FPM
ANZCA

19 October 2026

Medical Specialist Services Section
MBS Policy and Specialist Programs Branch
Sent via email: SurgicalServices@health.gov.au

MBS Item 18236 – Trigeminal Nerve Peripheral Branch

Thank you for approaching the Faculty of Pain Medicine for an opinion regarding the use of item numbers 18234 and 18236 in clinical practice. I apologise for the delay in provision of this response.

This opinion is provided from the perspective of anaesthesia and pain medicine. Colleagues in disciplines such as oral surgery, maxillofacial surgery and ENT surgery are likely to have relevant opinions on these issues.

Having reviewed the MBS schedule, it is clear that item number 18234 is to be used where a nerve block is performed on a primary branch of the trigeminal nerve. The wording in the accompanying note indicates that the procedure is to be performed on the specific primary nerve branch and whilst not specifically stated, this item number does not appear to refer to procedures performed on the trigeminal ganglion itself.

Item number 18236 applies to nerve block procedures performed on peripheral branches of each of the primary divisions of the trigeminal nerve. There are actually multiple peripheral branches of each division of the trigeminal nerve, although in practice, only a small number of these will be of practical clinical relevance, noting that blockade of these nerves can be used to provide anaesthesia over an area of the cranium, including the face. Some of the smaller peripheral nerves have vague surface markings and variable innervation patterns, making specific identification and blockade an uncertain endeavour

An important issue relates to the technical aspects of performing nerve blocks on the primary divisions of the trigeminal nerve. These are relatively inaccessible, with the branches emerging from specific parts of the skull base. The ophthalmic nerve, in particular, is not readily accessible to any form of percutaneous approach as far as I am aware and where anaesthesia is required in the territory of this nerve, only peripheral nerve techniques can be employed, usually targeting the supraorbital and/or supratrochlear nerves. Hence, to provide appropriate cutaneous analgesia for the area around the upper eyelid and forehead, a practitioner might need to perform two separate peripheral nerve blocks, given the impracticality of a specific injection to the ophthalmic division of the trigeminal nerve.

Nerve blockade of the maxillary division of the trigeminal nerve is better described but, again, this is a technically demanding procedure and the use of medical imaging is often preferred to improve safety and success. The need for specialised imaging equipment and specific technical skills potentially makes this a less likely option for practitioners working in an office setting and, again, this may steer practitioners towards use of a more peripheral technique to provide appropriate anaesthesia. Having said that, the main peripheral branch that would be approached for the purposes of anaesthesia of the facial skin in the infraorbital and maxillary regions would be the infraorbital nerve. Whilst the maxillary nerve does have a number of other branches, these tend to provide a supply to structures within the upper jaw and it is difficult to envisage circumstances in which approaches to these other nerves would be preferred over simple local anaesthetic techniques applied within the mouth. Two further, small cutaneous branches of the maxillary nerve are the zygomaticofacial and zygomaticotemporal nerves. These are very small branches supplying a similarly small (and variable) area. Approaches to these nerves are not really practicable and local infiltration to the relevant area may be sufficient in many cases.

The mandibular division of the trigeminal nerve leaves the base of the skull through the foramen ovale, entering the region of the infratemporal fossa where it divides into an anterior and a posterior branch. The

anterior branch supplies groups of muscles moving the mandible together with one sensory branch, the buccal nerve. The posterior branch carries sensation from the mandible and overlying skin together with deeper structures within the mouth and tongue. Specific blockade of the primary mandibular division of the trigeminal nerve is possible, but again, it is technically demanding and access to high-quality imaging will often be preferred. For this reason, the procedure is unlikely to be performed in an outpatient or office setting and specific peripheral nerve blocks would be performed.

For the purposes of providing anaesthesia over relevant skin areas, the three main nerves that would be approached would be the auriculotemporal nerve, the mental nerve (supplying an area around the chin) and the inferior alveolar nerve. The auriculotemporal and mental nerves are easily approached using percutaneous techniques. The inferior alveolar nerve can be approached through an intraoral technique that is widely employed in dentistry.

The buccal nerve supplies an area inside the mouth, particularly the cheek. However, it also supplies an area over the skin of the lower cheek. Blockade of this nerve might be considered, but a specific indication for this may not be so clear, given that simple local infiltration can often be as effective.

The peripheral approaches described are likely to be safer than direct techniques approaching the primary mandibular division of the trigeminal nerve, noting that there is a higher risk of complications with the nerve division block due to the proximity of needle placement to other neurological and vascular structures.

