



Cigna Medical Coverage Policy

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Subject **Acupuncture**

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INSTRUCTIONS FOR USE

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Coverage Policy

Acupuncture is specifically excluded under many benefit plans. Please refer to the applicable benefit plan document to determine benefit availability and the terms, conditions and limitations of coverage. Some plans that provide coverage for acupuncture include a maximum allowable benefit for duration of treatment or number of visits. When the maximum allowable benefit is exhausted, coverage will no longer be provided even if the medical necessity criteria described below are met.

If coverage is available for acupuncture, the following conditions of coverage apply.

Cigna covers acupuncture as medically necessary for any of the following indications:

- nausea and vomiting associated with pregnancy
- nausea and vomiting associated with chemotherapy
- postoperative nausea and vomiting

- postoperative dental pain

Cigna covers acupuncture as an adjunct to standard conservative therapy for the treatment of ANY of the following CHRONIC painful conditions when other conservative methods of treatment have failed, there is limitation resulting in impaired activities of daily living, and there is reasonable expectation treatment will result in significant therapeutic improvement over a clearly defined period of time:

- migraine or tension headache
- osteoarthritic knee pain
- neck pain
- low back pain

Cigna does not cover acupuncture when treatment is unlikely to result in sustained improvement or when there is no defined endpoint, including preventive, maintenance or supportive care, because it is considered not medically necessary.

Cigna does not cover acupuncture for any other indication, because it is considered experimental, investigational or unproven.

Cigna does not cover acupuncture point injection for ANY indication because it is considered experimental, investigational or unproven.

General Background

Acupuncture is a form of complementary and alternative medicine that has been widely practiced for many centuries. It involves the stimulation of specific anatomical locations on the skin through the penetration of fine needles, with the goal of relieving pain or treating disease. Stimulation can be accomplished manually (i.e., by a twisting motion of the hand) or through such methods as electrical stimulation (i.e., electroacupuncture), heating, laser, pressure, and herb moxibustion.

The theory of acupuncture is based on the assumption that there are patterns of energy flow (i.e., Qi) through the body that are essential for an individual's health. Proponents of acupuncture contend that illness can be traced to the imbalance of the Qi that runs in meridians or channels within the body. The insertion of needles in specific locations in various combinations and patterns along these meridians is claimed to restore the orderly energy flow, resulting in a return to a healthy state.

Acupuncture has been proposed as a treatment for acute and chronic pain conditions, including surgical analgesia, postoperative, musculoskeletal, neurological, vascular, and craniomandibular pain as well as the pain of malignancy. It has also been investigated as a treatment modality for a wide variety of other conditions, such as asthma, addictive behavior, nausea, vomiting, infertility, allergic rhinitis, depression, and bowel dysfunction, and as a weight-reduction method.

The clinical utility of acupuncture is widely debated. Evaluating the clinical efficacy of acupuncture in the context of clinical trials is challenging primarily because of the difficulty of designing randomized trials with appropriate blinding of both subjects and providers. Many studies lack appropriate controls, adequate study size, randomization and/or consistent outcome measures.

Study controls for comparing real acupuncture (also referred to as verum acupuncture) typically include a placebo, sham acupuncture, standard treatment, or no treatment. Sham acupuncture is the most often used control in studies evaluating the efficacy of acupuncture. However, there is no standardized method for employing sham acupuncture and no consensus on needle placement, making it difficult to generalize findings across studies. The goal of applying sham acupuncture is to refrain from stimulating acupuncture points. In many studies, sham is done at irrelevant acupuncture sites; however, evidence has shown sham acupuncture evokes physiological responses. Because the evidence suggests that sham acupuncture is not truly a physiologically neutral event, its use as a control in clinical trials is debatable. It is difficult to distinguish between the specific effects of treatment versus that of the placebo. It has been reported that the ratio of improvement in

sham groups was substantially higher than in truly inert placebo groups (Madsen, et al., 2009; Ezzo, et al., 2000). Although initially believed to have no effect, some researchers contend that needle placement in any position invokes a biological response that may interfere with the interpretation of findings.

A majority of states provide licensure or registration for acupuncture practitioners, although the scope of practice allowed under state requirements varies. The National Institutes of Health (NIH) Consensus Panel and the U.S. Food and Drug Administration (FDA) consider acupuncture safe when performed by qualified practitioners using sterile needles. The FDA requires that sterile, nontoxic needles be used and that they be labeled for single use by qualified practitioners. Acupuncture appears to be a relatively safe treatment with rare serious adverse side effects when performed by qualified practitioners who consistently adhere to the recommendations of the FDA regarding the use of sterile needles.

