



Medical Coverage Policy

Effective Date12/15/2026

Next Review Date9/15/2027

Coverage Policy Number..... 0587

Open Neuroplasty Lumbar Plexus

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benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses open surgical neuroplasty of the lumbar plexus, a procedure performed to relieve pressure on the nerve(s) by releasing scar tissue or other surrounding structures (e.g., fascia, ligaments) in the treatment of lumbar plexus-related neuropathies.

Coverage Policy

Lumbar Plexus–Related Neuropathy

1. Open neuroplasty of the lumbar plexus is considered **medically necessary** when **ALL** of the following criteria are met (a through d):
 - a. Documented nerve compression (i.e., MRI, CT, EMG/NCS, or ultrasound) involving the lumbar plexus or related nerve branch (e.g., lateral femoral cutaneous nerve [LFCN])
 - b. Clinical findings consistent with nerve involvement including sensory symptoms and/or motor deficits resulting in documented functional impairment
 - c. **EITHER** of the following:
 - i. symptoms have persisted despite at least 3 months of conservative treatments (i.e., activity modification, physical therapy, oral medications [e.g., NSAIDs, neuropathic pain agents], and/or local anesthetic/corticosteroid injection)), or
 - ii. conservative treatment is not indicated (e.g., acute trauma)
 - d. For suspected lateral femoral cutaneous nerve (LFCN) involvement, a positive diagnostic nerve block with temporary symptom relief

Other Conditions

2. Open neuroplasty of the lumbar plexus is considered **not medically necessary** for **ANY** other indication, including but not limited to conditions not consistent with lumbar plexus-related neuropathy (e.g., lumbar radiculopathy or other spinal nerve root pathology, generalized peripheral neuropathy).

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

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CPT®* Codes	Description
64714	Neuroplasty, major peripheral nerve, arm, or leg, open; lumbar plexus

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Background and Supporting Information

Lumbar Plexus–Related Neuropathy

The nervous system is composed of the central nervous system (brain and spinal cord) and the peripheral nervous system, which includes the nerves extending from the spinal cord. Peripheral nerves transmit electrochemical signals between the central nervous system and muscles or organs. The lumbar plexus, a component of the peripheral nervous system, is a network of nerves located in the lower back (lumbar region), formed from branches of spinal nerves (L1–L4) that extend outward from the spinal cord (anterior rami) and branch within the psoas muscle. Major branches include the femoral and obturator nerves, along with smaller sensory branches such as the lateral femoral cutaneous nerve (LFCN). Collectively, these nerves provide sensory innervation to the lower abdomen, groin, genital region, thigh, and medial leg, and contribute to motor function of the anterior thigh and adductor muscle groups. The lumbar plexus forms part of the larger lumbosacral plexus, an interconnected network coordinating motor and sensory function of the lower body. Due to its deep location within the pelvis and complex branching pattern, disorders affecting the lumbar plexus may be difficult to differentiate from more common lumbosacral radiculopathies (Castoro & Arnold, 2025; Rubin, 2020).

Lumbar plexus–related neuropathies may arise from a range of etiologies, including mechanical compression (e.g., anatomic constraints, external forces, repetitive motion, trauma, or postsurgical scarring), as well as inflammatory or immune-mediated processes, metabolic conditions (e.g., diabetes), and neoplastic processes. A well-recognized example is lateral femoral cutaneous nerve (LFCN) entrapment, commonly referred to as meralgia paresthetica, which results from compression of the LFCN as it passes under the inguinal ligament, leading to sensory symptoms in the anterolateral thigh. The plexus may also be affected by adjacent structural abnormalities such as hematomas, abscesses, aneurysms, or masses. Systemic conditions, particularly diabetes, may result in radiculoplexus neuropathy through inflammatory or microvascular mechanisms. Across these etiologies, nerve injury is commonly associated with impaired perfusion resulting in ischemia, intraneural edema, and segmental demyelination. In milder cases, injury may be limited to myelin disruption (neuropraxia) with potential for recovery following resolution of the underlying cause. More severe or prolonged injury may result in axonal damage or complete disruption, leading to Wallerian degeneration and more prolonged or incomplete recovery (Castoro & Arnold, 2025; Dhawan, 2021; Pitman et al., 2025; Scholz et al., 2023; Rubin, 2020).

Clinical presentation varies depending on the portion of the plexus involved but typically includes pain, sensory disturbance, and, in some cases, motor deficits. Pain is often localized to the anterior or medial thigh and may be described as aching, burning, or radiating. Sensory disturbances commonly affect the anterolateral or medial thigh, while motor involvement may manifest as weakness in hip flexion, knee extension, or thigh adduction due to involvement of the femoral and obturator nerves (Rubin, 2020). A distinguishing feature of plexopathies is that findings are often patchy and extend beyond a single nerve or root distribution, which can complicate differentiation from radiculopathy or mononeuropathy (Dhawan, 2021; Rubin, 2020).

