I. Policy

Intravenous infusion of anesthetics (e.g., ketamine or lidocaine) for the treatment of chronic pain, including, but not limited to chronic neuropathic pain, chronic daily headache and fibromyalgia, is considered investigational. There is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

Cross-reference:
MP-1.058 Implantable Infusion Pumps

II. Product Variations

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

FEP PPO*

* Refer to FEP Medical Policy Manual MP-10.01.15 Lidocaine Injection and 10.01.16 Ketamine. The FEP Medical Policy Manual can be found at: www.fepblue.org

III. Description/Background

Intravenous (IV) infusion of lidocaine or ketamine has been used for the treatment of chronic neuropathic pain. Chronic neuropathic pain disorders include phantom limb pain, postherpetic neuralgia, complex regional pain syndromes, diabetic neuropathy, and pain related to stroke or spinal cord injuries. For this application, one or more courses of intravenous infusion would be administered over a period of several hours or several days.
Neuropathic pain is often disproportionate to the extent of the primary triggering injury and may consist of thermal or mechanical allodynia, dysesthesia, and/or hyperalgesia. Allodynia is pain that occurs from a stimulus that normally does not elicit a painful response (e.g., light touch, warmth). Dysesthesia is a constant or ongoing unpleasant or electrical sensation of pain. Hyperalgesia is an exaggerated response to normally painful stimuli. In the latter, symptoms may continue for a period of time that is longer (e.g., 6 months or more) than clinically expected after an illness or injury. It is proposed that chronic neuropathic pain results from peripheral afferent sensitization, neurogenic inflammation, and sympathetic afferent coupling, along with sensitization and functional reorganization of the somatosensory, motor, and autonomic circuits in the central nervous system (CNS). Therefore, treatments focus on reducing activity and desensitizing pain pathways, thought to be mediated through N-methyl-d-aspartate (NMDA) receptors in the peripheral and CNS. Sympathetic ganglion blocks with lidocaine have been used for a number of years to treat sympathetically maintained chronic pain conditions, such as complex regional pain syndrome (CRPS, previously known as reflex sympathetic dystrophy). Test infusion of an anesthetic has also been used in treatment planning to assess patient responsiveness to determine whether medications, such as oral mexiletine or oral ketamine, may be effective. A course of intravenous (IV) lidocaine or ketamine, usually at subanesthetic doses, has also been examined. This approach for treating chronic neuropathic pain differs from continuous subcutaneous or IV infusion of anesthetics for the management of chronic pain conditions, such as terminal cancer pain, which are not discussed in this policy.

Chronic daily headache is defined as a headache disorder that occurs more than 15 days a month for at least 3 months. Chronic daily headache includes chronic migraine, new daily persistent headache, hemicranias continua, and chronic tension-type headache.

Courses of IV anesthetic agents may be given in the inpatient or outpatient setting as part of a pain management program, with the infusion of a subanesthetic dose preceded by a bolus infusion to achieve desired blood levels sooner. Lidocaine, which prevents neural depolarization through effects on voltage-dependent sodium channels, is also used systemically for the treatment of arrhythmias. Adverse effects for lidocaine are common, can be mild to moderate, and include general fatigue, somnolence, dizziness, headache, periorbital and extremity numbness and tingling, nausea, vomiting, tremors, and changes in blood pressure and pulse. Severe adverse effects may include arrhythmias, seizures, loss of consciousness, confusion, or even death. Lidocaine should only be given intravenously to patients with normal conduction on electrocardiography and normal serum electrolyte concentrations to minimize the risk of cardiac arrhythmias.

Ketamine is an antagonist of the NMDA receptor and a dissociative anesthetic. It is the sole anesthetic agent approved for diagnostic and surgical procedures that do not require skeletal muscle relaxation. Respiratory depression may occur with over dosage or too rapid a rate of administration of ketamine; it should be used by or under the direction of physicians experienced in administering general anesthetics. Ketamine is a schedule III controlled
substance. Psychological manifestations vary in severity from pleasant dream-like states to hallucinations and delirium and can be accompanied by confusion, excitement, aggression, or irrational behavior. The occurrence of adverse effects with IV anesthetics may be reduced by the careful titration of subanesthetic doses. However, the potential benefits of pain control must be carefully weighed against the potential for serious, harmful side effects.