In addition to adults, acupuncture is being performed to treat a variety of conditions in children. Treatment of children is more complex compared to adults, mainly due to physiological differences and fear of needles. As a result, instead of inserting needles techniques such as applied pressure, electricity or laser may be used (Libonate, et al., 2008) and are better tolerated. The amount of evidence to support safety and efficacy for use in children is limited and primarily focuses on post-operative nausea and vomiting and acute and chronic pain. Similar to adults, much of the data is limited by small sample size, lack of randomization, and mixed clinical outcomes. When used to treat postoperative and chemotherapy induced nausea and vomiting there is sufficient evidence to support safety and efficacy of acupuncture in children (Jindal, et al., 2008; Libonate, et al., 2008). There is limited data supporting efficacy for acupuncture when used to treat headaches in adolescents (Gottschling, et al., 2008; Kemper, et al., 2008 [Task Force on Complementary and Alternative Medicine and the Provisional Section on Complementary, Holistic, and Integrative Medicine, American Academy of Pediatrics]; Kundu, et al., 2007) and clinical outcomes are mixed (Jindal, et al., 2008). Additional applications may include nausea, pain and allergy (Kemper, et al., 2008), however further data from large well-designed clinical studies are needed to support safety and efficacy for these and a variety of other pediatric conditions such as asthma, allergic rhinitis, neurological disorders, gastrointestinal disorders, cancer pain, and addictions (Jindal, et al., 2008).

The published, peer-reviewed scientific literature provides sufficiently strong evidence to indicate that acupuncture is safe and effective in adults for the treatment of postoperative nausea and vomiting, nausea and vomiting associated with pregnancy or chemotherapy, and postoperative dental pain (Smith, et al., 2002; Smith and Crowther, 2002; Knight, et al., 2001; Lao, et al., 1999; Dundee, et al., 1989; National Institute of Health, [NIH], 1997; Lao, et al., 1995). Treatment duration for these conditions is generally short-term as a result of the condition being treated. There is also sufficient data in the peer-reviewed, published scientific literature supporting safety and efficacy for the use of acupuncture as an adjunctive treatment modality for chronic pain conditions including headaches (i.e., migraine, tension), low back pain, neck pain, and osteoarthritic knee pain. Depending on the pain condition being treated, a course of acupuncture may last several weeks. However, there is no consensus in the scientific literature regarding the optimal number of acupuncture treatments to administer or the duration of treatment for any condition. Furthermore, acupuncturists employ a variety of techniques making generalizations difficult.

Headaches

Evidence in the medical literature evaluating the safety and effectiveness of acupuncture as a treatment for chronic headaches consists largely of randomized controlled trials, case reports/series, and systematic reviews. Although many of the clinical trials have limitations and do not lead to strong, definitive conclusions, they are suggestive of improved clinical outcomes for chronic migraine and tension headaches (Sun, et al., 2008; Endres, et al., 2007; Alecrim-Adrade, et al., 2007; Diener, et al., 2006; Coeytaux, et al., 2005; Vickers, et al., 2004; Malchert, et al., 2003; Allais, et al., 2003; Malchert, et al., 2001). The number of treatment sessions and duration of treatment within these studies vary; the total treatment sessions ranged from one to 16 while the duration of treatment ranged from one single treatment (prevention at onset) to 24 weeks.

Sun and Gan (2008) published a systematic review evaluating the efficacy of acupuncture for treating various types of chronic headache (i.e., migraine, tension type). A total of 31 trials, using various sham designs, involving 3916 subjects were included in their review. Response rates (both early and late) of the acupuncture groups were significantly higher and showed a trend in favor of acupuncture. Furthermore, the authors noted that acupuncture was superior to medication therapy for headache intensity, headache frequency, physical function and response rate.

Data from randomized controlled trials has shown acupuncture to be effective for the treatment of various types of headaches, including chronic migraine, tension-type and daily headaches. Studies have generally compared acupuncture to sham acupuncture as the control group while some compared acupuncture to standard medical management or other forms of treatment such as transcutaneous nerve stimulation (TENS). Endres et al. (2007) reported that episodic or chronic tension-type headache improves after acupuncture treatment, although the authors noted the rationale for the effect is not clearly established. Acupuncture has also been shown to reduce the frequency of migraine headache (Wang, et al., 2011; Alecrim-Adrade, et al., 2007; Diener, et al., 2006; Vickers, et al., 2004). In addition, the study by Vickers, et al. (2004) evaluating acupuncture for chronic migraine or tension headaches, supported the use of less medication per year, fewer visits to general practitioners, and use of fewer sick days per year in the acupuncture group when compared to a control group (i.e., subjects receiving only standard care). Coeytaux and associates (2005) evaluated acupuncture as an adjunctive treatment for chronic daily headaches (typically arising from migraine or tension) and noted that acupuncture did improve clinical outcomes when used as an adjunct to medical management. Allais et al. (2003) reported acupuncture as the most effective treatment of migraine headaches in comparison to transcutaneous nerve stimulation (TENS) and infrared laser therapy.

