MEDICAL POLICY

POLICY TITLE	ACUPUNCTURE
POLICY NUMBER	MP-8.009

Original Issue Date (Created):	**1/31/2005**
Most Recent Review Date (Revised):	**8/14/2018**
Effective Date:	**1/1/2019** **RETIRED**

I. POLICY

Acupuncture (manual or electro-acupuncture), as an adjunct to traditional anesthesia, may be considered **medically necessary** for the treatment of episodic migraine and/or tension type headache when experienced for 15 days or more per month and lasting four hours a day or longer that failed first-line pharmacologic preventive therapy such as tricyclic antidepressants, beta blockers, calcium channel blockers, or valproic acid. Acupuncture is a non-pharmacological treatment option for patients with one or more of the following characteristics:

- Poor tolerance for specific pharmacological treatments; **or**
- Medical contraindications for specific pharmacological treatments; **or**
- Insufficient or no response to pharmacological treatment

Acupuncture (manual or electro-acupuncture) may be considered **medically necessary** as an alternative treatment option for chronic back and neck pain was well as chronic pain in patients with spinal cord injury. Pain symptoms must be at least 3 months in duration that has not responded to conservative treatment which includes physical therapy and/or pharmacotherapies such as non-steroidal anti-inflammatory drugs, muscle relaxants, and analgesics.

Acupuncture for all other indications, including the treatment of nausea and/ or vomiting and for opioid reduction or cessation in opiate users, is considered **investigational,** as there is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

Note: Benefits if covered by contract for acupuncture are limited 24 visits in a calendar year.

Cross-references:

MP 2.072 Trigger Point and Tender Point Injections
MP 4.041 Dry Needling of Myofascial Trigger Points
MP 4.014 Epidural Steroid Injections for Back Pain and Facet Nerve Blocks

II. PRODUCT VARIATIONS TOP

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

CHIP (aka Capital Cares 4Kids): Acupuncture is not a covered service.
PPO: Acupuncture is not a covered service.
HMO: Acupuncture is not a covered service.
POS: Acupuncture is not a covered service.
Indemnity: Acupuncture is not a covered service.
Special Care: Acupuncture is not a covered service.
FEP PPO: The Federal Employee Program (FEP) includes specific conditions under which acupuncture may be covered:

- When used to treat illnesses and/or injuries (i.e., used for other than inducing anesthesia);
- When provided as anesthesia for covered surgery;
- When provided as anesthesia for covered maternity care.

III. DESCRIPTION/BACKGROUND TOP

Acupuncture is a traditional form of Chinese medical treatment that has been practiced for over 2000 years. It involves piercing the skin with needles at specific body sites. The placement of needles into the skin is dictated by the location of meridians. These meridians, or channels, are thought to mark patterns of energy, called Qi (Chi), that flow through the human body. According to traditional Chinese philosophy, illness occurs when the energy flow is blocked or unbalanced, and acupuncture is a way to influence chi and restore balance. Another tenet of this philosophy is that all disorders are associated with specific points on the body, on or below the skin surface.

Several physiologic explanations of acupuncture's mechanism of action have been proposed including an analgesic effect from release of endorphins or hormones (e.g., cortisol, oxytocin), a biomechanical effect, and/or an electromagnetic effect.

There are 361 classical acupuncture points located along 14 meridians, and different points are stimulated depending on the condition treated. In addition to traditional Chinese acupuncture, there are a number of modern styles of acupuncture, including Korean and Japanese acupuncture. Modern acupuncture techniques can involve stimulation of additional non-meridian acupuncture points. Acupuncture is sometimes used along with manual pressure, heat (moxibustion), or electrical stimulation (electroacupuncture). Acupuncture treatment can vary by style and by practitioner, and is generally personalized to the patient. Thus, patients with the same condition may receive stimulation of different acupuncture points.

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Scientific study of acupuncture is challenging due to the multifactorial nature of the intervention, variability in practice, and individualization of treatment. There has been much discussion in the literature on the ideal control condition for studying acupuncture. Ideally, the control condition should be able to help distinguish between specific effects of the treatment and nonspecific placebo effects related to factors such as patient expectations and beliefs and the patient-provider therapeutic relationships. A complicating factor in selection of a control treatment is that it is not clear whether all 4 components (i.e., the acupuncture needles, the target location defined by traditional Chinese medicine, the depth of insertion, and the stimulation of the inserted needle) are necessary for efficacy. Sham acupuncture interventions vary; they can involve, e.g., superficial insertion of needles or insertion of needles at the "wrong" points. A consensus recommendation on clinical trials of acupuncture, published in 2002 by White et al, recommend distinguishing between a penetrating and a nonpenetrating sham control.

Acupuncture has been used to treat a large variety of conditions. This review addresses acupuncture for treating chronic pain, to ameliorate nausea and vomiting symptoms, and to alleviate withdrawal symptoms of opioid users.