Regulatory Status
Intravenous (IV) lidocaine systemically is approved by the U.S. Food and Drug Administration (FDA) for the acute treatment of arrhythmias and locally as an anesthetic. IV lidocaine for the treatment of chronic pain is an off-label use.

Ketamine hydrochloride injection is FDA-indicated for diagnostic and surgical procedures that do not require skeletal muscle relaxation, for the induction of anesthesia prior to the administration of other general anesthetic agents, and to supplement low-potency agents, such as nitrous oxide. IV ketamine for the treatment of chronic pain is an off-label use.

IV. RATIONALE

The most recent literature review was performed through August 27, 2015.

It is recognized that randomized controlled trials (RCTs) are extremely important to assess treatments of psychiatric and painful conditions, due to the expected placebo effect, the subjective nature of assessment in general, and the variable natural history. Uncontrolled trials and case series offer little useful evidence on the efficacy of intravenous (IV) anesthetics.

Lidocaine
A review of the peer-reviewed literature on MEDLINE for the period of 1994 through February 2004, when this evidence review was created, revealed that the degree and duration of pain relief with IV lidocaine does not appear to be clinically significant in most patients. While some patients have reported diminished pain concurrent with IV administration of lidocaine that may continue for an extended duration beyond the infusion period, overall, responses to IV lidocaine in relief of allodynia, dysesthesia, and hyperalgesia were mixed. These studies and a review of the evidence available in 2004 indicated a need for additional double-blinded RCTs to determine the incremental effects of lidocaine over active placebo and to compare IV lidocaine with other standard treatments for chronic pain, such as the use of antidepressants for fibromyalgia. It was concluded that a placebo response due to the significant adverse effects (AEs) with IV lidocaine warrants the use of active placebos to increase the probability of determining the true analgesic effect of lidocaine in clinical trials. In addition, further studies are needed to determine appropriate patient selection criteria, predictive values, effective dosage ranges, frequencies, and duration of treatment. Key studies, focusing on RCTs, are described next.
Spinal Cord Injury
In a double-blind, placebo-controlled, crossover study of 16 patients either poststroke or spinal cord injury, Attal et al reported IV lidocaine significantly reduced pain over placebo. However, the duration of this reduction lasted only 45 minutes. The 2005 literature review update identified a randomized, double-blind crossover trial of IV lidocaine in 24 patients with spinal cord injury–related neuropathic pain. In this trial, spontaneous and evoked pain were significantly reduced as measured on a visual analog scale (VAS), as administered before infusion and 25 to 35 minutes after infusion initiation. Mostly mild AEs (experienced by 19 patients) and relief of pain formed the basis of 21 patients identifying the lidocaine treatment period correctly. Identification of the correct treatment group draws into question whether successful blinding was achieved, thus limiting interpretation of results. This also suggests the need for an active placebo in future trials, as noted. The authors concluded that IV lidocaine (and like agents) may be a treatment option for spinal cord injury pain, although they noted, long-term treatment with lidocaine is usually not suitable.

Complex Regional Pain Syndrome
Wallace et al reported on a randomized, double-blind, placebo-controlled study of 16 patients with complex regional pain syndrome (CRPS) types I and II. While IV lidocaine significantly reduced the pain response to cool stimuli, mechanical pain relief was not significantly improved.

Fibromyalgia
In a randomized, double-blind, crossover study of 18 patients with fibromyalgia, Sorensen et al found mixed responses with IV lidocaine with ketamine, morphine, or both, suggesting that pain-processing mechanisms must differ in fibromyalgia. None of these patients responded to IV lidocaine alone. Vlainich et al reported a randomized, double-blind trial of IV lidocaine plus amitriptyline versus amitriptyline monotherapy in 30 patients with fibromyalgia. Infusion of lidocaine or saline was given once a week for 4 weeks. Pain intensity decreased in both groups over the course of treatment; but there was no significant difference between the treatment groups (VAS, 4.1 for combined treatment vs 4.0 for monotherapy).

Headache
A small RCT from 1991 found no significant difference between IV lidocaine and placebo for the treatment of acute migraine. No RCTs were identified that evaluate the long-term relief of chronic daily headache following IV infusion of lidocaine. Uncontrolled studies were identified, but they do not provide sufficient evidence on the efficacy of IV lidocaine treatment for this condition.