Cochrane reviews have been published supporting acupuncture as having benefit for the treatment of migraine headaches and tension-type headaches (Linde, et al., 2009a, Linde, et al., 2009b; Malchert, et al., 2001). In an early review, Malchert et al. (2001) stated that the evidence does support the value of acupuncture for the treatment of migraine headaches, although the quality and amount of evidence were not fully convincing. Linde et al. (2009a) reviewed trials that evaluated whether or not acupuncture was effective in the prophylaxis of migraine headache and concluded, "Collectively, the studies suggest that migraine patients benefit from acupuncture, although the correct placement of needles seems to be less relevant than is usually thought by acupuncturists." In a more recent Cochrane Review published by Linde, et al. (2009b) the authors evaluated acupuncture for treatment of tension-type headache and reviewed 11 trials in total. The authors concluded the available evidence does suggest that acupuncture could be a valuable non-pharmacological tool in patients with frequent episodic or chronic tension-type headaches.

Pain Conditions

Acupuncture has also been investigated for the treatment of pain conditions such as chronic neck and low back pain; although some of the evidence supporting the efficacy of acupuncture for these treatments has been contradictory. Various studies have compared the effectiveness of acupuncture to that of sham acupuncture, placebo, and massage therapy, as well as to the effectiveness of self-care for low back pain and neck pain.

Neck Pain: Chronic neck pain is a common condition with multiple etiologies, and is often treated with acupuncture. Although the evidence evaluating acupuncture as an alternative or adjunctive form of treatment for chronic neck pain is limited, some authors report that acupuncture is beneficial in the treatment of this condition (Blossfeldt, 2004; Irnich et al., 2001) while others claim there is a lack of evidence to support acupuncture as an effective treatment modality (White and Ernst, 1999). Nonetheless, while more robust research may be useful, the available evidence does suggest that acupuncture is a worthy option as an adjunct to other neck pain treatments. In general, the average number of acupuncture treatment sessions varies as well as the duration of treatment across clinical trials, however, the average number of treatment sessions for treating chronic neck pain range from one to two sessions per week provided over a range of three to 12 weeks.

Published evidence evaluating acupuncture for the treatment of neck pain is primarily in the form of systematic reviews and meta analysis (with some overlapping of studies) (Leaver, et al., 2010; Fu, et al., 2009; White and Ernst, 2009; Trinh, et al., 2007[Cochrane], Birch, et al., 2004) randomized controlled trials (Sun, et al., 2010; Vas, et al., 2006; Witt, et al., 2006; White, et al., 2004; Irnich, et al., 2001), and prospective clinical trials (Franca, et al., 2003; Zhu, et al., 2002, David, et al., 1998). The authors of one systematic review concluded that there was no convincing evidence to support the effectiveness of acupuncture for the treatment of chronic neck pain (i.e., ankylosing spondylitis, myofascial, osteoarthritic) after the authors reviewed 14 randomized controlled trials (White and Ernst, 1999). Nonetheless, the results of a Cochrane Review (Trinh, et al., 2007) suggested there was moderate evidence to support acupuncture as a treatment for chronic neck pain (i.e., mechanical neck disorders, myofascial, degenerative) was more effective for pain relief compared to sham acupuncture, decreased pain at short-term follow-up, and was more effective than inactive treatments for relieving pain post-treatment and was maintained at short-term follow-up. More recently in a publication regarding the results of the "Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorder", Hurwitz et al. (2008)

reported, "The evidence suggests that manual and supervised exercise interventions, low-level laser therapy, and perhaps acupuncture are more effective than no treatment, sham, or alternative interventions." However, the authors also noted none of the active treatments were clearly superior to any other in either the short- or long-term.

Despite limitations to the evidence, randomized controlled trials have supported the effectiveness of acupuncture as a treatment of chronic neck pain in general, without varying etiology. In a single-blind prospective study Vas et al., (2006) reported acupuncture was more effective compared to a placebo control (TENS placebo). The acupuncture group had a change in mean intensity of uncomplicated neck pain that was 62.2% compared to 20.4% among the control group. Witt and associates (2006) conducted a prospective, multicenter, randomized three-arm study to investigate the effectiveness of acupuncture combined with routine care in patients with chronic neck pain compared to treatment with routine care alone (the Acupuncture in Routine Care [ARC] Study, conducted in Germany). The authors reported improvement in neck pain and disability at three months follow-up, which was maintained through six months for both the acupuncture and control group. Sun et al. (2010) reported the results of a single-blind randomized trial (n=35) comparing acupuncture to sham acupuncture for treatment of chronic neck myofascial pain. The primary outcome was quality of life scores as measured by SF-36 with secondary outcomes measures of neck range of motion. The results of this trial did not demonstrate a significant difference in range of motion and motion related pain among groups however the authors noted the acupuncture group did have greater improvement in physical functioning and improvement in quality of life.

