5221.6305 COMPLEX REGIONAL PAIN SYNDROME (CRPS); REFLEX SYMPATHETIC DYSTROPHY; AND CAUSALGIA OF THE UPPER AND LOWER EXTREMITIES.

Subpart 1. **Scope.**

A. This clinical category encompasses:

(1) any condition diagnosed as complex regional pain syndrome, reflex sympathetic dystrophy, or causalgia, or any other condition included in ICD-9-CM codes 337.20, 337.21, 337.22, 337.29, 337.9, 354.4, 355.71, 355.9, or 733.7. For treatment on or after October 1, 2015, an ICD-10-CM code that is equivalent to an applicable ICD-9-CM code listed in this subitem must be used instead of the ICD-9-CM code. The General Equivalence Mappings tool established by the Centers for Medicare and Medicaid Services must be used to determine the equivalent ICD-10-CM code or codes; or

(2) any condition of the upper or lower extremity characterized by concurrent presence in the involved extremity of five of the following conditions: edema; local skin color change of red or purple; osteoporosis in underlying bony structures demonstrated by radiograph; local dyshidrosis; local abnormality of skin temperature regulation; reduced passive range of motion in contiguous joints; local alteration of skin texture of smooth or shiny; or typical findings of reflex sympathetic dystrophy on bone scan; or

(3) any condition of the upper or lower extremity that develops after trauma or nerve injury and is characterized by continuing pain, allodynia, or hyperalgesia that is nonanatomic in distribution and disproportionate to the original injury and to stimulation, and the patient has or has had edema, vasomotor abnormality, or sudomotor abnormality on examination, and there is no other explanation for the degree of pain and dysfunction.

B. Reflex sympathetic dystrophy occurs as a complication of another preceding injury. The treatment parameters of this part refer to the treatment of the body part affected by the reflex sympathetic dystrophy. The treatment for any condition not affected by reflex sympathetic dystrophy continues to be subject to whatever treatment parameters otherwise apply. Any treatment under this part for the reflex sympathetic dystrophy may be in addition to treatment received for the original condition.

C. Thermography may be used in the diagnosis of reflex sympathetic dystrophy, but is considered an adjunct to physical examination and is not reimbursed separately from the office visit.

Subp. 2. **Initial nonsurgical management.** Initial nonsurgical management is appropriate for all patients with reflex sympathetic dystrophy and must be the first phase

of treatment. Any course or program of initial nonsurgical management is limited to the modalities specified in items A to D.

A. Therapeutic injection modalities. The only injections allowed for reflex sympathetic dystrophy are sympathetic block, intravenous infusion of steroids or sympatholytics, or epidural block.

(1) Unless medically contraindicated, sympathetic blocks or the intravenous infusion of steroids or sympatholytics must be used if reflex sympathetic dystrophy has continued for four weeks and the employee remains disabled as a result of the reflex sympathetic dystrophy.

(a) Time for treatment response: within 30 minutes.

(b) Maximum treatment frequency: can repeat an injection to a limb if there was a positive response to the first injection. If subsequent injections demonstrate diminishing control of symptoms or fail to facilitate objective functional gains, then injections must be discontinued. No more than three injections to different limbs are reimbursable per patient visit.

(c) Maximum treatment duration: may be continued as long as injections control symptoms and facilitate objective functional gains, if the period of improvement is progressively longer with each injection.

(2) Epidural block may only be performed in patients who had an incomplete improvement with sympathetic block or intravenous infusion of steroids or sympatholytics.

B. Only the passive treatment modalities set forth in subitems (1) to (4) are indicated. These passive treatment modalities in a clinical setting or requiring attendance by a health care provider are not indicated beyond 12 weeks from the first modality initiated for treatment of the reflex sympathetic dystrophy.

(1) Thermal treatment includes all superficial and deep heating and cooling modalities. Superficial thermal modalities include hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, cold soaks, infrared, whirlpool, and fluidotherapy. Deep thermal modalities include diathermy, ultrasound, and microwave.

(a) Treatment given in a clinical setting:

i. time for treatment response, two to four treatments;

ii. maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and

iii. maximum treatment duration, 12 weeks of treatment in a clinical setting but only if given in conjunction with other therapies specified in this subpart.

(b) Home use of thermal modalities may be prescribed at any time during the course of treatment. Home use may only involve hot packs, hot soaks, hot water bottles, hydrocollators, heating pads, ice packs, and cold soaks which can be applied by the patient without professional assistance. Home use of thermal modalities does not require any special training or monitoring, other than that usually provided by the health care provider during an office visit.

(2) Desensitizing procedures, such as stroking or friction massage, stress loading, and contrast baths:

(a) time for treatment response, three to five treatments;

(b) maximum treatment frequency in a clinical setting, up to five times per week for the first one to two weeks decreasing in frequency thereafter; and

(c) maximum treatment duration in a clinical setting, 12 weeks. Home use of desensitizing procedures may be prescribed at any time during the course of treatment.

