Clinical Policy: Acupuncture Services

Reference Number: WNC.CP.278
Last Review Date: 03/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Acupuncture involves the manual and/or electrical stimulation of thin, solid, metallic needles inserted into the skin. Acupuncture has been studied for the treatment of many conditions, but some of the more common and studied indications include pain, nausea and vomiting, hypertension, chronic obstructive pulmonary disease, allergic rhinitis and addictive behavior.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that, when a covered benefit under the benefit plan contract, needle acupuncture is **medically necessary** when meeting all of the following:

A. Provided by a licensed acupuncturist or other appropriately licensed practitioner for whom acupuncture is within the practitioner's scope of practice and who has specific acupuncture training or credentialing;

B. Requested for a **member age 21 or older** for one or more of the following:

1. Low Back Pain (acute or chronic), as indicated by ALL of the following:
   a. No severe or progressive neurologic deficits
   b. Pain not due to cancer, infection, inflammatory arthropathy, high-velocity trauma, or fracture
   c. Patient not pregnant
2. Migraine headache prophylaxis needed, as indicated by ALL of the following:
   a. Migraine headache lasting 4 hours to 72 hours, as indicated by 5 or more attacks per month with **ALL** of the following:
      1. Headache symptoms, as indicated by 2 or more of the following:
         - Aggravation by or causing avoidance of routine physical activity
         - Moderate or severe pain intensity
         - Pulsating quality
         - Unilateral location
   b. Migraine-associated symptoms, as indicated by 1 or more of the following:
         - Nausea or vomiting
         - Photophobia or phonophobia
   c. Migraine headache frequency occurring fewer than 15 days per month.
   d. Symptoms present 12 months or longer

3. Tension headache recurring for more than 12 weeks despite medication or behavioral therapy (such as biofeedback or relaxation therapy)
4. Postoperative or chemotherapy induced nausea and vomiting;
5. Nausea and vomiting of pregnancy;
6. Chronic, neck, or shoulder pain;
7. Pain from clinically diagnosed osteoarthritis of the knee;

C. None of the following contraindications:
1. Severe neutropenia as seen after myelosuppressive chemotherapy;
2. Insertion of acupuncture needles at sites of active infection or malignancy.

An initial course of 6 visits over 1 month is considered medically necessary. If improvement in the condition occurs following the initial course of treatment, additional visits (up to 6 visits per authorization) may be authorized to maintain improvement.

II. It is the policy of WellCare of North Carolina that current evidence does not support the use of acupuncture for indications other than those listed above.

Background[1]

Acupuncture is a form of complementary and alternative medicine (CAM) and one of the oldest medical procedures in the world. It encompasses a large array of styles and techniques, however, the techniques most frequently used and studied are manual manipulation and/or electrical stimulation of thin, solid, metallic needles inserted into skin.[1]

The typical acupuncture treatment begins with identification of the patient's constitutional pattern. Once the diagnosis is established, fine metal needles are inserted into precisely defined points to correct disruption in harmony. Needles are removed after being in place for 10 to 15 minutes while the patient lies relaxed. Treatments can occur one to two times a week and the total number of sessions is variable dependent on the condition, disease severity and chronicity. Acute conditions are typically treated with acupuncture two to three times a week for two to three weeks then frequency is gradually reduced until treatment is no longer needed. Generally, treatment will last for two to three months. There is insufficient evidence in studies to establish a defined treatment protocol for any condition.[1]

There are many proposed models for the mechanism of action of the effects of acupuncture; however, the data have been either too inconsistent or inadequate to draw significant conclusions. The theory in regard to the analgesic effect of acupuncture, associates the neurotransmitter effects such as endorphin release at both the spinal and supraspinal levels. Functional MRI studies have demonstrated various physiologic effects, associating acupuncture points with changes in brain MRI signals. Another theory is that acupuncture points are associated with anatomic locations of loose connective tissue.[1]

Evidence from a number of randomized, blinded, placebo-controlled studies indicate that acupoint stimulation can be effective in the management of *postoperative nausea and vomiting*, particularly in women, with mixed results in pediatric populations. Acupoint stimulation for women undergoing chemotherapy also reduced nausea and vomiting in some studies, but no effect was reported in a study involving both men and women. The evidence regarding alleviation of morning sickness by acupoint stimulation is limited, less rigorous than for postoperative nausea and vomiting, and ambiguous.[5,9]

Recent data on acupuncture for *postoperative dental pain* is limited, but earlier evidence indicated promising results for this use. Data was most promising for pain relief following tooth extraction.[1,17]

There are a number of randomized controlled trials that establish improvement in *headache* frequency, intensity, response, use of relief medication and quality of life relative to usual care and relief treatment only. An updated Cochrane Review that previously noted promising, but insufficient evidence in support of acupuncture for migraine headache indicates, "there is consistent evidence that acupuncture provides additional benefit to treatment of acute migraine attacks only or to routine care," following the completion of 12 additional trials.[10] However, according to Hayes, ambiguity remains due to the low quality of the evidence and the variety of the studies evaluated, considering the diversity in acupuncture technique, number of treatment sessions, and length of follow-up.[15]

Acupuncture for *osteoarthritis pain* appears to be effective, particularly for pain in the knee. Recent literature has shown relief of pain and improved function in osteoarthritis of the knee for patients treated with acupuncture.[1,8]

Acupuncture has been studied for a variety of other reasons, but studies and evidence does not currently support its use for indications such as, but not limited to, arm pain, temporomandibular joint dysfunction, menstrual cramps and fibromyalgia.[1,6]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

CPT®* Codes	Description
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needles(s)
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needles(s)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
G43.001through G43.919	Migraine
G44.221 through G44.229	Chronic tension- type headache
M17.0 through M17.9	Osteoarthritis of knee
M25.511through M25.519	Pain in shoulder
M50.00 through M54.9	Other dorsopathies
O21.0 through O21.9	Excessive vomiting in pregnancy
R11.10 through R11.2	Nausea and vomiting

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	03/23	

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North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in :
   1. the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise); or
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

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Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy,

contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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