
Medical Policy



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***Current Policy Effective Date: 9/1/26**
(See policy history boxes for previous effective dates)

Title: Ganglion Impar Block for Chronic Pain

Description

The ganglion impar, otherwise known as the ganglion of Walther, is a small sympathetic ganglion located in the retroperitoneal space, in front of the coccyx and behind the rectum. A ganglion impar block (GIB) is a minimally invasive injection procedure that can help alleviate pain in the perineal area innervated by the ganglion impar.

Medical Policy Statement

Ganglion Impar Blockade for the treatment of chronic cancer related pain is **established** when criteria are met.

Inclusionary and Exclusionary Guidelines

Inclusions: Ganglion Impar Blockade is **established** when the following criteria are met:

- Chronic pain in the pelvic, rectal or perineal region due to cancer **OR**
- Anorectal pain that is chronic and associated with radiation therapy (example, radiation proctitis)

AND

- Pain has failed conventional pain management (example, non-opioid and opioid therapy)

Exclusions:

- All other indications not meeting the above criteria

CPT/HCPCS Level II Codes

Established codes:

64520

64999*

**To represent Ganglion Impar Block*

Other codes (investigational, not medically necessary, etc.):

NA

Notes:

- *Code(s) may not be covered by all contracts or certificates. Please consult customer or provider inquiry resources at BCBSM or BCN to verify coverage.*
- *Individual policy criteria determine the coverage status of the CPT/HCPCS code(s) on this policy. Codes listed in this policy may have different coverage positions (such as established or experimental/investigational) in other medical policies.*

Background

Cancer-related pain is a problem that affects a large proportion of cancer patients. It is estimated that adequate pain control with conventional analgesia is not achieved in 10–20% of patients. Therefore, invasive procedures (such as neurolytic blocks, locoregional anesthesia or spinal analgesia) were proposed as a fourth step in the analgesic ladder of the World Health Organization (WHO). The use of invasive procedures is also advocated by the leading worldwide associations of medical oncology and it is present in clinical guidelines of the European Society of Medical Oncology (ESMO), National Comprehensive Cancer Network (NCCN), and American Society of Clinical Oncology (ASCO) as an option for patients who are resistant to conventional analgesic therapies or with intolerable adverse effects related to these therapies. There is increasing evidence of the benefits of these techniques in early cancer stages. This should also be considered in survivors with pain that is associated with the targeted treatments previously performed and which is difficult to control.

Summary of Evidence

After review of meta-analysis, non-randomized studies, and case reports, ganglion impar block has been shown to provide pain relief in cancer related pain that is refractory to standard of care pain management with few complications. Blocking the ganglion impar can alleviate sympathetically mediated pain, reduce opioid consumption, and improve constipation, leading to better overall patient well-being and an improvement in the patient's quality of life (QOL). There is sufficient evidence to determine that the technology results in an improvement in net health outcomes.

Rationale

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to individuals and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms. The following is a summary of the key literature to date.

Sáenz et al (2011) reported the results of a small retrospective case series of 23 patients with coccydynia who had failed to respond to conservative management.¹ Patients were treated by radiologically guided ganglion blockade impar and/or caudal blockade with 1% lidocaine and 60–80 mg triamcinolone. Of these 23 patients, 21 were available for clinical review and completed a questionnaire. Sixteen patients with coccydynia due to trauma reported marked improvement in pain post-procedure. Five patients reported moderate or poor improvement, although none described worsening of pain at follow-up. None of the patients reported complications.

Gunduz et al (2015) reported on a retrospective pilot study evaluating results and follow up of 34 ganglion impar blocks in 22 patients with coccygodynia who did not respond to conservative treatment.² For achieving at least 50% relief of pain, reported by VAS scores, the success rate of a first injection was 82%. In patients treated successfully, relief lasted for a median duration of six months. Nine patients who presented for repeat treatment reported pain relief for a median period of 17 months. No relief was achieved in two of these patients when they presented for a third treatment. The authors concluded that ganglion impar blocks appear to be effective in patients who have coccygodynia resistant to conservative therapy, but controlled studies are required to elucidate the mechanism of this effect.

