM. In the ITT population, headache days decreased by 6.7 days, and by 7.7 (±8.7) days in the ICM population. The percentages of participants who experienced a 30% and 50% reduction in headache days and/or pain intensity were 59.5% and 47.8%
respectively. Excellent or good headache relief was reported by 65.4% of the ITT group and 67.9% of the intractable CM group. A total of 68% of the participants were satisfied with the headache relief provided by the neurostimulation system. More than half the subjects in both cohorts were satisfied with the headache relief provided by the device. There were a total of 209 adverse events (AEs), and 111/157 (70.7%) of the implanted patients experienced one or more AE. A total of 85 subjects (40.7%) required surgical intervention and 18 (8.6%) required hospitalization. Some of the participants (18%) experienced persistent pain and/or numbness with the device. The authors reported that although the surgical techniques associated with implantation of PNS devices for occipital nerve stimulation have improved, the complication rates are still high and refinements in both the technology and implantation techniques are required. A follow-up period of at least three years would be ideal for determining the overall sustainability of the therapy as well as the cumulative adverse event profile.

In a prospective case series study, Melvin et al. (2007) investigate the effectiveness of peripheral nerve stimulation in reducing occipital headache pain. This was a two-week pilot study involving 11 patients evaluated before and after implantation of PNS systems to treat C2-mediated occipital headaches. Most patients (91% and 64% respectively) reported reductions in medication use and numbers of headaches. Patients also reported a reduction in headache symptoms and the impact of headaches on activities. Two adverse events were encountered, one due to a loose connection and, the other caused by lead migration. The study design lacked randomized patient selection and a control group, and its data were collected by clinical staff rather than an independent third party, which could have influenced the patients’ responses.

Slavin et al. (2006) analyzed records of 14 patients with intractable occipital neuralgia treated with peripheral nerve stimulation. All of the patients in the study were diagnosed with chronic, intractable occipital neuralgia. Overall, 23 occipital nerves were stimulated in 14 patients. Seventeen trials in 10 patients were considered successful, and those patients had permanent internalization of the stimulator. At the time of the last follow-up examination (mean 22 months), seven patients with implanted peripheral nerve stimulation had adequate pain control. Two patients had their systems explanted because of loss of stimulation effect or significant improvement of pain, and one patient had part of their hardware removed because of infection. The authors stated this study had a large variation between patients in regard to the etiology of their occipital neuralgia; therefore, they were unable to find any correlation between etiology of occipital neuralgia and the outcome of stimulation.

In a case series study, Weiner et al. (1999) studied bilateral or unilateral percutaneous peripheral nerve electrical stimulation in 13 patients with medically refractory occipital neuralgia. In seven patients ablative therapies such as cryotherapy or C2 rhizotomy had also failed. The authors reported that this procedure provided 50% or greater relief of pain for all for up to five years (mean 2.4 years). Nine patients reported > 75% pain relief. In one patient symptoms of occipital neuralgia resolved completely and the device was explanted. The method of pain measurement was not reported and the study did not assess quality of life. A limitation of this study is the small number of study participants.

In a systematic review, Yang et al. (2016) evaluated the clinical efficacy and safety of ONS for treating migraine. A total of five randomized controlled trials, four retrospective studies, and one prospective study met the inclusion criteria. Results from the case series and retrospective studies indicated that ONS significantly reduced the pain intensity and the number of days with headache in patients with migraine. However, the evidence of ONS efficacy established by randomized controlled trials was limited. The mean complication incidence of ONS was 66% for the reviewed studies. The authors reported that future clinical studies should optimize and standardize the ONS intervention process and identify the relationship among the surgical process, efficacy, and complications resulting from the procedure.

Chen et al. (2015) conducted a systematic review and meta-analysis to examine the effectiveness and adverse effects of occipital nerve stimulation (ONS) for chronic migraine. A total of five randomized controlled trials (RCTs) (n=402) and seven case series (n=115) met the inclusion criteria. Pooled results from three multicenter RCTs show that ONS was associated with a mean reduction of 2.59 days of prolonged, moderate to severe headache per month at three months compared with a sham control. Results for other outcomes generally favor ONS over sham controls but quantitative analysis was hampered by incomplete publication and reporting of trial data. Lead migration and infections are common and often require revision surgery. The authors reported that while the effectiveness of ONS compared to sham control has been shown in multiple RCTs, the average effect
size is modest and may be exaggerated by bias as achieving effective blinding remains a methodological challenge. Measures to reduce the risk of adverse events and revision surgery are needed. Long-term data is limited. Apart from the one year results of one RCT, evidence is available from single-centre case series, which could only provide imprecise estimations with uncertain generalizability.