The U.S. Food and Drug Administration (FDA) has cleared acupuncture needles for marketing. The needles used in acupuncture, when intended for general use in "the performance of acupuncture," have been classified by the FDA to Class II devices (The Gray Sheet, April 8, 1996). The NIH Consensus Statement (1997) further states: "Acupuncture as a therapeutic intervention is widely practiced in the United States. While there have been many studies of its potential usefulness, many of these studies provide equivocal results because of design, sample size, and other factors. The issue is further complicated by inherent difficulties in the use of appropriate controls, such as placebos and sham acupuncture groups. However, promising results have emerged, for example, showing efficacy of acupuncture in adult postoperative and chemotherapy nausea and vomiting and in postoperative dental pain". The NIH reported that, while much of the research conducted has been on various pain problems, and while many other conditions have received attention in the literature, the quality or quantity of research evidence is not sufficient to provide firm evidence of efficacy at the current time.

Acupuncture is considered within the scope of practice of a licensed physician. However, some physicians may seek additional training in acupuncture. Non-physicians who have completed appropriate training may also be licensed to perform acupuncture. State regulations may affect the range of providers offering acupuncture.

IV. RATIONALE

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SUMMARY OF EVIDENCE

Pain-Related Conditions

For individuals who have episodic migraines who receive acupuncture, the evidence includes RCTs and systematic reviews. Relevant outcomes include symptoms, functional outcomes,

medication use, and treatment-related morbidity. Pooled analyses of 15 sham-controlled trials on episodic migraine in a Cochrane review found significantly better outcomes with acupuncture, which were considered to be clinically significant. Pooled analyses of trials on acupuncture vs medication found a significant benefit of acupuncture at the end of treatment but not at the end of the follow-up period. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have tension-type headaches who receive acupuncture, the evidence includes RCTs and systematic reviews. Relevant outcomes include symptoms, functional outcomes, medication use, and treatment-related morbidity. Pooled analyses in a Cochrane review on acupuncture for tension-type headaches consistently found statistically significant benefits of acupuncture compared with sham up to 5 to 6 months. The clinical significance of the findings was not assessed. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have low back pain who receive acupuncture, the evidence includes RCTs and systematic reviews. Relevant outcomes include symptoms, functional outcomes, medication use, and treatment-related morbidity. A Cochrane review identified a single sham-controlled trial on acute low back pain and outcomes were not significantly better with acupuncture. Findings for chronic back pain in the Cochrane review were mixed. Pooled analyses of sham-controlled randomized trials on chronic low back pain in 2 different meta-analyses found improvements in pain up to 3 months. No significant global improvement was observed at up to 3 months in the acupuncture group. Longer term sham-controlled data are not available. Pooled analyses found no clinically meaningful improvement regarding pain or function among the acupuncture recipients compared with the group receiving other treatments (e.g., pain immediately postintervention or during 10 to 36 weeks postintervention). The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have other pain-related conditions (e.g., shoulder pain, lateral elbow pain, carpal tunnel syndrome, cancer pain in adults, chronic pain in adults with spinal cord injury, pain in endometriosis, pain in rheumatoid arthritis) who receive acupuncture, the evidence includes a few RCTs and systematic reviews of these trials. Relevant outcomes include symptoms, functional outcomes, medication use, and treatment-related morbidity. The RCTs were of low quality and/or lacked significantly better outcomes with acupuncture than with control conditions. The evidence is insufficient to determine the effects of the technology on health outcomes.

Nausea and Vomiting

For individuals who have nausea or vomiting or are at high risk of nausea or vomiting who receive acupuncture, the evidence includes RCTs and meta-analyses. Relevant outcomes include symptoms, functional outcomes, medication use, and treatment-related morbidity. Two Cochrane reviews addressed acupuncture for treating nausea and vomiting in pregnancy. The few RCTs identified did not find significant differences in outcomes between acupuncture and sham acupuncture. A third Cochrane review addressed chemotherapy-induced nausea and vomiting.

Findings were not robust. A pooled analysis of 4 trials (1 on manual acupuncture, 3 on electroacupuncture) found that the acupuncture intervention was associated with a significantly lower incidence of acute vomiting during the next 24 hours. However, no individual trial had a significant finding for this outcome, and a pooled analysis of the 3 trials on electroacupuncture did not find a significant benefit from electroacupuncture on acute vomiting. Moreover, data from these trials were not available on 3 of the 4 outcomes of interest. A fourth Cochrane review addressed 10 interventions involving stimulation of the wrist acupuncture point PC6. Conclusions about acupuncture could not be drawn from this review because only a small number studies of assessed acupuncture and review findings were not stratified by intervention. The evidence is insufficient to determine the effects of the technology on health outcomes.