Gupta and Bhatnagar (2015) reported that intractable cancer pain not amenable to standard oral or parenteral analgesics is a horrifying truth in 10-15% of patients. Interventional pain management techniques are indispensable arsenal in physician's pain management armamentarium for severe, intractable pain and can be broadly classified into neuroablative and neuromodulation techniques. An array of neurolytic techniques (chemical, thermal, or surgical) can be employed for ablation of individual nerve fibers, plexuses, or intrathecal neurolysis in patients with resistant pain and short life-expectancy. Neuraxial administration of drugs and spinal cord stimulation to modulate or alter the pain perception constitutes the most frequently employed neuromodulation techniques. Lately there is a rising call for early introduction of interventional techniques in carefully selected patients simultaneously or even before starting strong opioids.³ Even though the interventional management has found a definite place in cancer pain, there is a dearth of evidence-based practice guidelines for interventional therapies in cancer pain. This may be because of lack of quality randomized controlled trials (RCTs) evaluating their safety and efficacy in cancer pain. Laying standardized guidelines based on existing and emerging evidence will act as a foundation step towards strengthening, credentialing, and dissemination of the specialty of interventional cancer pain management. This will also ensure an improved decision-making and quality of life (QoL) of the suffering patients.

LeClerc et al (2017), analyzed a retrospective, single-center study of the efficacy of repeated ganglion impar blocks in a cohort of 83 patients with chronic pelvic and perineal pain. The study involved 83 patients who received 3 ganglion impar blocks, with the procedure being performed using 0.75% ropivacaine via a lateral approach over the Co1-Co2 coccygeal joint with computed tomography (CT) guidance. The study found that out of the 220 blocks performed, 193 (87.7%) provided immediate but transient improvement of pain by more than 50%. Complete but transient pain relief after the procedure was observed in 119 (54.1%) procedures. The variation of the visual analog scale (VAS) score before and after each block was statistically significant ($P < 0.001$). Furthermore, the VAS score before repeated blocks was significantly improved with decreased pain intensity over time ($P = 0.001$).⁴ An analysis of the Patient Global Impression of Change (PGI-C) one month after the block demonstrated improvement in 41% of cases in the overall population and in 43.6% of cases in the subgroup of 62 patients treated by 3 blocks. However, the study had the limitation of being retrospective in nature and having a short-term follow-up. No further information was provided on the number of participants or the duration of the follow-up. In summary, the study found that repeated ganglion impar blocks provided a short-term reduction in pain intensity in individuals with chronic pelvic and perineal pain, likely due to the block's effect on sensitization phenomena. The strengths of the study include its analysis of a large cohort of 83 patients with chronic pelvic and perineal pain who received 3 ganglion impar blocks, and the use of computed tomography (CT) guidance for precise block placement. The study also utilized a standardized measurement of pain relief using the visual analog scale (VAS) and the Patient Global Impression of Change (PGI-C) to evaluate the effectiveness of the blocks. The majority of the blocks performed, 87.7%, provided immediate but transient improvement of pain by more than 50%, indicating a significant reduction in pain intensity. The VAS score before repeated blocks also showed significant improvement with decreased pain intensity over time, further supporting the short-term effectiveness of repeated ganglion impar blocks.

Gupta et al (2017) summarized a case report of an unusual complication following a ganglion impar block, a procedure used to alleviate chronic pelvic pain caused by advanced cancer. The case report describes a specific instance of a neurologic complication following a ganglion impar block.⁵ The patient was a 58-year-old woman with a history of advanced cervical cancer, who presented with chronic pelvic pain that was unresponsive to conventional treatments. A ganglion impar block was performed, and the patient reported significant pain relief immediately following the procedure. The authors of the report noted that cauda equina syndrome is a known potential complication of ganglion impar blocks, and that careful patient selection and technique are essential to minimize the risk of this and other neurologic complications. They recommend that providers performing these blocks be aware of the signs and symptoms of cauda equina syndrome and other potential complications, and that they have a low threshold for seeking consultation with neurology or other specialists if concerns arise. Overall, the case report highlights the importance of careful patient selection and technique when performing ganglion impar blocks, as well as the need for vigilance in monitoring for and managing potential complications. While these blocks can be effective in reducing opioid requirements and alleviating chronic pelvic pain, they are not without risks, and providers must be prepared to recognize and manage any adverse events that may occur.