Other Neuropathic Pain
Tremont-Lukats et al reported results of a randomized, double-blinded, placebo-controlled pilot trial in 32 subjects with ongoing neuropathic pain. Infusion of 5 mg/kg/h (but not 1 or 3 mg/kg/h) over a period of 6 hours was observed to decrease pain by approximately 30%. This effect lasted for the next 4 hours of observation. AEs were frequent; in 2 subjects, infusion was terminated early due to AEs. In a retrospective analysis, 104 patients with suspected neuropathic
pain who had undergone diagnostic IV lidocaine were found from screening 635 sequential charts; of these, 5 patients had requested discontinuation mid-infusion, resulting in a cohort of 99 patients with baseline and posttreatment numeric rating scale for pain (range, 0-10). Forty-two of the patients (42%) met the criteria of 30% or greater pain reduction; some of this subset was subsequently treated with mexiletine.

In a randomized, double-blind, placebo-controlled, crossover trial, Kvarnstrom et al evaluated the effects of lidocaine in 12 patients with long-term peripheral neuropathic pain of traumatic origin. The authors reported no significant differences in pain reduction over placebo on VAS. Wu et al evaluated the effects of IV lidocaine on 31 patients with postamputation pain in a randomized, double-blind, active placebo-controlled, crossover trial. They found stump pain was significantly reduced with IV lidocaine, yet phantom pain was not, and the stump pain relief was short-lived. In a study of 24 patients with postherpetic neuralgia, Baranowski et al reported IV lidocaine provided significant pain reduction over placebo; however, the pain was not eliminated. Medrik-Goldberg et al evaluated 30 patients with sciatica in a randomized, double-blind, 3-arm crossover trial. The authors found that lidocaine significantly reduced spontaneous pain as reported by VAS and pain evoked by straight leg raises. The pain reduction continued during saline infusion for 1 hour after the 2-hour lidocaine infusion. However, the evaluation did not extend beyond the 3-hour treatment period.

A 2005 Cochrane review examined controlled trials of lidocaine and its oral analogs (ie, mexiletine, tocainide, flecainide) for neuropathic pain treatment and found the drugs safely provided more pain relief than placebo and with similar effectiveness as other analgesics. The Cochrane review noted that further investigation is needed to determine the clinical meaning of statistically significant pain relief and to test for less toxic analogs. A separate publication by the same authors estimated an 11-point (of 100) improvement in pain scales, with IV lidocaine or oral analogs compared with placebo. Although AEs were reported as not significantly different from other active controls (amitriptyline, carbamazepine, gabapentin, morphine), the severity and nature of the AEs could not be assessed. As indicated in an accompanying editorial, “the limitations of the contributing studies preclude drawing useful conclusions about the adverse effect profiles of these drugs.” In addition, the authors noted that (1) lidocaine’s short serum half-life (120 minutes) precludes its use for chronic pain and (2) all trials measured pain relief within 24 hours because, in most patients, the effect disappears a few hours after treatment. Given the high frequency of AEs and the short duration of action, the health benefits of IV lidocaine remain unclear for chronic pain.

### Ketamine

A 2003 comprehensive systematic review of the treatment of chronic neuropathic pain with IV ketamine assessed the quality of evidence for ketamine’s effectiveness in central pain, CRPSs, fibromyalgia, ischemic pain, nonspecific pain of neuropathic origin, acute pain in patients with chronic neuropathic pain, orofacial pain, phantom/stump pain, and postherpetic neuralgia. Some small RCTs were available for review, and meta-analysis was considered not appropriate. The report concluded that, despite the use of ketamine for more than 30 years, there was
insufficient evidence to advocate its routine use for patients with chronic pain. Of particular concern were the significant AEs of this N-methyl-D-aspartate (NMDA) receptor antagonist in the central and peripheral nervous systems. Few data were available on appropriate dosing and long-term administration.

### Spinal Cord Injury

In 2004, Kvarnstrom et al assessed the effect of subanesthetic levels of IV ketamine or lidocaine on pain after spinal cord injury. This randomized, double-blind, placebo-controlled crossover trial found a 38% reduction in pain during ketamine infusion, with 5 of 10 subjects responding to treatment, compared with 1 of 10 in the lidocaine infusion group and 0 of 10 in the placebo group. AEs were common with both active treatments; ketamine produced 39 AEs in 9 of 10 subjects. They included somnolence, dizziness, out-of-body sensation, changes in hearing and vision, paresthesia, and other “unpleasant experiences.”