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In more severe cases, muscle atrophy and functional impairment may occur. Risk factors vary by etiology and may include diabetes, obesity, advancing age, trauma, prior surgery, and prolonged or external compression (e.g., tight fitting pants or heavy tight belts) (Castoro & Arnold, 2025; Scholz et al., 2023; Schönberg et al., 2023; Rubin, 2020).

Diagnosis requires a comprehensive and individualized approach incorporating clinical evaluation, electrodiagnostic studies, and imaging. A detailed history should assess symptom onset and progression, history of trauma, and associated systemic conditions such as diabetes or malignancy. Physical examination focuses on identifying patterns of weakness, reflex changes, and sensory loss to support localization to the plexus (e.g., dysesthesia of the lateral thigh to light touch or pinprick). Imaging, particularly magnetic resonance imaging (MRI) and MR neurography, is used to identify structural causes of nerve compression such as masses, fibrosis, or anatomic abnormalities, and to exclude spinal etiologies. Imaging findings may include nerve enlargement, edema, or signal abnormalities within affected nerve segments. Studies have reported MRI sensitivity of approximately 71–73% and specificity of 94–95%, and neurosonography sensitivity of 87–96% and specificity of 90–96%. Ultrasound may also be valuable for identifying focal nerve enlargement through side-to-side comparison of cross-sectional areas. Electrodiagnostic testing, including nerve conduction studies (NCS) and electromyography (EMG), may assist in confirming plexopathy, localizing the lesion, and assessing severity. Findings may include reduced motor and sensory amplitudes consistent with axonal loss and abnormal spontaneous activity on needle EMG in affected muscles. In individuals with suspected meralgia paresthetica, diagnostic nerve block of the lateral femoral cutaneous nerve (LFCN) is frequently used to confirm the diagnosis and support localization. Temporary symptom relief following local anesthetic injection is considered a positive diagnostic response and may help distinguish LFCN entrapment from alternative etiologies. Incorporation of diagnostic nerve injection as part of surgical selection has also been associated with higher rates of favorable postoperative outcomes (Castoro & Arnold, 2025; Finerty et al., 2025; Pitman et al., 2025; Scholz et al., 2023; Dhawan, 2021; Rubin, 2020).

Management of lumbar plexus-related neuropathies is individualized based on etiology and severity. Conservative treatment is typically first-line and may include activity modification, physical therapy, weight optimization, pharmacologic management of neuropathic pain (e.g. NSAIDs, steroids, gabapentinoids), and/or corticosteroid injections. Surgical intervention, including decompression and neurolysis, may be considered in patients with severe or persistent symptoms or when a clear structural source of compression is identified. The goal of surgical decompression (open neuroplasty) is to relieve nerve pressure caused by scar tissue, adhesions, or other compressive factors through direct access to the affected nerve, with the intent of improving nerve function and alleviating symptoms such as pain, weakness, or functional impairment (Castoro & Arnold, 2025; Scholz et al., 2023; Schönberg et al., 2023; Rubin, 2020).

U.S. Food and Drug Administration (FDA)

The FDA does not regulate surgical procedures. Any medical devices, drugs, biologics, or tests used as a part of these procedures may be subject to FDA regulation.

Literature Review: The available evidence evaluating open surgical neuroplasty of the lumbar plexus is limited and consists primarily of nonrandomized studies, including systematic reviews of observational data, prospective cohort studies, and retrospective case series evaluating surgical treatment for meralgia paresthetica. Across studies, comparators vary and include conservative management, local anesthetic or corticosteroid injections, and alternative surgical approaches such as neurectomy, nerve grafting, or nerve transfer. Overall, findings suggest that decompression of the lateral femoral cutaneous nerve (LFCN) may result in improvement or resolution of symptoms in a majority of selected individuals, with systematic review data reporting

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favorable outcomes in approximately 63% to 88% of cases, particularly when preceded by diagnostic confirmation (e.g., response to nerve block) and failure of conservative therapy. Broader evidence examining lumbosacral plexus interventions demonstrates variable outcomes depending on injury location and severity, with neurolysis associated with improvement in pain and function in select populations, though not consistently restoring function. Key limitations across the evidence base include the absence of randomized controlled trials, small sample sizes, heterogeneous study populations and interventions, reliance on subjective outcome measures, and variability in diagnostic and surgical selection criteria (Finerty et al., 2025; Reuter et al., 2025; Scholz et al., 2023; Nichols et al., 2022; Ataizi et al., 2019; Khalil et al., 2012).

