

## DRAFT Medical Coverage Policy | Surgical Deactivation of Migraine Headache Trigger Sites



**EFFECTIVE DATE:** 10|02|2012

**POLICY LAST REVIEWED:** 02|07|2024

### OVERVIEW

Surgical deactivation of trigger sites is a proposed treatment of migraine headache. The procedure involves identifying a patient's predominant migraine trigger site and transecting the branches of the trigeminal nerve supplying that area of head and neck. The treatment is based on the theory that migraine headaches arise due to inflammation of trigeminal nerve branches in the head and neck caused by irritation of the surrounding structures. The technique could potentially be used to treat other types of headache (e.g. tension headaches).

### MEDICAL CRITERIA

Not applicable

### PRIOR AUTHORIZATION

Not applicable

### POLICY STATEMENT

#### Medicare Advantage Plans

Surgical deactivation of migraine headache trigger sites is not covered as the evidence is insufficient to determine the effects of the technology on health outcomes.

#### Commercial Products

Surgical deactivation of migraine headache trigger sites is considered not medically necessary as the evidence is insufficient to determine the effects of the technology on health outcomes.

### COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement, or Benefit booklet applicable "not medically necessary" benefits/coverage.

### BACKGROUND

Migraine is a common headache disorder with a prevalence in the United States of approximately 18% in women and 6% in men. According to the International Headache Society (2018), migraine headache is a recurrent disorder with attacks lasting 4 to 72 hours. Typical features of migraine headaches include unilateral location, pulsating quality, moderate or severe intensity, and associated symptoms such as nausea, photophobia, and/or phonophobia.

### Treatment

A variety of medications are used to treat acute migraine episodes. They include medications taken at the onset of an attack to abort the attack (triptans, ergotamines), and medications to treat the pain and other symptoms of migraines once they are established (eg, non-opioid analgesics, antiemetics). Prophylactic medication therapy (eg, certain antidepressants, beta-blockers, and anti-seizure medications) may be appropriate for people with migraines that occur more than 2 days per week. In addition to medication, behavioral treatments such as relaxation and cognitive therapy are used to manage migraine headache.

### Surgical Deactivation

Surgical deactivation of trigger sites is another proposed treatment of migraine headaches. The procedure was developed by plastic surgeon (Bahman Guyuron, MD), following observations that some patients who had cosmetic forehead lifts reported improvement or elimination of migraine symptoms postsurgery.<sup>3,4</sup> The procedure is based on the theory that migraine headaches arise due to inflammation of trigeminal nerve branches in the head and neck caused by irritation of the surrounding musculature, bony foramen, and perhaps fascia bands. Accordingly, surgical treatment of migraines involves removing the relevant nerve sections, muscles, fascia, and/or vessels. The treatment is also based on the theory that there are specific migraine trigger sites and that these sites can be located in individual patients. In studies conducted by Guyuron's research group, clinical evaluation and diagnostic injections of botulinum toxin have been used to locate trigger sites. The specific surgical procedure varies according to the patient's migraine trigger site. The surgical procedures are performed under general anesthesia in an ambulatory care setting and take an average of 1 hour.

Surgical procedures have been developed at 4 trigger sites: frontal, temporal, rhinogenic, and occipital. Frontal headaches are believed to be activated by irritation of the supratrochlear and suborbital nerves by glabellar muscles or vessels. The surgical procedure involves removal of the glabellar muscles encasing these nerves. Fat from the upper eyelid is used to fill the defect in the muscles and shield the nerve. Temporal headaches may be activated by inflammation of the zygomatico-temporal branch of the trigeminal nerve by the temporalis muscles or vessels adjacent to the nerve. To treat migraines located at this trigger site, a segment (>2.5 cm) of the zygomatico-temporal branch of the trigeminal nerve is removed endoscopically. Rhinogenic headaches may involve intranasal abnormalities (eg, deviated septum), which may irritate the end branches of the trigeminal nerve. Surgical treatment includes septoplasty and turbinectomy. Finally, occipital headaches may be triggered by irritation of the occipital nerve caused by the semispinalis capitis muscle or the occipital artery. Surgery consists of removal of a segment of the semispinalis capitis muscle medial to the greater occipital nerve approximately 1 cm wide and 2.5 cm long, followed by insertion of a subcutaneous flap between the nerve and the muscle to avoid nerve impingement.