In 2010, Amr published results from a double-blind, randomized, placebo-controlled study of 40 patients with neuropathic pain secondary to spinal cord injury that was conducted in Egypt. All patients received gabapentin (300 mg) 3 times daily. The experimental group also received ketamine infusion (80 mg) over a 5-hour period daily for 7 days. The control group received infusion of isotonic saline over the same period. VAS scores for pain were similar in both groups at baseline (VAS of 84 of 100). During the week of infusion, VAS scores decreased more in the ketamine-infused group than in the gabapentin-only group (VAS score of 14 in the ketamine group vs 43 in the control group at day 7). In the control group, VAS pain scores remained about the same during the 4-week follow-up. Pain scores in the ketamine-infused group increased from 14 to 22 at 1-week follow-up and remained at that level for 2 weeks after infusion. By the third week after the ketamine infusion, VAS scores had increased to 43 and were the same as the placebo-control group. Three patients were reported to have had short-lasting delusions with ketamine infusion.

### Complex Regional Pain Syndrome

A network meta-analysis from 2014 evaluated the efficacy of all agent classes investigated in RCTs and provided a rank order of various substances. A total of 16 studies on bisphosphonates, calcitonin, NMDA analogs, analgesics, vasodilators, steroids, anticonvulsive agents, and radical scavengers were included in the analysis. Of these, only bisphosphonates, NMDA analogs (ketamine), and vasodilators showed better long-term pain reduction than placebo. The 2 RCTs on ketamine were published in 2009 by Schwartzman et al (N=19) and Sigtermans et al (N=60), the latter of which is described in further detail below.

These same studies were included in a 2013 Cochrane overview of interventions for CRPS, which found low-quality evidence that a course of IV ketamine may be effective for CRPS-related pain, although the effects were not sustained beyond 4 to 11 weeks posttreatment.

The largest double-blind RCT of ketamine for CRPS was the aforementioned European report by Sigtermans et al. Sixty patients were randomly assigned to ketamine (titrated up to 30 mg/h for a 70-kg patient) or saline infused over 4 days. The mean ketamine infusion rate was 22 mg/h.
(normalized to a 70-kg patient) at the end of the treatment phase. Blood samples were collected to assess the plasma concentration of ketamine, and patients were monitored for AEs. Two patients terminated ketamine infusion early due to psychomimetic effects (e.g., delusions, hallucinations). At baseline, numeric rating scale pain scores were 7.2 (maximum, 10) for ketamine and 6.9 for the placebo group. The lowest pain scores (ketamine, 2.7; placebo, 5.5) were observed at the end of the first week (no patients were lost to follow-up for the primary outcome measure). Although pain scores remained statistically lower through week 11, the clinically significant difference of 2 points was maintained until week 4. None of the secondary (functional) outcome measures were improved by treatment. Sixty percent of patients in the placebo group correctly indicated treatment assignment (slightly better than chance); 93% of patients in the ketamine group correctly indicated treatment assignment due primarily to psychomimetic effects.

Multiday courses of ketamine infusion in an inpatient setting have been reported for treatment of CRPS. A 2004 retrospective analysis described the effect of ketamine infusion in 33 patients with CRPS. Inpatient infusion of a subanesthetic dose of ketamine over 2 to 20 days was found to provide relief for 9 months (median, 4 months). Twelve patients received a second infusion, with a reported mean relief duration of 25 months (median, 36 months). Dosing was titrated by the occurrence of AEs, which included a feeling of inebriation, dizziness, blurred vision, or nausea. Hallucinations occurred in 6 of the 33 patients.

In 2008, Kiefer et al reported a multicenter (United States and Europe) prospective, open-label, phase 2 study of anesthetic dosing of ketamine in 20 patients with refractory CRPS. Symptoms were either long-standing (range, 6-68 months), spreading, or rapidly progressive, and refractory to conventional nonmedical (physical therapy, psychological approaches), or pharmacologic (mono- or combined therapy) and interventional treatments (at least 3) including selective nerve blocks, epidural analgesia, brachial plexus blocks, sympathetic ganglion blocks, intravenous regional sympathetic blocks, spinal cord stimulation, surgical sympathectomy, or intrathecal drug delivery systems. Patients were intubated and mechanically ventilated (except for the first 3 patients). Ketamine infusion was titrated up to a dose of 7 mg/kg/h with infusion over 5 days, then tapered downward until consciousness was attained. Midazolam was coadministered to a level of deep sedation to attenuate agitation and other AEs. All patients received IV low-dose heparin, the proton pump inhibitor pantoprazole, and clonidine to control cardiovascular and psychomimetic AEs of ketamine. Intubated patients received enteral nutrition with insulin as needed to maintain normoglycemia. Standard intensive care monitoring along with blood gas analysis, blood chemistry, and screening for infectious complications was performed regularly.