Nalini et al (2018) followed five patients with Chronic perineal pain (CPP) who received a neurolytic ganglion impar block via a transcoccygeal approach.⁶ This is a systematic review and meta-analysis study, published in the journal of anesthesiology and clinical pharmacology.

The patients had different etiologies of CPP, and the pain was described as excruciating and burning. The visual analog scale (VAS) score for pain at presentation was 6-7/10, which increased to 9-10/10 during bowel movements. The patients experienced significant pain relief throughout the two-month follow-up period, with an average decrease in VAS score by 50% after 14.8 ± 3.1 minutes and no complications were observed. The transcoccygeal approach is recommended due to its better technical feasibility and lower risk of visceral injuries. However, ossification of the sacrococcygeal disc can make needle placement difficult, and in such cases, an inferior approach through the joint space between the first and second coccygeal segments is recommended. The sacrococcygeal junction is obstructed by joint fusion in 51% of patients with coccyx pain, compared to only 12% fusion at the first intercoccygeal joint. In summary, the ganglion impar block, accessed via a transcoccygeal approach, is a safe and effective treatment option for chronic perineal pain (CPP) in pelvic cancer survivors. This approach is recommended due to the direct course, definite end point, and smaller volume of neurolytic requirement. CPP can negatively impact the quality of life of patients, as many are on high-dose opioids, which can lead to constipation and worsen anorectal pain. Blocking the ganglion impar can alleviate sympathetically mediated pain, reduce opioid consumption, and improve constipation, leading to better overall patient well-being.

Ferreira and Pedro (2020) summarized a case report of a patient with ovarian carcinoma who underwent two ganglion impar neurolyses, resulting in improved pain control and quality of life. The reported case refers to a cancer patient whose quality of life was significantly affected by pelvic-perineal pain, which made it impossible or difficult to perform simple daily tasks. The article highlights the importance of pain control in cancer patients and suggests that ganglion impar neurolysis can be a viable option for patients who do not respond to other treatments. The authors also emphasize the need to address the fourth step of the WHO analgesic ladder, which includes interventional procedures like ganglion impar neurolysis, as an option for cancer patients, including those in palliative care.⁷ Pain control was achieved for 3 months with the first ganglion impar neurolysis, which is consistent with the median duration of benefit reported in the literature. The second procedure was less effective, but coupled with superior hypogastric plexus neurolysis, it allowed pain control for another 2 months. In summary, patients gained better quality of life, improved quality of sleep, improved accomplishments of daily tasks, and improvement of social interaction during this period.

Okcu et al (2022) summarized a case report of the first case of rectal perforation during the application of ganglion impar blockade using the transsacrococcygeal technique. The patient, who was diagnosed with coccygodynia and received the ganglion impar blockade, developed a rectal perforation, which was probably caused by the structurally short presacral space and the use of a wrong needle. The case study emphasizes the importance of using technically appropriate needles and taking precautions to avoid rectal perforation in ganglion impar blockade.⁸ In conclusion, care should be taken to avoid rectal perforation and to use technically appropriate needles in ganglion impar blockade applications.

An UpToDate review on “Coccydynia (coccygodynia)” (Foye, 2026) states that “For patients with persistent coccydynia (> 2 months), we suggest management with coccygeal injections containing local anesthetic or local anesthetic plus glucocorticoid (Grade 2C)”.⁹

Supplemental Information

Clinical Practice Guidelines

NCCN Supportive care Guidelines Version 1.2026 Adult Cancer Pain: Includes ganglion impar block as a neurodestructive procedure used for treatment for cancer related rectal/perineal pain.