Back Pain: Evidence in the form of systematic reviews, randomized controlled trials, meta analyses and observational studies evaluate the use of acupuncture for treating low back pain. While the etiology of back pain is not typically specified, the subjects enrolled in the majority of clinical trials were experiencing chronic low back pain with few having acute episodes. Much of the published evidence is conflicting/contradictory, some authors report that acupuncture may be beneficial (Trigkilidas, 2010; Furlan, et al., 2004; Meng, t al., 2003; Molsberger, et al., 2002; Leibing, et al., 2002; Carlsson, et al., 2001) while others report the benefit is unclear (Cherkin, et al., 2003; Kerr, et al., 2003; van Tulder, et al., 1999; Ernst and White, 1998). Some authors did not define the number of treatment sessions and/or duration of treatment although similar to other pain conditions, treatment sessions ranged from one to five times per week, (averaging one to two treatments), over a duration of four to 12 weeks.

In May 2009 the National Institute for Health and Clinical Excellence (NICE) published guidelines for back pain which included a course of acupuncture as a treatment option. Trigkilidas (2010) sought to determine if the treatment option was justified based on recent evidence. In 2010 Trigkilidas published results of a systematic review of RCTs evaluating acupuncture for the treatment of chronic low back pain. Out of 15 studies identified, four studies met inclusion criteria and were reviewed. Methodological flaws were noted and included recruitment methods which could lead to bias, small sample population in some studies with high loss to follow-up and difficulty in reproducing the intervention. Based on 'the results of these studies the authors concluded acupuncture can be effective for managing patients with back pain, particularly if they have positive expectations.

Yuan et al. (2008) published a systematic review of RCTs evaluating the effectiveness of acupuncture for nonspecific low back pain (i.e., chronic, subacute, combined). After reviewing 23 trials the authors concluded there was moderate evidence that acupuncture is more effective than no treatment, there was strong evidence that there is no significant difference between acupuncture and sham acupuncture for short-term pain relief and there was strong evidence supporting acupuncture as a useful supplement to other forms of conventional therapy for low back pain. Manheimer and associates (2005) published the results of a meta-analysis that was conducted to assess acupuncture's effectiveness for treating low back pain (acute and chronic). Although the quality and quantity of the trials varied, 33 randomized controlled trials met inclusion criteria for the review. According to the results of the review, acupuncture effectively relieved chronic low back pain compared to no treatment, however, there was no evidence to indicate that acupuncture is more effective than other active therapies.

Some studies suggest acupuncture is superior to no treatment or sham therapy for short-term relief of back pain. Haake et al. (2007) reported the results of a randomized controlled trial (n=1162) evaluating whether acupuncture is more efficacious in reducing chronic low back pain than conventional therapy or sham acupuncture. Both acupuncture groups had improvement in pain intensity or back specific disability without

concomitant therapies when compared to the conventional treatment group. Brinkhaus et al. (2006) reported acupuncture was more effective in improving pain than no acupuncture in patients with chronic low back pain, although there were no significant differences between acupuncture and minimal acupuncture. The study group consisted of 298 patients, randomized to treatment with acupuncture, minimal acupuncture, or a waiting list control. Inoue et al. (2006) randomized 31 patients with low back pain to receive either acupuncture or sham acupuncture performed at the most painful point on the lower back of patients. Their results suggested that acupuncture at the most painful point provided immediate relief of low back pain. Hsieh, et al. (2006) compared acupuncture (n= 64) to physical therapy (n=65) in patients with chronic low back pain and concluded that acupuncture was more efficacious in relieving back pain than physical therapy.

In a published observational study of patients with chronic low back pain (n=2564), conducted by Weidenhammer et al. (2007), the study results indicated that after six months follow-up, 45.5% of patients had clinically significant improvement in functional ability scores, and the mean number of days with pain was decreased by half.

Thomas et al. (2005) conducted a randomized controlled trial evaluating acupuncture as a treatment for chronic low back pain. The authors compared outcomes in two populations: patients who received traditional acupuncture in addition to conventional primary care (n=159) and patients who received usual care only (n=80) for persistent nonspecific low back pain. Traditional acupuncture care was safe and acceptable to patients with non-specific low back pain and both acupuncture and usual care were associated with clinically significant improvement at 12 and 24-month follow-up. Adding acupuncture was significantly more effective in reducing bodily pain than usual care at 24-month follow-up.

