

Cigna Medical Coverage Policy- Therapy Services Acupuncture

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INSTRUCTIONS FOR USE

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- 1) the terms of the applicable benefit plan document in effect on the date of service*
- 2) any applicable laws/regulations*
- 3) any relevant collateral source materials including Cigna-ASH Medical Coverage Policies and*
- 4) the specific facts of the particular situation*

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Acupuncture is subject to the terms, conditions and limitations of the benefits as described in the applicable plan's schedule of copayments. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.

GUIDELINES

ACUPUNCTURE

Medically Necessary

If coverage for acupuncture services are available in the applicable benefit plan document, acupuncture may be provided as treatment for ANY of the following conditions when ALL of the medical necessity factors and ALL of the treatment planning /outcomes listed below are met:

- Tension-type Headache; Migraine Headache with or without Aura
- Musculoskeletal joint and soft tissue pain (e.g., hip, knee, spine) resulting in a functional deficit (e.g., inability to perform household chores, interference with job functions, loss of range of motion)
- Nausea Associated with Pregnancy (only when co-managed)
- Post-Surgical Nausea (only when co-managed)

- Nausea Associated with Chemotherapy; (only when co-managed)

Medical Necessity Factors:

- Medically necessary services must be delivered toward defined reasonable and evidence-based goals;
- Medical necessity decisions must be based on patient presentation including diagnosis, severity, and documented clinical findings;
- Continuation of treatment is contingent upon progression towards defined treatment goals and evidenced by specific significant objective functional improvements (e.g., outcome assessment scales, range of motion)
- Certain conditions require that the patient is being co-managed by a medical physician in order to be considered medically necessary;
- Medically necessary services including monitoring of outcomes and progress with a change in treatment or withdrawal of treatment if the patient is not improving or is regressing.

Treatment Planning/Outcome Factors:

- An individualized treatment plan (e.g., frequency and duration of service) is appropriately correlated with clinical findings and clinical evidence;
- Treatment is expected to result in significant therapeutic improvement over a clearly defined period of time;
- Therapeutic goals are functionally oriented, realistic, measurable, and evidence-based;
- Proposed date of release/discharge from treatment is estimated;
- Functional Outcome Measures (FOM)¹, when used, demonstrates Minimal Clinically Important Difference (MCID)¹ from baseline results through periodic re-assessments;
- Documentation substantiates practitioner's diagnosis and treatment plan;
- Demonstration of progression toward active home/self-care and discharge, and;
- Maximum therapeutic benefit has not been reached.

Not Medically Necessary

Acupuncture is considered not medically necessary for either of the following indications:

- Treatment intended to improve or maintain general physical condition
- Maintenance acupuncture services, when significant therapeutic improvement is not expected

Experimental, Investigational, Unproven

Acupuncture for any other indication, including infertility and recurrent pregnancy loss, is considered experimental, investigational or unproven.

ACUPUNCTURE POINT INJECTION THERAPY

Acupuncture point injection therapy is considered experimental, investigational or unproven.

DESCRIPTION AND 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). The practice of traditional acupuncture is predicated upon several fundamental underlying principles. It is predicated upon the existence of a series of meridians that course through the body along which are located discrete points that correspond to specific organs and/or have particular clinical significance. A vital energy, "chi," flows through

¹ *Not all outcome measures have MCID's determined and supported in the literature. Actual significance of these findings requires correlation with the overall clinical presentation, including updated subjective and objective examination findings*

the meridians and the acupuncture points and regulating bodily functions. It is the disruption of this flow of energy that therapeutic acupuncture is said to address.

Acupuncture typically utilizes unique diagnostic procedures to evaluate the meridian/chi system. This includes an evaluation of the patient's chief complaint and related health status through standardized diagnostic interviewing and examination techniques. Interviews are based on the traditional Ten Questions and examinations include, but are not limited to, evaluation of meridians, points, general vitality and behavior, the radial pulses and the tongue. Based upon the patient's complaint and the findings of these diagnostic procedures, individualized treatment regimens are developed that specify treatment variables such as the acupuncture points to be utilized, needle placement, and type of needle stimulation.

