



# Geisinger Health Plan Policies and Procedure Manual

**Policy: MP292**

**Section: Medical Benefit Policy**

**Subject: Sympathetic Nerve Block**

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**Applicable line of business:**

<b>Commercial</b>	<b>x</b>	<b>Medicaid</b>	<b>x</b>
<b>Medicare</b>	<b>x</b>	<b>ACA</b>	<b>x</b>
<b>CHIP</b>	<b>x</b>		

**I. Policy:** Sympathetic Nerve Block

**II. Purpose/Objective:**

To provide a policy of coverage regarding Sympathetic Nerve Block

**III. Responsibility:**

- A. Medical Directors
- B. Medical Management

**IV. Required Definitions**

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

**Commercial**

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

**Medicare**

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

**CHIP**

Geisinger Health Plan Kids (GHP Kids) is a Children's Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

**Medicaid**

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

## V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

### Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

### **INDICATIONS: REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE**

Sympathetic nerve Block may be considered medically necessary when **all of the following criteria are met:**

1. Organic etiology of pain based on history and physical exam, leading to a diagnosis of **any of the following:**
  - Complex regional pain syndrome Type I or II
  - Intra-abdominal cancer
  - Scleroderma
  - Inoperable vascular ischemic pain secondary to peripheral vascular disease
  - Herpes Zoster
  - Postherpetic neuralgia
  - Raynaud's Syndrome
  - Phantom Limb Pain
  - Radiation lumbosacral neuritis
  - Frost Bite

**And**

2. No evidence of infection or psychogenic origin of pain; **and**
3. Pain and disability moderate-to-severe degree as evidenced by Pain Disability Index; **and**
4. Documented failure or contraindication to physical therapy or chiropractic care\*. There must be documentation of a minimum of 4 weeks of physical therapy or chiropractic care at least 2 times per week for the four weeks (minimum of 8 visits) within one year of the request for injections. The therapy **MUST** be associated with the body area that will be treated with the requested injections. A home exercise program is not an adequate substitute for formal physical therapy or chiropractic care. If the provider indicates the member cannot do physical therapy or chiropractic care due to pain, the provider must submit documentation from an evaluating physical therapist or chiropractor dated within 4 weeks of the request indicating the member cannot tolerate therapy services. Please note that one visit for injection to allow the member to attend therapy is not considered medically necessary. Please also note that completion of less than the minimum number of therapy or chiropractor visits due to non-compliance is not an acceptable alternative to this requirement in the absence of documentation the member was unable to tolerate therapy services; **and**

**\*Physical therapy /chiropractic requirement not applicable to Medicare business segment**

5. Documented failure or contraindication to pharmacologic therapy. There must be documentation of the use of at least two (2) classes of medications from the following list of medication classes must be submitted for review: NSAIDs, opiates, non-opioid analgesics, anti-epileptic medications used for treatment of chronic pain, antidepressant medications used for treatment of chronic pain, ASA or ASA derivatives, muscle relaxants, steroids, such as prednisone or Medrol or documented contraindication to each of these drug classes.

#### **LIMITATIONS:**

If the medical necessity for sympathetic nerve block is met, no more than two (2) injections may be performed at a single setting. No more than 3 procedures will be approved in a 12-week period of time per region, with at least 14 days between injections in the initial therapeutic phase. If there is greater than 50% reduction in symptoms or physical and functional improvement for at least 2 months, the provider may request repeat injections performed at intervals of at least 2 months and limited to a maximum total of 4 therapeutic procedures per region per 12 months.

If special circumstances are documented, then repeat injections are limited to a maximum of 6 procedures in 12 months.

For GHP Family: The Benefit Limit Exception (BLE) process will apply to requests for more than six (6) injections per calendar year.

#### **EXCLUSIONS:**

- The Plan does NOT provide coverage for the use of sphenopalatine ganglion block in the treatment of headache or non-headache facial pain because it is considered unproven. Although the catheters used to administer the anesthetic agent are FDA approved, there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this treatment on health outcomes when compared to established treatments or technologies (See MP318)
- Use of intravenous phentolamine (Regitine) test for diagnosis of CRPS is unproven and not covered
- Intravenous regional sympathetic block with guanethidine is unproven and not covered
- Intrapleural analgesia for treatment of reflex sympathetic dystrophy is unproven and not covered
- Bioelectric nerve block for treatment of CRPS is unproven and not covered

#### **Medicaid Business Segment:**

Any requests for services that do not meet criteria set in the PARP may be evaluated on a case by case basis

#### **CODING ASSOCIATED WITH:** Sympathetic Nerve Block

***The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services, Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements***

64505 Sphenopalatine ganglion block

64510 Injection, anesthetic agent; stellate ganglion (cervical sympathetic)

64520 Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)

64530 Injection, anesthetic agent; celiac plexus, with or without radiological monitoring

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

#### **LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.**

#### **REFERENCES:**

Hayes. Medical Technology Directory. Nerve Blocks for the Treatment of Chronic Nonmalignant Pain. September 22, 2011. Updated September 26, 2012. Updated September 26, 2013.

Reflex Sympathetic Dystrophy Syndrome Association (RSDSA). Complex regional pain syndrome: treatment guidelines. Clinical practice guidelines (second edition) for the diagnosis, treatment, and management of reflex sympathetic dystrophy/complex regional pain syndrome (RSD/CRPS). Reflex Sympathetic Dystrophy Syndrome Association (RSDSA); 2006 Jun. 67 p.

Abdi S. Prevention and management of complex regional pain syndrome in adults. UpToDate. November 21, 2012.

Cohen SP, Kapoor SG, Rathmell JP. Intravenous infusion tests have limited utility for selecting long-term drug therapy in patients with chronic pain: a systematic review. *Anesthesiology*. 2009 Aug;111(2):416-31.

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Perez R, Kwakkel G, Zuurmond W, de Lange J. Treatment of reflex sympathetic dystrophy (CRPS type 1): a research synthesis of 21 randomized clinical trials. *J Pain Symp Management*. 2001;21:511-526. This policy will be revised as necessary and reviewed no less than annually.

Zernikow B, Wager J, Brehmer H, Hirschfeld G, Maier C. Invasive Treatments for Complex Regional Pain Syndrome in Children and Adolescents. *Anesthesiology*. 2015;122(3):699-707.

Liou H, Kong MJ, Alzubaidi SJ, et al. Single-center review of celiac plexus/retrocrural splanchnic nerve block for non-cancer related pain. *Acad Radiol*. 2021 Nov;28 Suppl 1:S244-S249

Strand DS, Law RJ, Yang D, et al. AGA clinical practice update on the endoscopic approach to recurrent acute and chronic pancreatitis: expert review. *Gastroenterology*. 2022 Oct;163(4):1107-1114.

This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 1/2015

**Revised:** 9/15, 7/17(revise drug requirement);7/19 (add sphenopalatine nerve block language) 9/21 (revise frequency limitations), 9/24 (revise exclusions)

**Reviewed:** 11/16, 6/18, 7/20, 9/22, 9/23, 9/25

**CMS UM Oversight Committee Approval:** 12/23; 11/24

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Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.