Osteoarthritic Knee Pain: Researchers also suggest that acupuncture is an effective complement to standard care for chronic osteoarthritis of the knee. Some of the conclusions are limited by the poor quality of the study design. In a majority of the studies osteoarthritis was confirmed by radiographs. Although clinical trials have yielded inconsistent results for a variety of reasons, there is some evidence supporting the efficacy of acupuncture as an adjunct or alternative treatment for osteoarthritis of the knee (Miller, et al., 2009; Jubb, et al., 2008; Manheimer, et al., 2007; White, et al., 2007; Williamson, et al., 2007; Scharf, et al., 2006; Witt, et al., 2006; Witt, et al., 2005; Berman, et al., 2004; Vas , et al., 2004; Ezzo, et al., 2001). Treatment sessions within these studies ranged from one to two treatment sessions per week, for an average of eight to 12 weeks.

Miller and colleagues (2009) published the results of a randomized controlled clinical trial (n=55) assessing the efficacy of acupuncture as an adjunct therapy to standard care in a group of elderly patients with osteoarthritis of the knee for at least six months duration. Primary outcome measures were changes in Knee Society Score (KSS) and in KSS function and pain ratings at therapy onset, after eight weeks and at 12 weeks. The authors noted significant improvements in all scores for both groups at eight weeks and 12 weeks compared with baseline. Acupuncture had a longer lasting effect—significant differences between the intervention group and control group in the KSS was not noticeable until after 12 weeks (eight weeks of therapy and one month follow-up).

Jubb et al. (2008) conducted a randomized controlled trial to monitor the effect of acupuncture on patients with symptomatic osteoarthritis of the knee for more than six months duration. The study population consisted of 64 subjects: 34 who received acupuncture (manual and electroacupuncture) and 34 who received non-penetrating sham ('placebo' needle) acupuncture with a primary endpoint of change in pain after a course of 10 treatments, measured by the WOMAC pain subscale. At five weeks, the authors reported a statistically significant improvement (p=0.035) in favor of the acupuncture group however at nine weeks after treatment there was no longer a significant difference between the groups. Within group analysis showed a statistically significant difference in WOMAC stiffness or function and visual analog scale for pain (secondary outcomes) one month following treatment (i.e., nine weeks) although the difference between the groups had been lost.

Evidence in the form of systematic reviews also supports the effectiveness of acupuncture for the treatment of knee pain. Manheimer et al. (2007) published the results of a systematic review and meta-analysis of the effects of acupuncture for treating osteoarthritis of the knee. All of the studies reviewed included participants with osteoarthritic knee pain of five years or more and all but one study required radiograph evidence of the condition. When evaluating efficacy, compared with sham acupuncture, real acupuncture provided clinically irrelevant short-term and long-term (six months after baseline) improvement in pain and function. When compared to waiting list and usual care groups, the patients reported clinically relevant short-term improvement

in pain and function. White et al. (2007) published the results of a systematic review and meta-analysis of evidence from randomized controlled trials on acupuncture's effect in reducing pain and increasing function in patients with chronic knee pain. All subjects had chronic knee pain for at least three months or osteoarthritis of the knee confirmed by radiographs. The authors noted that for pain reduction and improvement of function in the short term, acupuncture was significantly superior compared to sham acupuncture, and remained significantly superior at long-term outcome. Acupuncture was also superior compared to no additional care for both pain and function, although the authors reported that results were weakened by heterogeneity. The authors acknowledged there was some evidence that acupuncture is superior to placebo for chronic knee pain; however, further long-term large-scale studies are needed to provide a more definitive conclusion regarding acupuncture for knee arthritis.

Randomized controlled trials have also demonstrated the efficacy of acupuncture when used to treat osteoarthritic knee pain. Williamson and colleagues (2007) reported the results of a trial evaluating patients who received acupuncture (n=60), physiotherapy (n=60) or standard management (n=61) prior to knee surgery due to osteoarthritic pain. In all subjects pain was present for at least three months. At seven weeks, the acupuncture group had lower knee scores compared to the other groups, although this was not present at 12 weeks. Visual analog scores were lower at 12 weeks for the acupuncture and physiotherapy groups. Scharf et al. (2006) compared acupuncture with sham acupuncture and conservative therapy in patients with chronic osteoarthritic knee pain (greater than six months duration) and noted the acupuncture groups had higher success rates when compared to conservative care. There was no difference between acupuncture groups. Witt and associates (2006) evaluated a group of patients with chronic pain (due to osteoarthritis of the knee and hip) as part of the Acupuncture in Routine Care Study (ARC). The authors compared acupuncture to control subjects who did not receive acupuncture and reported improvement in WOMAC scores, and quality of life improvements which were more pronounced in the acupuncture group compared to the control group, with treatment success maintained through six months. Acupuncture plus routine care was associated with clinical improvement in patients with osteoarthritis of the knee or hip. In 2005 Witt and colleagues investigated the efficacy of acupuncture compared with minimal acupuncture and with no acupuncture in patients with pain and dysfunction resulting from osteoarthritis of the knee. The results of the study indicated that the patients who received acupuncture had less pain and better function after eight weeks than patients who received minimal acupuncture or no acupuncture; significant improvements in WOMAC subscales; and significantly better results for almost all secondary outcome measures than did the other groups (Witt, et al., 2005). The results of earlier published randomized trials have also supported the efficacy of acupuncture as a treatment of osteoarthritic knee pain (Berman, et al., 2004; Vas, et al., 2004; Ezzo, et al., 2001).

