Sympathetic Blockade

Policy Number: 2021T0627A
Effective Date: November 1, 2021

Instructions for Use

Table of Contents Page

Related Commercial Policies
None

Coverage Rationale

Sympathetic blockade using a local anesthetic is proven and medically necessary for treating the following indications:

- Pancreatic cancer with severe abdominal or back pain
- Complex regional pain syndrome (CRPS)

For medical necessity clinical coverage criteria, refer to the InterQual® 2021, Apr. 2021 Release, CP: Procedures, Sympathetic Blockade.

Click here to view the InterQual® criteria.

Sympathetic blockade is unproven and not medically necessary for treating the following indications:

- Chronic pancreatitis
- Chronic abdominal or back pain

Documentation Requirements

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

CPT Code*	Required Clinical Information
Sympathetic Blockade	
64520	Medical notes documenting the following, when applicable: • Diagnosis • History of the medical condition(s) requiring treatment or surgical intervention • Documentation of signs and symptoms; including onset, duration, and frequency • Physical exam • Relevant medical history • Treatments tried, failed, or contraindicated; include the dates and reason for discontinuation

*For code descriptions, see the Applicable Codes section.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
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

References

Drewes AM, Bouwense SAW, Campbell CM, et al.; Working group for the International (IAP – APA – JPS – EPC) Consensus Guidelines for Chronic Pancreatitis. Guidelines for the understanding and management of pain in chronic pancreatitis. Pancreatology. 2017 Sep-Oct;17(5):720-731.

Fabbri C, Luigiano C, Lisotti A, et al. Endoscopic ultrasound-guided treatments: are we getting evidence based–a systematic review. World J Gastroenterol. 2014 Jul 14;20(26):8424-48.

LeBlanc JK, DeWitt J, Johnson C, et al. A prospective randomized trial of 1 versus 2 injections during EUS-guided celiac plexus block for chronic pancreatitis pain. Gastrointest Endosc. 2009 Apr;69(4):835-42.

Löhr JM, Dominguez-Munoz E, Rosendahl J et al.; Working Group. United European Gastroenterology evidence-based guidelines for the diagnosis and therapy of chronic pancreatitis (HaPanEU). United European Gastroenterol J. 2017 Mar;5(2):153-199.

Mercadante S, Klepstad P, Kurita GP, et al.; European Palliative Care Research Collaborative (EPCRC). Sympathetic blocks for visceral cancer pain management: A systematic review and EAPC recommendations. Crit Rev Oncol Hematol. 2015 Dec;96(3):577-83.

Stevens T, Costanzo A, Lopez R, et al. Adding triamcinolone to endoscopic ultrasound-guided celiac plexus blockade does not reduce pain in patients with chronic pancreatitis. Clin Gastroenterol Hepatol. 2012 Feb;10(2):186-91, 191.e1.

Policy History/Revision Information

Date	Summary of Changes
11/01/2021	• New Medical Policy

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

This Medical Policy may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.