In a systematic review, Jasper and Hayek (2008) evaluated the strength of evidence that occipital nerve stimulation is an effective treatment of benign headache. Varied types of headache etiologies including migraine, transformed migraine, chronic daily headache, cluster headache, hemicraniectomy, occipital neuralgia, and cervicogenic headache have been studied with peripheral nerve field stimulation and found responsive to stimulation of the suboccipital region, known commonly as occipital nerve stimulation. No randomized controlled trials were identified. Occipital nerve stimulation was reportedly successful for 70–100% of patients. The authors reported that reduction of pain in patients with occipital headaches and transformed migraine is significant and rapid with occipital nerve stimulation. No long-term adverse events occurred. Several short-term incidents occurred including infection, lead displacement, and battery depletion. The authors reported that the body of evidence as a whole is limited.

In a Hayes Medical Directory Report on Occipital Nerve Stimulation for Chronic Cluster Headache and Chronic Migraine Headache the authors report that “Overall, the quality of the evidence supporting the use of occipital nerve stimulation (ONS) for the treatment of refractory chronic cluster and migraine headaches is very low, reflecting the limited number, weak design, and small sample size of most of the available studies. Only one of the eight studies was a randomized controlled trial (RCT), none of the other studies provided any control, and six had sample sizes less than 15 patients. One consequence of the small sample size is the limited ability to use inferential statistics to test ONS-related changes in headache outcomes. Thus, most of the reviewed study findings were descriptive and not necessarily reflective of a treatment effect of ONS. One of the reviewed studies did not systematically collect data or define outcome measures, and instead presented outcomes as case studies. Most of the studies did not report patient exclusion criteria, and many studies provided minimal reporting of inclusion criteria. Although all of the patients had a diagnosis of cluster or migraine headache, other variables could have varied considerably across patients (e.g., concomitant health conditions, duration of time living with headache, age, etc.). An additional drawback is that firm conclusions regarding ONS for a specific headache diagnosis of either cluster or migraine would be difficult given that only four studies examined ONS for each headache type. However, most of the studies were recent (six of eight in the last 3 years), highlighting that the application of ONS to these headache types is emerging and likely to include a growing body of literature in the future. An important consideration is the potential for cluster and migraine headaches to have unique mechanisms of action and thus unique responses to ONS. Additional studies are needed to look at each of these primary headaches in isolation. In summary, although all of the reviewed studies demonstrated beneficial effects of ONS for the majority of patients, these findings require replication in large sample, prospective, RCTs”. The 2014, 2015 and 2016 annual reviews state that the review of abstracts indicates the results of these studies will not change their conclusions (Hayes, 2012, 2014, 2015, 2016).

In a Hayes Health Technology Brief on Electrical Stimulation of the Occipital Nerve for Treatment of Occipital Neuralgia the authors summary of the evidence states, “Results of the available studies provide preliminary evidence that subcutaneous electrical stimulation of the greater and lesser occipital nerves offers long-term relief in some patients who have intractable occipital neuralgia. Although the available studies of this technique are small and uncontrolled, most of the patients had experienced symptoms of occipital neuralgia for more than 2 years and had failed to respond adequately to optimal conservative treatments. The overall quality of the evidence is low since the studies are all small in size and none of them compared the outcomes of patients treated with ONS with patients in a control group. Since occipital neuralgia is a rare disorder, it does not seem feasible to conduct large-scale, randomized controlled trials to evaluate the efficacy of electrical stimulation therapy versus other standard therapies. Furthermore, while a study that included randomization of patients to optimal medical therapy versus ONS would be ideal, the patients who are good candidates for ONS are usually referred because they have failed optimal medical therapy. Larger studies with longer periods of follow-up are needed to confirm the benefits reported in the available studies. Despite the remaining questions and paucity of solid evidence, ONS may be a reasonable option for carefully selected patients with occipital neuralgia that is refractory to standard treatment, and that is having a negative impact on quality of life” (Hayes, 2011; 2014).
National Institute for Health and Clinical Excellence (NICE) (United Kingdom) NICE Clinical Guidance on Occipital Nerve Stimulation for Intractable Chronic Migraine issued in 2013 states, “The evidence on occipital nerve stimulation (ONS) for intractable chronic migraine shows some efficacy in the short term but there is very little evidence about long-term outcomes. With regard to safety, there is a risk of complications, needing further surgery” (NICE, 2013).