Other Indications

The volume of literature reporting on the efficacy of acupuncture for other indications is extensive and includes conditions such as menstrual cramps, tennis elbow, fibromyalgia, myofascial pain, carpal tunnel, temporomandibular joint pain, and correction of breech presentation. However, the overall body of evidence for these indications is generally of poor quality, consisting of numerous uncontrolled studies, small case series, case reports, and anecdotal information. Sample sizes are generally inadequate to identify real differences between treatment and control groups, data on long-term outcomes are lacking, there is no consensus regarding patient selection criteria, well-designed, large-population, randomized, controlled clinical trials are lacking. Several systematic reviews of the literature involving acupuncture have concluded that, while acupuncture may be superior to various controls, there is insufficient evidence to conclude that it is better than placebo for most indications. In addition, technology assessments conducted by the Agency for Healthcare Quality and Research (AHRQ) concluded there is insufficient evidence to support the efficacy of acupuncture for the treatment of fibromyalgia and osteoarthritis (AHRQ, 2003a; AHRQ, 2003b). Acupuncture has not been proven effective in the peer-reviewed published scientific literature for the treatment of any of the following conditions, including but not limited to:

- acute pain
- addictive behaviors, including chemical and tobacco addictions
- allergies
- as a weight reduction modality
- asthma
- attention-deficit/hyperactivity disorder
- autism spectrum disorders

- bowel dysfunction
- bursitis
- carpal tunnel syndrome
- correction of breech presentation
- depression
- dermatitis or psoriasis
- dysmenorrhea
- epicondylitis (tennis elbow)
- fibromyalgia
- hypertension
- in lieu of traditional anesthesia
- infertility
- labor
- myofascial pain syndrome
- neuropathies
- nocturnal enuresis
- pain of malignancy
- plantar fasciitis
- post-stroke rehabilitation
- reflex sympathetic dystrophy
- temporomandibular joint disorders (TMJ)
- tinnitus
- urinary incontinence (all types)

Acupuncture Point Injection Therapy

Acupuncture point injection therapy is a procedure where pharmaceuticals and natural biologic products such as vitamins, herbal extracts and other homeopathics, are injected into the body at acupuncture points to prevent or treat disease. One solution in particular, isotonic saline, when injected theoretically allows activation of the acupuncture point for a longer period of time enhancing the therapeutic effect. There is insufficient evidence in the peer-reviewed published scientific literature to support safety and efficacy at this time, data comparing the effectiveness of different products, methods of stimulation and overall clinical utility is lacking.

Professional Societies/Organizations

Professional societies and organizations have studied and commented on the safety and efficacy of acupuncture for various diseases and conditions. Recommendations from initial reports were based on varying levels of evidence and there was little consensus regarding what conditions acupuncture may be considered effective for (National Institute of Health [NIH], 1997; United Kingdom National Health Service [Vickers, 2001]; Alberta Heritage Foundation for Medical Research [Tait, et al.] 2002; World Health Organization [WHO], 2003).

More recent consensus statements or formal recommendations regarding acupuncture in general are lacking in the published literature, however some professional societies have addressed the use of acupuncture in other guidelines. The American College of Physicians (ACP) and American Pain Society developed evidence-based clinical practice guidelines for diagnosing and treating low back pain in the primary care setting. According to the guideline recommendations, acupuncture is considered a moderately effective nonpharmacologic therapy for treating chronic low back pain (Chou, et al., 2007).

Additionally, the American Academy of Orthopaedic Surgeons (AAOS) published clinical practice guidelines for the treatment of osteoarthritis of the knee (AAOS, 2008). According to this guideline however, due to conflicting evidence regarding the benefits of acupuncture, the AAOS was unable to recommend for or against the use of acupuncture as an adjunctive therapy for pain in patients with symptomatic osteoarthritis of the knee.

