

General

Increasing Denials of Genicular Nerve Procedures Threaten Post-TKA Pain Management and May Drive Opioid Utilization

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Total knee arthroplasty (TKA) remains one of the most commonly utilized orthopedic surgeries for end-stage knee osteoarthritis, yet a substantial minority of patients continue to experience chronic postsurgical pain. Contemporary cohort studies and meta-analyses suggest that approximately 20% of patients report persistent pain after TKA, with a meaningful subset describing moderate-to-severe pain that impairs function and health-related quality of life.¹⁻³ These patients frequently exhaust conservative measures with limited relief and often are not candidates for revision surgery.

Over the past decade, genicular nerve interventions such as nerve blocks followed by thermal or cooled radiofrequency ablation (RFA) have demonstrated significant promise in the management algorithm for chronic knee pain, especially following TKA. Randomized controlled trials and prospective studies in knee osteoarthritis demonstrate that genicular nerve blocks and RFA can provide clinically meaningful pain reduction and functional improvement, often lasting several months or longer.⁴⁻⁷ A growing literature further confirms that genicular RFA has been integrated into real-world interventional pain practices and can effectively treat knee pain related to osteoarthritis as well as chronic pain following TKA.^{8,9} Several recent reports extend this evidence base specifically to chronic pain after otherwise uncomplicated TKA.^{7,9-11} These studies, along with ongoing publications, collectively support the view that genicular nerve blocks and RFA are rational, evidence-informed options for managing refractory post-TKA knee pain, rather than experimental curiosities.

Yet, in our recent experience as interventional pain specialists working closely with orthopedic colleagues, we are seeing a troubling trend of insurance payers increasingly reclassifying genicular nerve blocks and RFA as “experimental” or “investigational” for knee pain, including after

TKA, and denying coverage despite more and more published data. These denials effectively remove one of the few minimally invasive options available for patients whose prostheses are mechanically sound but who live with disabling pain. In many cases, revision surgery is neither indicated nor likely to improve symptoms, leaving both the orthopedic surgeon and the pain specialist with a shrinking set of tools.

When these procedures are restricted, clinicians are often forced back toward systemic pharmacotherapy, including an increased reliance on opioids, for patients with recalcitrant pain. This movement runs directly counter to contemporary pain-care policy and guideline recommendations, which emphasize judicious opioid use, preference for non-opioid and nonpharmacologic strategies when possible, and a careful balancing of benefits and risks of long-term opioid therapy. For a patient with persistent pain after TKA and intact hardware, denying coverage for targeted interventions such as genicular nerve blocks or RFA forces pain medicine specialists to go back to the opioid prescription pad, which is difficult to reconcile with these principles.

We respectfully urge orthopedic and pain societies, along with insurance carriers, to recognize and highlight the accumulating data supporting genicular nerve interventions for chronic knee pain after TKA. We also encourage professional organizations to engage payers to re-evaluate coverage determinations for these procedures in light of the available evidence. Without expanded access to genicular nerve blocks and ablation procedures, we risk an unintended drift back toward increased opioid prescribing in a population where safer, more targeted options exist.

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