MEDICAL COVERAGE POLICY	
SERVICE: Regional Sympathetic Blocks	
Policy Number:	**101**
Effective Date:	**01/01/2020**
Last Review:	**10/30/2019**
Next Review Date:	**10/30/2020**

Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Regional Sympathetic Blocks

PRIOR AUTHORIZATION: CPT codes 64510 and 64520 require Prior Authorization.

POLICY: SWHP may consider sympathetic blocks (stellate ganglion block and lumbar sympathetic block) medically necessary for the treatment of complex regional pain syndrome when conservative treatments (analgesia and physical therapy) have failed.

Up to 3 sympathetic blocks may be considered medically necessary to demonstrate therapeutic effectiveness. It the member experiences no pain relief after 3 injections, additional injections are not considered medically necessary.

Repeat sympathetic blocks for CRPS beyond the first 3 injections are considered medically necessary when provided as part of a comprehensive pain management program, which includes physical therapy, patient education, psychosocial support, and oral medications.

Sympathetic blocks more frequently than once every 7 days will generally not be considered medically necessary.

NOTE: The following procedures will be reviewed for medical necessity by eviCore®.

64510 Injection, stellate ganglion (cervical sympathetic)

64520 Injection, lumbar or thoracic (paravertebral sympathetic)

OVERVIEW: Regional sympathetic blocks (Stellate Ganglion Blocks and Lumbar Sympathetic Blocks) refers to the injection of local anesthetic along the sympathetic ganglia of the anteriolateral aspect of the spinal column under fluoroscopy to reduce sympathetic nervous system activity related to the affected limb.

Complex regional pain syndrome is defined by the International Association for the Study of Pain (IASP) “as a variety of painful conditions following injury which appear regionally having a distal predominance of abnormal findings, exceeding in both magnitude and duration the expected clinical course of the inciting event and often resulting in significant impairment of motor function, and showing variable progression over time.”[1] In addition to injury, CRPS can also occur as a result of various medical disorders or illnesses. The diagnostic criterion for CRPS are as follows:

1. Continuing pain that is disproportionate to any inciting event must report at least one (1) of the symptoms in the following categories:
   a. Sensory: reports of hyperesthesia
   b. Vasomotor: reports of temperature asymmetry and/or skin color changes and/or skin color asymmetry
   c. Sudomotor/edema: reports of edema and/or sweating changes and/or sweating asymmetry
   d. Motor/trophic: reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin).

Regional sympathetic blocks should be performed using fluoroscopy. Performance of regional sympathetic blocks without the use of fluoroscopic guidance is considered not medically necessary.

MANDATES: There are no mandated benefits.

CODES:

Important note:
CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	64510 Injection, anesthetic agent; stellate ganglion (cervical sympathetic) 64517 Injection, anesthetic agent; superior hypogastric plexus 64520 Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic) 64530 Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring
CPT Not Covered:	
ICD10 codes:	G90.511 – complex regional pain syndrome I of right upper limb G90.512 – complex regional pain syndrome I of left upper limb G90.513 – complex regional pain syndrome I of both upper limbs G90.519 – complex regional pain syndrome I of unspecified upper limb G90.521 – complex regional pain syndrome I of right lower limb G90.522 – complex regional pain syndrome I of left lower limb G90.523 – complex regional pain syndrome I of both lower limbs G90.529 – complex regional pain syndrome I of unspecified lower limb M96.1 – Postlaminectomy syndrome, not elsewhere classified

CMS: There is no NCD. There is no LCD

POLICY HISTORY:

Status	Date	Action
New	7/26/2010	New policy
Reviewed	10/17/2011	Reviewed.
Reviewed	10/4/2012	Reviewed.
Reviewed	10/3/2013	Codes added
Reviewed	06/19/2014	Reference to LCD added.
Reviewed	07/02/2015	No changes
Reviewed	07/28/2016	Updated language per LCD

Reviewed	06/27/2017	Minor updates. Removed LCD reference
Reviewed	05/08/2018	Updated coverage language
Reviewed	08/07/2018	Added PA to two codes
Reviewed	10/30/2019	No changes

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to SWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

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