Outcomes were assessed at 1 week and 1, 3, and 6 months after treatment. Pain intensity decreased from a numeric rating scale of 9 at baseline to 0.5 at 1 week and remained low (2.0) at 6 months. Three patients relapsed but with lower pain (3.8) than at baseline. Pain relief was 94%, 89%, and 79% at 1, 3, and 6 months, respectively. Upper- and lower-extremity movement improved from 3.2 at baseline to 0.4 at 6 months for arm movement and from 2.3 at baseline to 0.6 at 6 months for walking. At 6 months, there was a significant difference in the ability to
perform activities of daily living; 1 patient rated total impairment; 3, severe impairment; 6, moderate impairment; and 10 patients, no impairment. Impairment in the ability to work was rated at baseline as complete by 11, severe by 5, and moderate by 4 patients. At 6 months, 2 patients remained unable to work, 4 had moderate impairment, and 14 patients reported no impairment. Psychotropic AEs resolved in the first week in most patients, although 5 patients reported difficulties with sleeping and recurring nightmares for 1 month following treatment. Muscle weakness was reported in all patients for up to 4 to 6 weeks posttreatment. As indicated by the authors, a strong placebo response to this intensive intervention was expected, and a large, multicenter RCT would be needed to definitively establish efficacy and safety. At this time, the beneficial effect of IV administration of ketamine is considered suggestive but not proven; additional trials are needed.

In 2011, Noppers et al reported ketamine-induced hepatotoxicity in 3 of 6 patients during the second of two 100-hour intravenous infusions. The 3 patients developed elevated liver enzymes during the start of the second 100-hour infusion, which began 16 days after the first. One of the patients also developed an itching rash and fever. Infusions were terminated and the liver enzymes returned to reference values within 2 months. The study was stopped early due to the AEs.

**Fibromyalgia**

In 2011, Noppers et al reported a randomized, double-blind, active placebo-controlled trial that was conducted in Europe using a 30-minute infusion of S(+)-ketamine (n=12) or midazolam (n=12). Baseline VAS pain scores were 5.4 in the ketamine group and 5.8 in the midazolam group. At 15 minutes after termination of infusion, significantly more patients in the ketamine group showed a reduction in VAS pain of greater than 50% than in the placebo group (8 vs 3). There was no significant difference between the groups at 180 minutes after infusion (6 vs 3), at the end of week 1 (2 vs 0) or end of week 8 (2 vs 2, all respectively). There was no difference between groups on the Fibromyalgia Impact Questionnaire measured weekly over 8 weeks. In this well-conducted study, a short infusion of ketamine (30 minutes) did not have a long-term analgesic effect on fibromyalgia pain.

**Other Chronic Pain**

A study published in 2008 compared the efficacy of placebo, ketamine, calcitonin, and combined calcitonin and ketamine to relieve phantom limb pain (N=20, within-subject design). One-hour infusion of ketamine or ketamine plus calcitonin resulted in greater than 40% improvement in pain immediately after treatment. The mean and maximum pain scores remained significantly better than placebo for 48 hours after treatment.

A 2012 retrospective analysis from an academic medical center in the United States identified 49 patients with severe refractory pain who had undergone 369 outpatient ketamine infusions during a 5-year period. Eighteen patients were diagnosed with CRPS, and 31 had other diagnoses including refractory headache (n=8) and severe back pain (n=7). All patients exhibited signs of central sensitization. Following pretreatment with midazolam and ondansetron, ketamine
infusions were administered at the highest tolerated dose for a duration ranging from 30 minutes to 8 hours. The interval between infusions ranged from 12 to 680 days (median, 233.7 days). The immediate reduction in VAS was 7.2 for patients with CRPS and 5.1 for non-CRPS pain. Query of available patients (59%) indicated that for 38%, pain relief lasted more than 3 weeks. AEs, which included confusion and hallucination, were considered minimal. A 2006 retrospective analysis described outpatient ketamine treatment in 13 patients with severe neuropathic pain; diagnoses included CRPS (n=8), migraine (n=1), neuropathy (n=3), and phantom limb (n=1). Low-dose ketamine (beginning at 0.12 mg/kg/h with slow upward titration) was delivered by a programmable pump through a peripherally inserted central catheter line. With an average infusion duration of 16 days, pain severity decreased 38% (VAS range, 7.7-4.8) with an 85% response rate. About half of the patients reported a perceived benefit 1 month after treatment. AEs included fatigue, dizziness, confusion, and spinal pain. No patients reported hallucinations.