Summary

Despite the lack of strong scientific evidence, acupuncture is accepted as a form of complementary and alternative medicine for selected conditions, including treatment of postoperative nausea and vomiting, nausea and vomiting associated with pregnancy or chemotherapy, and postoperative dental pain. Treatment for these conditions is generally of short duration. Clinical studies provide some evidence to support the effectiveness of

acupuncture for the treatment of chronic headaches, low back and neck pain and osteoarthritis of the knee. Acupuncture may be a viable option as an adjunctive method of treatment for these conditions, when other conventional modalities have failed, and when there is reasonable expectation treatment will result in significant therapeutic improvement over a clearly defined period of time. While there is no consensus regarding the number of treatment sessions or duration of treatment, published scientific evidence suggests acupuncture is effective for pain relief, when performed one to two times weekly for 10 to 12 weeks on average. Acupuncture is considered not medically necessary when treatment is unlikely to result in sustained clinical improvement or when there is no defined endpoint for treatment, such as when provided for preventive, maintenance or supportive treatment. Acupuncture as a treatment for any other condition, including acupuncture point injection therapy, has not been proven effective in the published peer-reviewed scientific literature.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Acupuncture

Covered when medically necessary:

CPT®* Codes	Description
97810	Acupuncture, one or more needles without electrical stimulation; initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, one or more needles without electrical stimulation; each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)
97813	Acupuncture, one or more needles with electrical stimulation; initial 15 minutes of personal one-on-one contact with the patient
97814	Acupuncture, one or more needles with electrical stimulation; each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

ICD-9-CM Diagnosis Codes	Description
307.81	Tension headache
338.18	Other acute postoperative pain
338.28	Other chronic postoperative pain
339.10- 339.12	Tension type headache
346.00- 346.93	Migraine
353.2	Cervical root lesions, not elsewhere classified
353.4	Lumbosacral root lesions, not elsewhere classified
564.3	Vomiting following gastrointestinal surgery
643.00	Mild hyperemesis gravidarum, unspecified as to episode of care
643.03	Mild hyperemesis gravidarum, antepartum
643.10	Hyperemesis gravidarum with metabolic disturbance, unspecified as to episode of care
643.13	Hyperemesis gravidarum with metabolic disturbance, antepartum
643.20	Late vomiting of pregnancy, unspecified as to episode of care
643.23	Late vomiting of pregnancy, antepartum
643.80	Other vomiting complicating pregnancy, unspecified as to episode of care
643.83	Other vomiting complicating pregnancy, antepartum
643.90	Unspecified vomiting of pregnancy, unspecified as to episode of care

643.93	Unspecified vomiting of pregnancy, antepartum
715.06	Osteoarthritis, generalized, lower leg
715.16	Osteoarthritis, localized, primary, lower leg
715.26	Osteoarthritis, localized, secondary, lower leg
715.36	Osteoarthritis, localized, not specified whether primary or secondary, lower leg
715.86	Osteoarthritis involving, or with mention of more than one site, but not specified to generalized, lower leg
715.96	Osteoarthritis, unspecified whether generalized or localized, lower leg
721.0	Cervical spondylosis without myelopathy
721.1	Cervical spondylosis with myelopathy
721.3	Lumbosacral spondylosis without myelopathy
721.42	Lumbar spondylosis with myelopathy
722.0	Displacement of cervical intervertebral disc without myelopathy
722.10	Displacement of lumbar intervertebral disc without myelopathy
722.4	Degeneration of cervical intervertebral disc
722.52	Degeneration of lumbar or lumbosacral intervertebral disc
722.71	Intervertebral disc disorder with myelopathy, cervical region
722.73	Intervertebral disc disorder with myelopathy, lumbar region
722.93	Other and unspecified disc disorder, lumbar
723.0	Spinal stenosis in cervical region
723.1	Cervicalgia
723.3	Cervicobrachial syndrome (diffuse)
723.2	Cervicocranial syndrome
723.8	Other syndromes affecting cervical region
723.9	Unspecified musculoskeletal disorders and symptoms referable to neck
724.02	Spinal stenosis, lumbar region
724.2	Lumbago
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.5	Unspecified backache
724.6	Disorders of sacrum
724.70	Unspecified disorder of coccyx
724.9	Ankylosis of spine, NOS
739.1	Nonallopathic lesions, cervical region
739.3	Nonallopathic lesions, lumbar region
739.4	Nonallopathic lesions, sacral region
739.6	Nonallopathic lesions, lower extremities
756.12	Spondylolisthesis
787.01-787.03	Nausea and vomiting
846.0	Sprains and strains of sacroiliac region, Lumbosacral
847.0	Sprains and strains of other and unspecified parts of back, neck
847.2	Sprains and strains of other and unspecified parts of back, Lumbar
847.3	Sprains and strains of other and unspecified parts of back, Sacrum

Experimental, investigational or unproven and not covered when used to report acupuncture for the following indications:

ICD-9-CM Diagnosis Codes	Description
001-139.8	Infections and parasitic diseases
140.0-239.9	Neoplasms
240.0-279.9	Endocrine, nutritional and metabolic diseases and immunity disorders
280.0-289.9	Diseases of the blood and blood forming organs
290.0-299.9	Organic psychotic conditions

300.00-307.80	Neurotic disorders, personality disorders, and other nonpsychotic mental disorders
307.89-316	Neurotic disorders, personality disorders, and other nonpsychotic mental disorders
327.0-327.8	Organic sleep disorders
330.0-337.9	Hereditary and degenerative diseases of the central nervous system
338.11	Acute pain due to trauma
338.19	Other acute pain
338.2-338.4	Chronic pain
339.0-339.09	Other headache syndromes
339.20-339.89	Other headache syndromes
340-345.9	Other disorders of the central nervous system
347.0-347.1	Cataplexy and narcolepsy
348.0-348.9	Other conditions of brain
350.1-359.9	Disorders of the peripheral nervous system
360.0-379.9	Disorders of eye and adnexa
380.0-389.9	Disorders of the ear and mastoid process
390-459.9	Disorders of the circulatory system
460-519.9	Disorders of the respiratory system
520-564.2	Diseases of the digestive system
564.4-579.9	Diseases of the digestive system
580.0-629.9	Diseases of the genitourinary system
634.00-638.99	Other pregnancy with abortive outcomes
642.0-642.9	Hypertension complicating pregnancy, childbirth and the puerperium
644.00-644.13	Early or threatened labor
646.00-646.99	Other complications of pregnancy not elsewhere classified
648.00-648.99	Other current conditions in the mother classifiable elsewhere but complicating pregnancy, childbirth or the puerperium
652.10-652.23	Malposition and malpresentation of fetus, breech
660.00-660.94	Obstructed labor
661.00-661.94	Abnormality of forces of labor
662.00-662.34	Long labor
680.0-709.9	Diseases of the skin and subcutaneous tissue
710.0-714.9	Arthropathies and related disorders
715.00-715.05	Osteoarthritis
715.07-715.09	Osteoarthritis
715.10-715.15	Osteoarthritis
715.17-715.19	Osteoarthritis
715.20-715.25	Osteoarthritis
715.27-715.29	Osteoarthritis
715.30-715.35	Osteoarthritis

715.37-715.39	Osteoarthritis
715.80-715.85	Osteoarthritis
715.87-715.89	Osteoarthritis
715.90-715.95	Osteoarthritis
715.97-715.99	Osteoarthritis
716.00-716.99	Other and unspecified arthropathies
717.0-717.9	Internal derangement of knee
718.00-718.99	Other derangement of joint
719.00-719.99	Other and unspecified disorders of joint
723.5	Torticollis, unspecified
723.6	Panniculitis specified as affecting neck
724.01	Spinal stenosis, thoracic region
724.1	Pain in thoracic spine
724.8	Other symptoms referable to back
725-729.99	Rheumatism, excluding the back
732.0-732.9	Osteochondropathies
733.00-733.99	Other disorders of bone and cartilage
734	Flat foot
735.0-735.9	Acquired deformity of toe
736.0-736.9	Acquired deformities of limbs
737.0-737.9	Curvature of spine
738.0-738.9	Other acquired deformity
739.0	Nonallopathic lesions, head region
739.2	Nonallopathic lesions, thoracic region
739.5	Nonallopathic lesions, pelvic region
739.6	Nonallopathic lesion, lower extremities
739.7	Nonallopathic lesion, upper extremities
739.8	Nonallopathic lesion. rib cage
739.9	Nonallopathic lesion, abdomen and other
740.0-759.9	Congenital anomalies
760.0-779.9	Certain conditions originating in the perinatal period
780.0-799.9	Symptoms, signs and ill-defined conditions
800.0-999.9	Injury and Poisoning
V15.09	Personal history of allergy other than to medicinal agents
V72.0-V72.9	Special investigations and examinations
V82.0-V82.9	Special screenings for other conditions
	All other codes

Acupuncture Point Injection

Experimental, investigational or unproven and not covered when used to report acupuncture point injection therapy:

CPT[®]* Codes	Description
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
20551	Injection(s); single tendon origin/insertion

20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553	Injection(s); single or multiple trigger point(s), 3 or more muscle(s)

ICD-9-CM Diagnosis Codes	Description
	All Codes

***Current Procedural Terminology (CPT®) © 2011 American Medical Association: Chicago, IL.**

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Policy History

<u>Pre-Merger Organizations</u>	<u>Last Review Date</u>	<u>Policy Number</u>	<u>Title</u>
Cigna HealthCare	3/15/2008	0024	Acupuncture

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