A majority of states provide licensure or registration for acupuncture practitioners, although the scope of practice allowed under state requirements varies. Depending upon the jurisdiction, those licensed to administer acupuncture may include licensed acupuncturists (LAc), medical/osteopathic physicians (MD/DO), chiropractors (DC), naturopaths (ND), oriental medicine doctors (OMD), podiatrists (DPM), dentists (DDS/DMD), nurse practitioners (NP), physician assistants (PA), as well as other designated health care providers. Depending upon the practitioner's training, different systems of acupuncture diagnosis and treatment may be used. 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.

Depending on the pain condition being treated, a course of acupuncture may last several weeks. Although 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, in general, there should be a reasonable expectation for clinical improvement. If no improvement is documented after an initial trial of two-four weeks treatment, an alternative treatment plan should be considered. If lack of clinical improvement continues following subsequent treatments re-evaluation by the referring provider may be indicated. If measurable objective improvement is made, then progress towards identified goals should be clearly documented and the treatment plan updated accordingly. The necessity of continued care beyond a therapeutic trial is dependent upon objective evidence of improvement (i.e., functional gain).

Multiple different biological mechanisms have been proposed and studied to explain acupuncture. All of these proposed mechanisms are centrally mediated and not merely local physiologic responses. Most commonly it is thought that the stimulation of the acupuncture needle triggers the release of endogenous opioids (endorphins). This effect seems the most pronounced in electro-acupuncture. Another possible mechanism is through the diffuse noxious inhibitory control pathway (DNIC). According to DNIC, a noxious stimulus applied to any region of the body can induce immediate suppression of pain transmission in neurons of the trigeminal caudalis and/or the spinal dorsal horn. Another theory proposes that the descending serotonergic inhibitory pathway is key to acupuncture analgesia. In addition, there is some preliminary evidence that acupuncture may have effects on the inflammatory response mediated through the autonomic nervous system. Current available evidence indicates that insertion of acupuncture needles has an effect above waiting list controls but there is limited available evidence to define whether exact needle placement on established "Traditional" Acupuncture points is necessary to produce a result.

None of the mechanisms of action postulated for acupuncture effects are sufficiently well understood to have established a dispositive answer to describe the exact physiological mechanism by which acupuncture produces its analgesic and antiemetic effects.

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.

DOCUMENTATION GUIDELINES

Evaluation

An initial evaluation service is essential to determine whether any acupuncture services are medically necessary, to gather baseline data, establish a treatment plan, and develop goals based on the data. . . The initial evaluation service must include: An appropriate level of clinical history, examination, and medical decision-making relevant and appropriate to the individual's complaint(s) and presentation;

- Subjective historical evaluation based on standardize method such as the 10 questions;
- Specific standardized and non-standardized tests, assessments, and tools;
- Interpretation and synthesis of all relevant clinical findings derived from history and physical examination for the purpose of clinical decision-making;
- Subjective and objective measurable, description of functional status using comparable and consistent methods;
- Summary of clinical reasoning and consideration of contextual factors with recommendations;
- The establishment of a working diagnosis;
- Plan of care with specific treatment techniques or activities to be used in treatment sessions that should be updated as the individual's condition changes;
- Frequency and duration of treatment (treatment dose);
- Functional, measurable, and time-framed long-term and short-term goals based on appropriate and relevant evaluation data; and
- Prognosis and discharge plan.

Treatment Sessions

Acupuncture treatment can vary from Acupuncture alone (CPT codes 97810, 97811, 97813, 97814) to the use of a variety of modalities and procedures depending on the patient's condition, response to care, and treatment tolerance. All services must be supported in the treatment plan and be based on an individual's clinical condition. An acupuncture treatment session may include:

- A brief evaluation of the patient's progress and response to previous treatment(s);
- Acupuncture with or without electric stimulation
- Related passive modalities (e.g.: indirect moxibustion, hot/cold packs
- Functional education in self-care and home management
- Reassessment of the individual's condition, diagnosis, plan, and goals as part of the treatment session
- Coordination, communication, and documentation
- Reevaluation, if there is a significant change in the individual's condition or there is a need to update and modify the treatment plan