Finerty et al. (2025) conducted a systematic review of 21 non-randomized studies (n=616) evaluating diagnostic criteria used to select individuals for surgical treatment of meralgia paresthetica. The review assessed associations between diagnostic modalities and surgical outcomes following decompression or neurectomy of the lateral femoral cutaneous nerve (LFCN), with a mean follow-up of 3.5 years. Clinical history and response to local anesthetic injection of the affected nerve were the most consistently utilized diagnostic criteria, used in 100% and 90% of studies, respectively. Overall, 84.7% of surgical cases reported a favorable postoperative outcome, generally reflecting improvement or resolution of symptoms after surgery, with outcome rates ranging from 64.3% to 100% across individual studies. Studies that incorporated diagnostic nerve injection as part of surgical selection demonstrated higher rates of favorable outcomes compared with those that did not (88% versus 77%, $p=0.00041$), supporting the use of targeted diagnostic confirmation when selecting individuals for surgical intervention. A higher rate of favorable outcomes was also reported among studies that utilized electromyography (97% versus 83%); however, the number of individuals evaluated with electromyography was limited. No other diagnostic modality demonstrated a consistent association with improved outcomes or achieved statistical significance. Study limitations include lack of randomized controlled trials, small study populations, heterogeneous diagnostic criteria, and non-standardized outcome measures.

Reuter et al. (2025) conducted a prospective single-arm study evaluating outcomes after open lateral femoral cutaneous nerve (LFCN) decompression surgery for meralgia paresthetica. The study included 26 individuals (15 males; 11 females; mean age 48.3 years; mean BMI 27.0 kg/m²) who underwent LFCN decompression with a minimum follow-up of one year. Surgery was indicated for persistent LFCN-related symptoms including pain or paresthesia that were unresponsive to at least three months of conservative treatment such as lifestyle changes, weight loss, and medication. Individuals were also required to demonstrate significant symptom improvement following a preoperative ultrasound-guided nerve block, with or without ultrasound evidence of nerve entrapment. Outcomes were assessed using pre- and postoperative questionnaires evaluating pain, sensory function, and social limitations, including the Brief Pain Inventory and Pain Disability Index. Of the 26 individuals included, 80.8% reported prior surgery or significant trauma in the pelvic region or affected area, 34.6% reported prior injury, 73.1% reported prior surgery, 19.2% had a hip prosthesis, and 15.4% had type 1 or type 2 diabetes. Three individuals who reported no preoperative pain and underwent decompression for sensory deficits affecting daily activities were excluded from pain outcome assessment. Postoperatively, 95.8% of individuals experienced pain relief, and 76.9% achieved complete pain elimination (numeric rating scale [NRS] score of 0). Mean pain decreased from 6.6 preoperatively to 0.7 postoperatively ($p<0.001$), and maximum pain decreased from 8.0 to 1.0 ($p<0.001$). Sensory outcomes also improved, with 61.2% achieving full sensory preservation and 95.8% reporting improvement in numbness affecting the anterolateral thigh. Additionally, Pain Disability Index findings showed improvement across family life and daily chores, hobbies and sports, and social activities. Results indicated that individuals with prior injury or surgery in the affected region had greater pain reduction than those without these histories. Individuals with diabetes had lower observed pain reduction than those without diabetes, suggesting that localized traumatic or

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postsurgical compression may be more responsive to decompression than systemic or metabolic etiologies. Limitations include small sample size, single-center design, lack of a control group, absence of randomization, reliance on self-reported outcomes, and inconsistent reporting of the final analytic sample.

Nichols et al. (2022) conducted a systematic review evaluating surgical interventions, including neurolysis, for lumbosacral plexus (LSP) injuries. Injuries were categorized as isolated femoral nerve injuries, isolated obturator nerve injuries, isolated sciatic nerve injuries, and multilevel LSP injuries. For isolated femoral nerve injuries, 12 studies included 65 individuals; one study of exploration with neurolysis included 22 individuals with reduced hip flexion and knee extension preoperatively, all of whom recovered to a median Medical Research Council (MRC) grade 3 postoperatively. For isolated obturator nerve injuries, 21 studies included 28 individuals, all with iatrogenic injury during pelvic or abdominal surgery; two studies of exploration with neurolysis included 3 individuals with impaired medial thigh sensation, neuropathic pain radiating down the medial thigh, and hip adduction weakness, all of whom recovered hip adduction to MRC grade 5 with reduced pain at a mean follow-up of 26.0 ± 19.8 months. For multilevel LSP injuries, 22 studies included 73 individuals; eight studies of exploration with neurolysis included 25 individuals, most presenting with sensory deficits, severe root injuries on imaging, and functional impairment. At final follow-up, 8 individuals reported improvement in neuropathic pain and function, 9 recovered at least MRC grade 4 strength, and 3 had no recovery; overall, MRC grade 3 recovery occurred in 12 of 15 individuals with adequate follow-up. Limitations included heterogeneous injury patterns, mixed surgical techniques, small sample sizes, reliance on case reports and case series, lack of comparison groups, inconsistent outcome reporting, and inability to perform formal meta-analysis.