Opioid Dependence
For individuals who have opioid dependence who receive acupuncture, the evidence includes RCTs and systematic reviews. Relevant outcomes include symptoms, functional outcomes, medication use, and treatment-related morbidity. A Cochrane review identified a single RCT, which did not find a significant benefit from acupuncture in reducing opioid consumption in patients with chronic non-cancer-related pain. A narrative systematic review concluded that there is insufficient evidence from high-quality RCTs to draw conclusions about the efficacy of acupuncture in the treatment of opiate addiction. The evidence is insufficient to determine the effects of the technology on health outcomes.

> and needs for research attending the use of acupuncture for surgical anesthesia and relief of chronic pain. Until the pending scientific assessment of the technique has been completed and its efficacy has been established, Medicare reimbursement for acupuncture, as an anesthetic or as an analgesic or for other therapeutic purposes, may not be made. Accordingly, acupuncture is not considered reasonable and necessary within the meaning of §1862(a) (1) of the Act."

In addition, Centers for Medicare & Medicaid Services issued a 2003 national coverage analysis on acupuncture for fibromyalgia[28] and a 2003 decision analysis on acupuncture for OA,[29] both indicating noncoverage of the service.

V. DEFINITIONS

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N/A

VI. BENEFIT VARIATIONS

TOP

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 BlueCross for benefit information.

VII. DISCLAIMER

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Capital BlueCross'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 BlueCross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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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.

Covered when medically necessary:

CPT Codes ®							
97810	97811	97813	97814				

ICD-10-CM Diagnosis Codes	Description
G43.001	Migraine without aura, not intractable, with status migrainosus
G43.009	Migraine without aura, not intractable, without status migrainosus
G43.011	Migraine without aura, intractable, with status migrainosus
G43.019	Migraine without aura, intractable, without status migrainosus
G43.101	Migraine with aura, not intractable, with status migrainosus
G43.109	Migraine with aura, not intractable, without status migrainosus
G43.111	Migraine with aura, intractable, with status migrainosus
G43.119	Migraine with aura, intractable, without status migrainosus
G43.401	Hemiplegic migraine, not intractable, with status migrainosus
G43.409	Hemiplegic migraine, not intractable, without status migrainosus
G43.411	Hemiplegic migraine, intractable, with status migrainosus

G43.419	Hemiplegic migraine, intractable, without status migrainosus
G43.B0	Ophthalmoplegic migraine, not intractable
G43.B1	Ophthalmoplegic migraine, intractable
G44.201	Tension-type headache, unspecified, intractable
G44.209	Tension-type headache, unspecified, not intractable
G44.211	Episodic tension-type headache, intractable
G44.219	Episodic tension-type headache, not intractable
G44.221	Chronic tension-type headache, intractable
G44.229	Chronic tension-type headache, not intractable
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M53.81	Other specified dorsopathies, occipito-atlanto-axial region
M53.82	Other specified dorsopathies, cervical region
M53.83	Other specified dorsopathies, cervicothoracic region
M53.84	Other specified dorsopathies, thoracic region
M53.85	Other specified dorsopathies, thoracolumbar region
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.18	Radiculopathy, sacral and sacrococcygeal region
M54.2	Cervicalgia
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.5	Low back pain
M54.6	Pain in thoracic spine
M54.81	Occipital neuralgia

M54.89	Other dorsalgia
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of lumbar region

IX. REFERENCES

TOP

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X. POLICY HISTORY

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MP 8.009	**CAC 10/26/04**
	CAC 10/25/05
	CAC 9/26/06
	CAC 7/31/07
	CAC 1/29/08
	CAC 3/31/09
	CAC 11/24/09 Revised policy to include information on electroacupuncture
	CAC 11/30/10 Consensus review
	CAC 6/26/12 Consensus review; no changes; references updated.
	CAC 9/24/13 Consensus review; no changes to policy statements; references updated. Administrative code review completed.
	CAC 7/22/14 Consensus review. No changes to the policy statements References updated. Rationale added**.** Coding reviewed, coding format updated.
	CAC 3/24/15 Coding reviewed
	CAC 7/21/15 Consensus review. No changes to the policy statements. Reference update. Codes reviewed.
	CAC 7/26/16 Consensus review. No changes to the policy statements. References updated. Coding reviewed.
	Admin update 1/1/17: Product variation section reformatted.
	CAC 3/28/17 Minor Review. Align with BCBSA; partial adoption. Medically necessary for tension/ episodic migraine headache as well as for an alternative therapy for chronic back, neck, and spinal cord pain. All other uses are considered investigational. Rationale and references added. Coding reviewed and diagnosis codes changed.
	1/1/18 Admin Update: Medicare variations removed from Commercial Policies.
	1/25/18 Consensus review. No changes to the policy statements. References and rationale updated**.**
	8/14/18 Retirement due to change for 1/1/19 benefit, will be managed by benefit only.

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