Documentation of treatment sessions should include at a minimum:

- Date of treatment
- Specific treatment(s) provided that match the procedure codes billed
- Total treatment time
- The individual's response to treatment
- Skilled ongoing reassessment of the individual's progress toward the goals
- Any progress toward the goals in objective, measurable terms using consistent and comparable methods
- Any barriers to expected progress or changes to the plan of care
- Name and credentials of the treating clinician

Measuring Progress in Acupuncture: Monitoring for clinically significant changes in historical/examination findings and functional status including, but not limited to:

- Pain level per VAS 1-10 scale and Frequency of symptoms
- Reported interference with daily functional activities

- Validated Functional Outcome Measures specific for condition (Clinically significant therapeutic progress (MCID, improvement in pain, impairments and objective evaluation findings)
- Length of time of relief after treatment rendered
- Monitoring for significant changes in reported patient medication or other resource utilization
- Tenderness on palpation
- Range of motion
- Observation (e.g. behavior, mobility, appearance of affected area)
- Barriers to expected progress (e.g.: co-morbid conditions, extremes of age, socio-economic factors)

Acupuncture Treatment Service: The Acupuncture service includes a brief assessment of the patient's condition, as well as documentation of the patient's response to the treatment. A reevaluation (an Established Patient E/M service) is indicated when services above and beyond the usual pre-service and post-service work associated with the acupuncture services is required. This may include circumstances where there are new clinical findings, a rapid change in the individual's status, or failure to respond to treatment interventions.

The E/M services may include all or some of the components of the initial evaluation, such as:

- Data collection with objective measurements taken based on appropriate and relevant assessment tests and tools using comparable and consistent methods;
- Clinical decision-making as to whether acupuncture care is still indicated;
- Organizing the composite of current health conditions and deciding a priority/focus of treatment;
- Identifying the appropriate intervention(s) for new or ongoing goal achievement;
- Modification of intervention(s);
- Revision in plan of care if needed;
- Evaluation of any meaningful changes in function;
- Deciphering effectiveness of intervention(s); and
- Updating the discharge plan as appropriate.

Standardized Tests and Measures/Functional Outcome Measures (FOMs)

Measuring outcomes is an important component of an acupuncturist's practice. Outcome measures are important in direct management of individual patient care and for the opportunity they provide the profession in collectively comparing care and determining effectiveness.

The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient, providing a means to quantify change in the patient's functioning. Outcome measures, along with other standardized tests and measures used throughout the episode of care provide information about whether predicted outcomes are being realized. As the patient reaches the termination of acupuncture services and the end of the episode of care, the acupuncturist, again, measures the outcomes of their services. Standardized outcome measures provide a common language with which to evaluate the success of interventions, thereby providing a basis for comparing outcomes related to different intervention approaches. Measuring outcomes of care within the relevant components of function (including body functions and structures), activity, and participation, among patients with the same diagnosis, is the foundation for determining which intervention approaches comprise best clinical practice.

LITERATURE REVIEW

Acupuncture

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.

There are now several thousand RCTs evaluating the effectiveness of acupuncture for hundreds of different conditions. Two distinct areas of effectiveness have emerged from these studies: As an analgesic for somatic pain syndromes and as an anti-emetic. The literature for these two domains is examined below.

SOMATIC PAIN: Meta-Analyses and Systematic Reviews

Vickers et al. conducted a meta-analysis of trials of acupuncture for chronic pain (Vickers et al., 2012). Eligible trials included those for mechanical low back and neck pain, shoulder pain, headache and osteoarthritis. Study subjects were required to have had pain for a minimum of four weeks and be followed for at least four weeks after the end of treatment. There were no restrictions on what outcomes measures could be used. The analysis identified 29 trials that met these criteria with a total of 17,922 individual patients analyzed.