In an UptoDate review on chronic migraine the authors state that “There are inconsistent data from small randomized trials regarding the benefit of occipital nerve stimulation for the treatment of chronic migraine. In the largest trial, there was no significant difference at 12 weeks for the primary endpoint, the percentage of patients that had a ≥50 percent reduction in mean daily pain score in the active compared with the control group. However, there were statistically significant if modest improvements with active stimulation for a number of secondary endpoints, including the percentage of patients with a ≥30 percent reduction in mean daily pain score, and reduction in the mean number of headache days and migraine-related disability. The findings from these reports are limited by concerns about blinding in the control (sham treatment) groups, given that active treatment causes paresthesia, and relatively high rates of complications, including lead migration in 14 to 24 percent of subjects. Further trials are needed to determine if occipital nerve stimulation is a useful therapy for chronic migraine” (Garza, et al., 2017). This review does not mention the use of surgical interventions as therapeutic options.

Professional Societies/Organizations
Sweet et al. (2015) conducted a systematic review of the literature to provide recommendations for the use of occipital nerve stimulation (ONS) for the treatment of patients with medically refractory occipital neuralgia (ON). A multidisciplinary task force of volunteer neurosurgeons and pain management physicians comprised a Guidelines Task Force responsible for the formation of this evidence-based guideline. A total of nine studies met the criteria for inclusion in this guideline. All articles provided Class III Level evidence. Based on the data derived from this systematic literature review, the following Level III recommendation was made: the use of ONS is a treatment option for patients with medically refractory ON.

American Association of Neurological Surgeons (AANS)/Congress of Neurological Surgeons (CNS) Classification of Evidence on Therapeutic Effectiveness and Levels of Recommendation state:

Class I evidence
- Level I recommendation: Evidence from ≥ 1 well-designed, randomized controlled clinical trials, including overview of such trials

Class II evidence
- Level II recommendation: Evidence from ≥ 1 well-designed comparative clinical studies, such as nonrandomized cohort studies, case-control studies, and other comparable studies, including less well designed randomized, controlled trial

Class III evidence
- Level III recommendation: Evidence from case series, comparative studies with historical controls, case reports, and expert opinion, as well as significantly flawed, controlled trials

The 2012 American Academy of Neurology (AAN) evidence based guideline update: NSAIDs and other complementary treatments for episodic migraine prevention in adults does not mention local injection therapies, ablative treatments, electrical stimulation or neurosurgeries as complimentary treatments for migraine (Holland, et al, 2012).

The American Association of Neurological Surgeons (AANS) patient website states, “Often, occipital neuralgia symptoms will improve or disappear with heat, rest, physical therapy including massage, anti-inflammatory medications, and muscle relaxants. Oral anticonvulsant medications such as carbamazepine and gabapentin may also help alleviate pain. Percutaneous nerve blocks may not only be helpful in diagnosing occipital neuralgia, but can also help alleviate pain. Nerve blocks involve either the occipital nerves or in some patients, the C2 and/or C3 ganglion nerves. It is important to keep in mind that repeat blocks using steroids may cause serious adverse effects.” Surgical intervention (i.e., microvascular decompression, occipital nerve stimulation)
may be considered when the pain is chronic, severe and does not respond to conservative treatment” (AANS, 2013).

The American Board of Internal Medicine’s (ABIM) Foundation Choosing Wisely® Initiative (2014): No relevant statements.

Use Outside of the US
The Eon™ stimulator (St. Jude Medical, Inc.) has received CE mark approval in Europe for the treatment of chronic migraines (Hitt, 2012).

The British Association for the Study of Headache (BASH) established guidelines for healthcare professionals in the diagnosis and management of migraine, tension-type, cluster, and medication-overuse headaches in 2010. The guideline cites occipital nerve stimulation as a possible treatment, but it states that occipital nerve stimulation is still under investigation at specialist centers. No specific guidelines were set for occipital nerve stimulation.