For individuals who have migraine headaches who receive surgical deactivation of headache trigger sites, the evidence includes randomized controlled trials. Relevant outcomes are symptoms, change in disease status, ~~morbidity events~~, and treatment-related morbidity. Three randomized controlled trials have been published; only one used a sham control and blinded patients to treatment group. All three reported statistically significantly better outcomes at 12 months in patients who received decompression surgery for migraine headache than the control intervention. However, the trials were subject to methodologic limitations (eg, unclear and variable patient selection processes, variability in surgical procedures depending on trigger site). In addition, findings from 2 trials not blinded or sham-controlled were subject to the placebo effect. Additional sham-controlled randomized studies are needed. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have non-migraine headaches who receive surgical deactivation of headache trigger sites, the evidence includes no published studies. Relevant outcomes are symptoms, change in disease status, morbid events, and treatment-related morbidity. The evidence is insufficient to determine the effects of the technology on health outcomes.

## **CODING**

### **Medicare Advantage Plans and Commercial Products**

There is no specific CPT or HCPCS code(s) for surgical deactivation of migraine headache trigger sites. Therefore, providers should report this service with an unlisted procedure code(s).

If any of the following CPT code(s) are reported with a diagnosis of Migraines (refer to list of ICD-10 CM listed, below), the service will be considered not covered for Medicare Advantage Plans and not medically necessary for Commercial Products:

**30140** Submucous resection inferior turbinate, partial or complete, any method

**30520** Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

**64716** Neuroplasty and/or transposition; cranial nerve (specify)

**67900** Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

### ICD-10-CM

G43.001-G43.919

G43.E01 - G43.E19 (New Codes Effective 10/01/2023)

### RELATED POLICIES

Unlisted Procedures

### PUBLISHED

Provider Update, April 2024

Provider Update, May 2023

Provider Update, June 2022

Provider Update, April 2021

Provider Update, May 2020

### REFERENCES

1. Bigal ME, Lipton RB. The epidemiology, burden, and comorbidities of migraine. *Neurol Clin.* May 2009; 27(2): 321-34. PMID 19289218
2. Headache Classification Committee of the International Headache Society (IHS) The International Classification of Headache Disorders, 3rd edition. *Cephalalgia.* Jan 2018; 38(1): 1-211 . PMID 29368949
3. Guyuron B, Reed D, Kriegler JS, et al. A placebo-controlled surgical trial of the treatment of migraine headaches. *Plast Reconstr Surg.* Aug 2009; 124(2): 461-468. PMID 19644260
4. Liu MT, Armijo BS, Guyuron B. A comparison of outcome of surgical treatment of migraine headaches using a constellation of symptoms versus botulinum toxin type A to identify the trigger sites. *Plast Reconstr Surg.* Feb 2012; 129(2): 413-419. PMID 21987048
5. Stewart WF, Lipton RB, Kolodner KB, et al. Validity of the Migraine Disability Assessment (MIDAS) score in comparison to a diary-based measure in a population sample of migraine sufferers. *Pain.* Oct 2000; 88(1): 41-52. PMID 11098098
6. Yang M, Rendas-Baum R, Varon SF, et al. Validation of the Headache Impact Test (HIT-6™) across episodic and chronic migraine. *Cephalalgia.* Feb 2011; 31(3): 357-67. PMID 20819842
7. Martin BC, Pathak DS, Sharfman MI, et al. Validity and reliability of the migraine-specific quality of life questionnaire (MSQ Version 2.1 ). *Headache.* Mar 2000; 40(3): 204-15. PMID 10759923
8. Guyuron B, Kriegler JS, Davis J, et al. Comprehensive surgical treatment of migraine headaches. *Plast Reconstr Surg.* Jan 2005; 115(1): 1-9. PMID 15622223
9. Guyuron B, Kriegler JS, Davis J, et al. Five-year outcome of surgical treatment of migraine headaches. *Plast Reconstr Surg.* Feb 2011; 127(2): 603-608. PMID 20966820
10. Headache Classification Committee of the International Headache Society (IHS). The International Classification of Headache Disorders, 3rd edition (beta version). *Cephalalgia.* Jul 2013; 33(9): 629-808. PMID 23771276
11. Mathew PG. A critical evaluation of migraine trigger site deactivation surgery. *Headache.* Jan 2014; 54(1 ): 142-52. PMID 24116941
12. Omranifard M, Abdali H, Ardakani MR, et al. A comparison of outcome of medical and surgical treatment of migraine headache: In 1 year follow-up. *Adv Biomed Res.* 2016; 5: 121 . PMID 27563631
13. Loder E, Weizenbaum E, Frishberg B, et al. Choosing wisely in headache medicine: the American Headache Society's list of five things physicians and patients should question. *Headache.* 2013; 53(10): 1651-9. PMID 24266337

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