In response to the specific questions raised, I offer the following comments:

1). In what clinical circumstances would multiple peripheral branch blocks of the trigeminal nerve be indicated during a single treatment episode? (Excluding situations where a primary branch block would instead be used)

- ***i. In such circumstances, how many distinct peripheral branch blocks might be clinically relevant?***

As noted earlier, there is really no defined approach to the ophthalmic division of the trigeminal nerve and hence one or more peripheral blocks will always be a standard approach where anaesthesia is required in the territory of this nerve. However, a maximum of two peripheral blocks are justifiable; specifically, to the supraorbital and supratrochlear nerves.

For anaesthesia in territory of the maxillary division of the trigeminal nerve, specific approaches to the primary division are described, although for practical purposes, a peripheral approach would often be preferable and in this respect, in the great majority of situations, there is only one peripheral nerve that would be approached, this being the infraorbital nerve.

With regard to the mandibular nerve, an approach to the nerve as it leaves the skull could be considered although, as noted above, this requires specific technical skills and equipment and does, potentially, carry some more serious complications.

Noting the comments that I have made earlier, it can be seen that in many situations, performing one or more peripheral nerve blocks in mandibular nerve territory could be easier and more convenient than approaching the main division of the mandibular nerve.

As to the number of nerve blocks that should reasonably be performed at any one stage, this is much more difficult to define. However, within the ophthalmic division, typically only a maximum of two peripheral nerve blocks would be appropriate. At the maxillary division, only a single peripheral nerve block would be appropriate, and in mandibular nerve territory, a maximum of three nerve blocks could potentially be appropriate. The numbers I have quoted above apply only to one side.

A broader question relates to the indications for performing such nerve blocks, particularly if multiple nerve blocks are required. For extensive skin surgery, justification could be made for performing several nerve

blocks although this would generally only be on one side. However, it is also the case that simple local infiltration is more than adequate for many superficial skin procedures.

In some circumstances, anaesthesia of groups of individual peripheral nerves might be considered, although such circumstances would be uncommon. A scenario that springs to mind is the situation of a patient suffering from postherpetic neuralgia following shingles. This can be extremely painful and anaesthesia of one or more peripheral nerves within trigeminal territory would be quite reasonable in such circumstances. Typically, postherpetic neuralgia will not affect all three divisions of the trigeminal nerve and it almost invariably affects only one side. This again would put a ceiling on the number of blocks performed.

2. Is the distinction between 18234 (trigeminal nerve, primary branch block) and 18236 (trigeminal nerve, peripheral branch block) sufficiently clear for claiming purposes?

The wording in the MBS schedule is quite clear. I do not think this needs to be changed.

3. Would a restriction on multiple claims of 18236 for a single patient on the same occasion or within a 24-hour period create any unintended consequences for patient care?

In broad terms, as long as a sensible approach was adopted, understanding that some circumstances might warrant the use of multiple nerve blocks on one side of the face, I do not think that an appropriate restriction would have major impacts on patient care. Based on the reasoning I have given above, it is difficult to see circumstances in which more than six peripheral nerve blocks could or should be applied to branches of the trigeminal nerve on a single patient in one session. Even this would represent exceptional circumstances.

4. Are there further options the Department could consider in reviewing this item?

I think that consideration should be given to actual specification of the nerves that can be treated – i.e. the item should cover only specifically identified nerves. This is already the case in part, noting that the infraorbital nerve is mentioned in item 18236. Based on my reasoning above, use of the item should be confined to blockade of the supraorbital nerve, the supratrochlear nerve, the infraorbital nerve, the inferior alveolar nerve, the mental nerve and the auriculotemporal nerve. As noted above, colleagues in other disciplines may have different views on this matter and in particular, it would be useful to determine whether other craft groups consider it necessary to specify blockade of the lingual nerve as an addition to this grouping.

The accompanying notes to many Medicare items often emphasise that practitioners should record details of the procedures that they are undertaking to assist with review, should the need arise. I think that this is a situation where meticulous record keeping would be especially important, noting that if patterns appear that might suggest excessive use of multiple peripheral nerve blocks, data should be recorded that clearly identifies which nerves have been treated, together with clear clinical indications for doing so.

I trust these comments are helpful. Please do not hesitate to contact me at the Faculty of Pain Medicine if you require further information on this matter.

With best regards



Dr Dilip Kapur
Director of Professional Affairs
Faculty of Pain Medicine, ANZCA