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22590</td>
<td>Arthrodesis, posterior technique, craniocervical (occiput-C2)</td>
</tr>
<tr>
<td>62281</td>
<td>Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic</td>
</tr>
<tr>
<td>63020</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical</td>
</tr>
<tr>
<td>63035</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>63040</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical</td>
</tr>
<tr>
<td>63043</td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>63048</td>
<td>Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>63075</td>
<td>Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctectomy; cervical, single interspace</td>
</tr>
<tr>
<td>63076</td>
<td>Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctectomy; cervical, each additional interspace (List separately)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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</tr>
<tr>
<td>63185</td>
<td>Laminectomy with rhizotomy; 1 or 2 segments</td>
</tr>
<tr>
<td>64590</td>
<td>Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling</td>
</tr>
<tr>
<td>63190</td>
<td>Laminectomy with rhizotomy; more than 2 segments</td>
</tr>
<tr>
<td>64550</td>
<td>Application of surface (transcutaneous) neurostimulator</td>
</tr>
<tr>
<td>64553</td>
<td>Percutaneous implantation of neurostimulator electrode array; cranial nerve</td>
</tr>
<tr>
<td>64555</td>
<td>Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)</td>
</tr>
<tr>
<td>64568</td>
<td>Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator</td>
</tr>
<tr>
<td>64569</td>
<td>Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator</td>
</tr>
<tr>
<td>64570</td>
<td>Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator</td>
</tr>
<tr>
<td>64575</td>
<td>Incision for implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)</td>
</tr>
<tr>
<td>64585</td>
<td>Revision or removal of peripheral neurostimulator electrode array</td>
</tr>
<tr>
<td>64633</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint</td>
</tr>
<tr>
<td>64634</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>64640</td>
<td>Destruction by neurolytic agent; other peripheral nerve or branch</td>
</tr>
<tr>
<td>64716</td>
<td>Neuroplasty and/or transposition; cranial nerve (specify)</td>
</tr>
<tr>
<td>64722</td>
<td>Decompression, unspecified nerve(s) (specify)</td>
</tr>
<tr>
<td>64744</td>
<td>Transection or avulsion of; greater occipital nerve</td>
</tr>
<tr>
<td>64999†</td>
<td>Unlisted procedure, nervous system</td>
</tr>
<tr>
<td>0282T</td>
<td>Percutaneous or open implantation of neurostimulator electrode array(s), subcutaneous (peripheral subcutaneous field stimulation), including imaging guidance, when performed, cervical, thoracic or lumbar; for trial, including removal at the conclusion of trial period (Code deleted 12/31/2016)</td>
</tr>
<tr>
<td>0283T</td>
<td>Percutaneous or open implantation of neurostimulator electrode array(s), subcutaneous (peripheral subcutaneous field stimulation), including imaging guidance, when performed, cervical, thoracic or lumbar; permanent, with implantation of a pulse generator (Code deleted 12/31/2016)</td>
</tr>
<tr>
<td>0284T</td>
<td>Revision or removal of pulse generator or electrodes, including imaging guidance, when performed, including addition of new electrodes, when performed (Code deleted 12/31/2016)</td>
</tr>
<tr>
<td>0285T</td>
<td>Electronic analysis of implanted peripheral subcutaneous field stimulation pulse generator, with reprogramming when performed (Code deleted 12/31/2016)</td>
</tr>
</tbody>
</table>

†Note: Considered Experimental, Investigational/Unproven when used to report ganglionectomy, neurectomy or pulsed radiofrequency ablation of the occipital nerve.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0720</td>
<td>Transcutaneous electrical nerve stimulation (TENS) device, 2 lead, localized stimulation</td>
</tr>
<tr>
<td>E0730</td>
<td>Transcutaneous electrical nerve stimulation (TENS) device, 4 or more leads, for multiple nerve stimulation</td>
</tr>
<tr>
<td>E0745</td>
<td>Neuromuscular stimulator, electronic shock unit</td>
</tr>
<tr>
<td>L8679</td>
<td>Implantable neurostimulator, pulse generator, any type</td>
</tr>
<tr>
<td>L8680</td>
<td>Implantable neurostimulator electrode, each</td>
</tr>
</tbody>
</table>
L8682 | Implantable neurostimulator radiofrequency receiver
L8683 | Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685 | Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686 | Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
L8687 | Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688 | Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension


References