Ataizi et al. (2019) reported a retrospective case series of 13 individuals with meralgia paresthetica who underwent lateral femoral cutaneous nerve decompression and neurolysis after failure of at least three months of conservative therapy and diagnostic confirmation with nerve block, demonstrating significant improvement in pain scores ($p = 0.001$) with complete symptom resolution in all individuals at long-term follow-up (mean 38 months), although recovery was delayed up to 12 months in those with metabolic etiologies.

Khalil et al. (2012) conducted a Cochrane systematic review to evaluate treatment options for meralgia paresthetica, including conservative measures, injections, and surgical interventions. No randomized controlled trials were identified, and available evidence was derived from observational studies. The review notes that the condition may resolve without intervention, with one study reporting spontaneous improvement in 20 of 29 cases (69%). Four studies evaluating corticosteroid and local anesthetic injections reported cure or improvement in 130 of 157 cases (83%). Among studies assessing surgical interventions, improvement was reported in 264 of 300 cases (88%) treated with decompression (neurolysis) and 45 of 48 cases (94%) treated with neurectomy. Limitations include the absence of high-quality studies and reliance on nonrandomized observational data.

Professional Societies/Organizations: A review of publicly available guidance from relevant professional societies including the American Academy of Orthopaedic Surgeons (AAOS), American Association of Neurological Surgeons (AANS), Congress of Neurological Surgeons (CNS), American Society of Interventional Pain Physicians (ASIPP), American Society of Pain and Neuroscience (ASPN), American Society of Regional Anesthesia and Pain Medicine (ASRA), American Academy of Pain Medicine (AAPM), and the American Society of Anesthesiologists (ASA), did not identify clinical practice guidelines, consensus statements, or position statements addressing open surgical neuroplasty of the lumbar plexus. Although these organizations publish evidence-based direction related to musculoskeletal conditions, spine surgery, interventional pain procedures, and

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perioperative management, including topics such as spine trauma, lumbar fusion, regional anesthesia, interventional pain techniques, and perioperative nerve injury prevention, none provide recommendations regarding indications, patient selection, or outcomes for open lumbar plexus neuroplasty or surgical decompression of the lumbosacral plexus.

American Academy of Orthopaedic Surgeons (AAOS): The American Academy of Orthopaedic Surgeons (AAOS) provides patient education on meralgia paresthetica, describing it as a compressive neuropathy of the lateral femoral cutaneous nerve (LFCN) typically diagnosed through clinical history, physical examination, and, when needed, adjunctive testing such as imaging, electrodiagnostic studies, or diagnostic nerve block to confirm the source of symptoms. Treatment guidance emphasizes identification and removal of the underlying source of compression, with conservative measures (e.g., activity modification, weight loss, and avoidance of restrictive clothing) as first-line management. Corticosteroid or local anesthetic injections may provide temporary symptom relief and may also aid in diagnosis. Surgical decompression is described as rarely required and generally reserved for persistent or severe cases that do not respond to conservative and non-operative interventions.

Other Conditions

Open neuroplasty of the lumbar plexus is intended for individuals with confirmed lumbar plexus-related neuropathy or focal nerve entrapment and is not appropriate when findings are inconsistent with this diagnosis. Clinical references emphasize the importance of differentiating lumbar plexopathy from other neurologic conditions, including lumbar radiculopathy, generalized peripheral neuropathy, and isolated mononeuropathies, through careful correlation of clinical findings with imaging and electrodiagnostic testing to ensure accurate localization of pathology (Castoro & Arnold, 2025; Dhawan, 2021; Rubin, 2020). In the absence of concordant clinical, imaging, and/or electrodiagnostic evidence localizing symptoms to the lumbar plexus or a related nerve branch, surgical decompression is unlikely to provide benefit.