Regulatory Status

Ganglion impar block and radiofrequency thermocoagulation of the ganglion impairment for the treatment of chronic coccydynia are procedures and, therefore, not subject to FDA regulation. However, any medical devices, drugs, biologics, or tests used as a part of this procedure may be subject to FDA regulation.

Government Regulations

National:

No NCD

Local:

Noridian Health Care Solutions

(L35456) Nerve Blockade for Treatment of Chronic Pain and Neuropathy

Original Effective Date: 10/1/2015

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

For the purposes of this LCD and consistent with standard community understanding and the recommendations of specialty societies, pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain is chronic when it has been present, continuously or intermittently, despite therapy for three months or more.

Nerve blocks cause the temporary interruption of conduction of impulses in peripheral nerves or nerve trunks by the injection of local anesthetic solutions. Their utility in the diagnosis and treatment of non-neuropathic pain and specific syndromes mediated by sympathetic nervous system overactivity has been established.

- Diagnostic - to determine the source of pain e.g., to identify or pinpoint a nerve that acts as a pathway for pain; to determine the type of nerve that conducts the pain; to distinguish between pain that is central (within the brain and spinal cord) or peripheral (outside the brain and spinal cord) in origin; or to determine whether a neurolytic block or surgical lysis of the nerve should be performed. The type of diagnostic test may include injecting saline to stimulate pain or injecting an anesthetic agent to evaluate the patient's response, as an initial diagnostic step so that other pain relief options may be considered.

- Therapeutic - to treat painful conditions that respond to nerve blocks (e.g., celiac block for pain of pancreatic cancer) and /or “inappropriate” sympathetic nervous system activity. An appropriate injection of local anesthetic induces a temporary interruption in the conduction of impulses by peripheral nerves or nerve trunks. Longer-lasting or permanent blockade may be induced with the injection of neurolytic agents and/or application of thermal (not pulsed) radiofrequency. When blockade has been of value in the relief of acute or chronic cancer related pain, somatic or epidural blockade may be maintained through the infusion of local anesthetics via indwelling catheter.

Prior to blockade, all patients with pain complaints require an evaluation that includes, at a minimum, an assessment of the source of the pain and treatment of any underlying pathology. Evaluation must be documented in the patient’s records. In addition, those patients who do not respond to injections or otherwise continue with persistent or poorly responsive pain should be referred for a multi-disciplinary or other collaborative comprehensive evaluation.

Imaging guidance with fluoroscopy, CT or ultrasound may be necessary to perform somatic nerve blockade. Only fluoroscopic or CT guidance may be covered for epidural injections. It is inappropriate to bill for fluoroscopy (CPT® codes 77002 or 77003) with a 59 modifier when the procedure(s) billed on that date of service for the same patient by the same provider are included in the CPT® description of the procedure(s) performed.

SOMATIC NERVE BLOCK

- Radiculopathy and other neurological deficits require further evaluation and management prior to performing the blocks.

EPIDURAL BLOCK

This policy does not cover epidural blocks, which are covered in another Noridian policy. Please refer to L39240/A58993.

Summary of Evidence

NA

Analysis of Evidence (Rationale for Determination)

NA

(The above Medicare information is current as of the review date for this policy. However, the coverage issues and policies maintained by the Centers for Medicare & Medicare Services [CMS, formerly HCFA] are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. For the most current information, the reader should contact an official Medicare source.)