Ongoing and Unpublished Clinical Trials

Some currently unpublished trials that might influence this review are listed in Table 1.

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<td>NCT01920555</td>
<td>Double-Blind, Placebo-Controlled Trial of Ketamine Therapy in Treatment-Resistant Depression (TRD)</td>
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Summary of Evidence

The evidence for intravenous (IV) anesthetics in patients who have complex regional pain syndrome (CRPS), fibromyalgia, chronic headache, or other chronic neuropathic pain conditions includes several randomized controlled trials. Relevant outcomes are symptoms, change in disease status, morbid events, functional outcomes, quality of life, medication use, and treatment-related morbidity. Evidence, primarily from outside of the United States, suggests that IV courses of ketamine may provide at least temporary relief to some chronic pain patients. However, the intense treatment protocols, severity of adverse effects, and limited durability raises questions about the overall health benefit of this procedure. Additional clinical trials are needed to evaluate the long-term safety of repeat courses of IV anesthetics. The evidence is insufficient to determine the effects of the technology on health outcomes.
The evidence for IV anesthetics in patients who have depression or obsessive compulsive disorder is limited. Relevant outcomes are symptoms, change in disease status, morbid events, functional outcomes, quality of life, medication use, and treatment-related morbidity. Several trials on the IV infusion of ketamine for the treatment of suicidal ideation in patients with depression are ongoing. The evidence is insufficient to determine the effects of the technology on health outcomes.

**Practice Guidelines and Position Statements**

The 2010 practice guidelines for chronic pain management from the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine discuss a variety of treatment options for chronic pain. Use of ionotropic \( N \)-methyl-\( D \)-aspartate receptor antagonists and topical agents for neuropathic pain is addressed; IV infusion of lidocaine or ketamine is not mentioned.

**U.S. Preventive Services Task Force Recommendations**

Not applicable.

**Medicare National Coverage**

There is no national coverage determination (NCD).

**V. DEFINITIONS**

**COMPLEX REGIONAL PAIN SYNDROME** (CRPS) is a chronic pain syndrome with two forms. CRPS 1 currently replaces the term “reflex sympathetic dystrophy syndrome.” It is a chronic nerve disorder that occurs most often in the arms or legs after a minor or major injury. CRPS 1 is associated with severe pain; changes in the nails, bone, and skin; and an increased sensitivity to touch on the affected limb. CRPS 2 replaces the term “causalgia,” and results from an identified injury to the nerve.

**VI. BENEFIT VARIATIONS**

The existence of this medical policy does not mean that this service is a covered benefit under the member’s contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member’s individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and providers should consult the member’s benefit information or contact Capital for benefit information.
VII. DISCLAIMER

Capital’s medical policies are developed to assist in administering a member’s benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member’s benefit information, the benefit information will govern. Capital considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational and therefore not covered when used to report intravenous anesthetics for the treatment of chronic pain as outlined in the policy statement:

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IX. REFERENCES

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<tr>
<td><strong>Policy Number</strong></td>
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*Other:
Tabers Cyclopedic Medical Dictionary, 19th edition.*
## MEDICAL POLICY

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### X. POLICY HISTORY

| MP-2.168 | CAC 11/22/11 New policy. Criteria previously found in MP-4.014 Pain Control. Intravenous infusion of anesthetics (e.g., ketamine or lidocaine) for the treatment of chronic pain remains investigational.  
Admin Change 2/27/12 FEP variation added.  
04/08/13- Admin code review-  
CAC 3/25/14 Consensus review. References updated; no changes to the policy statements. Rationale added for this review. BCBSA adopted.  
CAC 6/2/15 Consensus review. Added chronic daily headaches to the list of “all other” investigational indications. Updated references and rationale. Codes reviewed.  
CAC 5/31/16 Consensus review. No change to the policy statement. References and rationale updated. Coding reviewed.  
Administrative Update 11/22/16 - Variation reformatting 10/21/16. |

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Top

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.