Health Equity Considerations

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

References

1. American Academy of Orthopaedic Surgeons (AAOS). Burning Thigh Pain (Meralgia Paresthetica). OrthoInfo. Accessed Jun 25, 2026. Available at URL address: <https://orthoinfo.aaos.org/en/diseases--conditions/burning-thigh-pain-meralgia-paresthetica>
2. Ataizi ZS, Ertlav K, Ercan S. Surgical options for meralgia paresthetica: long-term outcomes in 13 cases. *Br J Neurosurg*. 2019 Apr;33(2):188-191. doi: 10.1080/02688697.2018.1538480. Epub 2018 Nov 19. PMID: 30451004.

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3. Castoro R, Arnold WD. Entrapment Neuropathies. *Neurol Clin.* 2025 Nov;43(4):657-672. doi: 10.1016/j.ncl.2025.05.005. Epub 2025 Aug 28. PMID: 41161989.
4. Dhawan PS. Electrodiagnostic Assessment of Plexopathies. *Neurol Clin.* 2021 Nov;39(4):997-1014. doi: 10.1016/j.ncl.2021.06.006. Epub 2021 Aug 31. PMID: 34602223.
5. Finerty JT, Garden AR, Everhart JS. Diagnostic criteria utilized for selection of patients for meralgia paresthetica surgery: a systemic review. *Neurosurg Rev.* 2025 Feb 28;48(1):273. doi: 10.1007/s10143-025-03411-6. PMID: 40016533.
6. Khalil N, Nicotra A, Rakowicz W. Treatment for meralgia paraesthetica. *Cochrane Database Syst Rev.* 2012 Dec 12;12(12):CD004159. doi: 10.1002/14651858.CD004159.pub3. PMID: 23235604; PMCID: PMC7197425.
7. Nichols DS, Fenton J, Cox E, Dang J, Garbuzov A, McCall-Wright P, Chim H. Surgical Interventions for Lumbosacral Plexus Injuries: A Systematic Review. *Plast Reconstr Surg Glob Open.* 2022 Aug 24;10(8):e4436. doi: 10.1097/GOX.0000000000004436. PMID: 36032367; PMCID: PMC9400934.
8. Pitman J, Lin Y, Tan ET, Sneag DB. MR Neurography of the Lumbosacral Plexus: Technique and Disease Patterns. *Radiographics.* 2025 Jun;45(6):e240099. doi: 10.1148/rg.240099. PMID: 40372937.
9. Reuter F, Schwaiger K, Panzenbeck P, Gruber M, Mahrhofer M, Geroldinger M, Gohritz A, Wechselberger G, Russe E. Outcomes of lateral femoral cutaneous nerve decompression surgery in meralgia paraesthetica: assessment of pain, sensory deficits, and quality of life. *Int Orthop.* 2025 Apr;49(4):863-870. doi: 10.1007/s00264-025-06463-x. Epub 2025 Mar 7. PMID: 40053067.
10. Rubin DI. Brachial and lumbosacral plexopathies: A review. *Clin Neurophysiol Pract.* 2020 Aug 13;5:173-193. doi: 10.1016/j.cnp.2020.07.005. PMID: 32954064; PMCID: PMC7484503.
11. Scholz C, Hohenhaus M, Pedro MT, Uerschels AK, Dengler NF. Meralgia Paresthetica: Relevance, Diagnosis, and Treatment. *Dtsch Arztebl Int.* 2023 Sep 29;120(39):655-661. doi: 10.3238/arztebl.m2023.0170. PMID: 37534445; PMCID: PMC10622057.
12. Schönberg B, Pigorsch M, Huscher D, Baruchi S, Reinsch J, Zdunczyk A, Scholz C, Uerschels AK, Dengler NF. Diagnosis and treatment of meralgia paresthetica between 2005 and 2018: a national cohort study. *Neurosurg Rev.* 2023 Feb 13;46(1):54. doi: 10.1007/s10143-023-01962-0. PMID: 36781569; PMCID: PMC9925535.
13. Wang S, Xia D, Song D, Lu N, Chen A. Could nerve transplantation be the future of this field: a bibliometric analysis about lumbosacral plexus injury. *Int J Surg.* 2024 Jun 1;110(6):3734-3744. doi: 10.1097/JS9.0000000000001332. PMID: 38518081; PMCID: PMC11175794.

Revision Details

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Type of Revision	Summary of Changes	Date
Annual Review	- Revised policy statements for medically necessary open neuroplasty of the lumbar plexus to clarify clinical findings and conservative treatments - Added policy statement for diagnostic nerve block for suspected LFCN involvement - Revised not medically necessary policy statement to clarify conditions not consistent with lumbar plexus-related neuropathy	9/15/2026
New Policy	N/A	12/1/2025

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