(3) Electrical stimulation includes galvanic stimulation, TENS, interferential, and microcurrent techniques.

(a) Treatment given in a clinical setting:

i. time for treatment response, two to four treatments;

ii. maximum treatment frequency, up to five times per week for the first one to three weeks, decreasing in frequency thereafter; and

iii. maximum treatment duration, 12 weeks of treatment in a clinical setting, but only if given in conjunction with other therapies.

(b) Home use of an electrical stimulation device may be prescribed at any time during a course of treatment. Initial use of an electrical stimulation device must be in a supervised setting in order to ensure proper electrode placement and patient education:

i. time for patient education and training, one to three sessions; and

ii. patient may use the electrical stimulation device unsupervised for one month, at which time effectiveness of the treatment must be reevaluated by the provider before continuing home use of the device.

(4) Acupuncture treatments. Endorphin-mediated analgesic therapy includes classic acupuncture and acupressure:

(a) time for treatment response, three to five sessions;

(b) maximum treatment frequency, up to three times per week for the first one to three weeks, decreasing in frequency thereafter; and

(c) maximum treatment duration, 12 weeks.

C. Active treatment includes supervised and unsupervised exercise. After the first week of treatment, initial nonsurgical management must include exercise. Exercise is essential for a return to normal activity and must include active patient participation in activities designed to increase flexibility, strength, endurance, or muscle relaxation. Exercise must be specifically aimed at the involved musculature. Exercises must be evaluated to determine if the desired goals are being attained. Strength, flexibility, or endurance must be objectively measured. While the provider may objectively measure the treatment response as often as necessary for optimal care, after the initial evaluation the health care provider may not bill for the tests sooner than two weeks after the initial evaluation, and monthly thereafter.

(1) Supervised exercise. One goal of a supervised exercise program must be to teach the patient how to maintain and maximize any gains experienced from exercise. Self-management of the condition must be promoted:

(a) maximum treatment frequency, up to five times per week for three weeks. Should decrease in frequency thereafter; and

(b) maximum duration, 12 weeks.

(2) Unsupervised exercise must be provided in the least intensive setting and may supplement or follow the period of supervised exercise. Maximum duration is unlimited.

D. The health care provider must document the rationale for the use of any medication. Treatment with medication may be appropriate during any phase of treatment and must comply with all of the applicable parameters in part 5221.6105. The prescribing health care provider must determine that ongoing medication is effective treatment for the patient's condition and that the most cost-effective regimen is used.

Subp. 3. **Surgery.**

A. Surgical sympathectomy may only be performed in patients who had a sustained but incomplete improvement with sympathetic blocks by injection.

B. Spinal cord stimulators have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of a spinal cord stimulator is indicated because the patient:

(a) has intractable pain;

(b) is not a candidate for another surgical therapy; and

(c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefitting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with a spinal cord stimulator is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to a spinal cord stimulator.

(3) Long-term use of a spinal cord stimulator is indicated if the treating health care provider documents that there has been at least a 50 percent improvement in pain during a trial screening period of at least three days, compared to the patient's pain level immediately preceding the trial screening period.

C. Intrathecal drug delivery systems have very limited application and are indicated only if the conditions of subitems (1), (2), and (3) are satisfied.

(1) The treating health care provider determines that a trial screening period of an intrathecal drug delivery system is indicated because the patient:

(a) has intractable pain;

(b) is not a candidate for another surgical therapy; and

(c) has no untreatable major psychological or psychiatric comorbidity that would prevent the patient from benefitting from this treatment. The treating health care provider shall refer the patient for a consultation by a psychologist or psychiatrist to assess the patient for psychological or psychiatric comorbidities. If an untreated comorbidity is diagnosed, reassessment for treatment with an intrathecal drug delivery system is indicated if the psychologist or psychiatrist determines that the comorbidity no longer prevents the patient from benefitting from the treatment.

(2) Before the trial screening is conducted, a second opinion, from a provider outside of the treating provider's practice, must confirm that all the conditions of subitem (1) are satisfied and the patient has no contraindications to an intrathecal drug delivery system.

(3) Long-term use of an intrathecal drug delivery system is indicated if the treating health care provider documents that there has been at least a 50 percent improvement in pain during a trial screening period of at least 24 hours, compared to the patient's pain level immediately preceding the trial screening period.

Subp. 4. **Chronic management.** If the patient continues with symptoms and objective physical findings after surgery, or the patient refuses surgery, or the patient was

not a candidate for surgery, and if the patient's condition prevents the resumption of the regular activities of daily life including regular vocational activities, then the patient may be a candidate for chronic management. Any course or program of chronic management must satisfy all of the treatment parameters of part 5221.6600.

Statutory Authority: *MS s 14.386; 176.103; 176.135; 176.83*

History: *19 SR 1412; 35 SR 138; 39 SR 286; 40 SR 328*

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