Related Policies

- Facet Joint Denervation
 - Sacroiliac Joint Fusion (Percutaneous or Minimally Invasive) for the Treatment of Low Back Pain
-

References

1. Sáenz MC, Cerrillo JI, Colomo CV, Vélez GS, Pizarro AQ, Collado FJ. Infiltration of impar and caudal ganglia in the management of traumatic coccydynia refractory to conventional analgesic treatment. *Revista Española de Cirugía Ortopédica y Traumatología (English Edition)*. 2011;55(5):340-345.
2. Gunduz OH, Sencan S, Kenis-Coskun O. Pain Relief due to Transsacrococcygeal Ganglion Impar Block in Chronic Coccygodynia: A Pilot Study. *Pain medicine (Malden, Mass)*. 2015;16(7):1278-1281.
3. Bhatnagar S, Gupta M. Evidence-based Clinical Practice Guidelines for Interventional Pain Management in Cancer Pain. *Indian J Palliat Care*. 2015 May-Aug;21(2):137-47. doi: 10.4103/0973-1075.156466. PMID: 26009665; PMCID: PMC4441173.
4. Le Clerc QC, Riant T, Levesque A, Labat JJ, Ploteau S, Robert R, Perrouin-Verbe MA, Rigaud J. Repeated Ganglion Impar Block in a Cohort of 83 Patients with Chronic Pelvic and Perineal Pain. *Pain Physician*. 2017 Sep;20(6):E823-E828. PMID: 28934788.
5. Gupta N, Garg R, Saini S, Bharti SJ, Kumar V. An Unusual Complication After Ganglion Impar Block for Chronic Cancer Pain Management. *AANA J*. 2017 Dec;85(6):424-426. PMID: 31573500.
6. Nalini KB, Shivanna S, Vishnu MS, Mohan CVR. Transcoccygeal neurolytic ganglion impar block for perineal pain: A case series. *J Anaesthesiol Clin Pharmacol*. 2018 Oct-Dec;34(4):544-547. doi: 10.4103/joacp.JOACP_301_16. PMID: 30774240; PMCID: PMC6360889.
7. Ferreira F, Pedro A. Ganglion Impar Neurolysis in the Management of Pelvic and Perineal Cancer-Related Pain. *Case Rep Oncol*. 2020 Jan 20;13(1):29-34. doi: 10.1159/000505181. PMID: 32110217; PMCID: PMC7036554.
8. Okçu M, Şencan S, Hakan Gündüz O. Rare complication of ganglion impar blockade with the transsacrococcygeal approach: A case of rectal perforation. *Turk J Phys Med Rehabil*. 2022 Jun 7;69(1):121-124. doi: 10.5606/tftrd.2022.8874. PMID: 37201018; PMCID: PMC10186016.
9. Update to date. Coccydynia (coccygodynia) Foye 2026 An UpToDate review on "Coccydynia (coccygodynia)" (Foye, 2026) states that "For patients with persistent coccydynia (> 2 months), we suggest management with coccygeal injections containing local anesthetic or local anesthetic plus glucocorticoid (Grade 2C)". [Coccydynia \(coccygodynia\) - UpToDate](#) accessed 4/8/26
10. National Comprehensive Cancer Network. Adult Cancer Pain. Version 1.2026 January 23, 2026 [pain.pdf](#) accessed 4/8/2026

The articles reviewed in this research include those obtained in an Internet based literature search for relevant medical references through 4/8/26, the date the research was completed.

Joint BCBSM/BCN Medical Policy History

Policy Effective Date	BCBSM Signature Date	BCN Signature Date	Comments
9/1/25	6/17/25		Joint policy established (jf) Vendor Managed: NA
9/1/26	6/16/26		• Routine maintenance (jf/no) • Vendor managed: NA • Formatting changes made: ○ Sections rearranged for better flow ○ Added Description and Background separated ○ MPS edited ○ Notes edited in code section

Next Review Date: 2nd Qtr, 2027

Pre-Consolidation Medical Policy History

Original Policy Date	Comments
BCN:	Revised:
BCBSM:	Revised:

BLUE CARE NETWORK BENEFIT COVERAGE
POLICY: GANGLION IMPAR BLOCK FOR CHRONIC PAIN

I. Coverage Determination:

Commercial HMO (includes Self-Funded groups unless otherwise specified)	Covered; criteria apply.
BCNA (Medicare Advantage)	See Government Regulations section of policy.
BCN65 (Medicare Complementary)	Coinsurance covered if primary Medicare covers the service.