The analysis found acupuncture to be superior to both sham and no acupuncture control for each of the four conditions studied (all $p < 0.001$). The effect sizes were similar across all pain conditions. Patients receiving acupuncture had less pain, with scores 0.23 (95% C.I. 0.13, 0.33), 0.16 (95% C.I. 0.07, 0.25) and 0.15 (95% C.I. 0.07, 0.24) standard deviations lower than sham controls for back and neck pain, osteoarthritis, and chronic headache respectively; the effect sizes in comparison to no acupuncture controls were 0.55 (95% C.I. 0.51, 0.58), 0.57 (95% C.I. 0.50, 0.64) and 0.42 (95% C.I. 0.37, 0.46). It is worth noting that the differences between acupuncture and sham are quite modest when compared to the differences between acupuncture and no acupuncture. Sensitivity analyses including for publication bias did not change these findings. The authors concluded, "Our results from individual patient data meta-analyses of nearly 18,000 randomized patients on high quality trials provide the most robust evidence to date that acupuncture is a reasonable referral option for patients with chronic pain."

A Cochrane Review of acupuncture for peripheral joint arthritis identified sixteen trials (3498 individual patients) of adequate quality for review (Manheimer et al., 2010). Twelve of these trials included only people with OA of the knee, three were for OA of the hip and one trial included both hip and knee. Acupuncture showed statistically significant, short term improvements in OA pain and function. However these differences were not considered to be clinically significant. Using only studies with sham controls deemed adequate to blind participants, these differences were small and not statistically significant. On a pain scale of 0-20, these differences were in the range of 3-4 points. On a functional scale of 0-68, improvements ranged from 3 to 11 points. However, greater effects were seen when compared to waiting list controls. The overall conclusion was that at both 8 and 26 week end points, acupuncture offered small benefits in pain and function. These benefits were deemed to be at least partially due to non-specific treatment effects.

Linde et al. conducted a Cochrane Review of acupuncture for tension-type headaches (Linde et al., 2009). Eleven trials with 2317 subjects met the inclusion criteria. Two of the trials compared acupuncture to routine care (including self-care) and found clinically and statistically significant benefits to acupuncture for both headache frequency and pain intensity. In these two trials 47% of patients receiving acupuncture reported a decrease in the number of headache days by at least 50%, compared to 16% of patients in the control groups. Six of the trials compared acupuncture to some form of sham acupuncture where needle placement was not guided by any specific acupuncture findings. In this comparison, 50% of the "true" acupuncture patients experienced a greater than 50% reduction in headache pain compared to 41% in the sham controls. Three trials compared acupuncture to massage, physiotherapy, or relaxation. The methodological quality of these studies was poor and the results difficult to interpret, but overall there appeared to be a slight benefit to acupuncture compared to these interventions. A previous Cochrane review of this topic yielded inconclusive results. However, the addition of six newer trials in this review led the authors to conclude that acupuncture could be "a valuable non-pharmacological tool in patients with frequent episodic or chronic tension-type headaches."

Another Cochrane Review examined acupuncture for migraine headache prophylaxis (Linde et al., 2009). Twenty-two trials with 4419 participants met the inclusion criteria. Six of the trials compared acupuncture to no treatment or routine care. The acupuncture care resulted in fewer headaches than in the controls over 3-4 months. One of the trials followed patients for nine months and the treatment effects were undiminished. Fourteen trials compared acupuncture to some form of sham intervention. The results of single trials varied considerably, but the pooled results did not show any clinically or statistically significant benefit to the “true” acupuncture. Four trials compared acupuncture to drug prophylaxis and demonstrated slightly better outcomes and fewer side effects in the acupuncture groups. Overall the authors conclude that acupuncture should be considered a valid treatment option for migraine prophylaxis.

A systematic review and meta-analysis of acupuncture for non-specific low back pain by Lam et al. was published in *Spine* (Lam et al., 2013). They identified 32 relevant studies, 25 of which had usable data for a meta-analysis. They found clinically significant benefits to acupuncture when compared to sham acupuncture and no treatment in both pain and function. They also compared acupuncture to other common treatment modalities including NSAIDs, muscle relaxants and analgesics and found acupuncture to offer comparable relief. However, these findings were qualified because of the low overall quality of the studies.

The Cochrane Review for neck pain (Trinh et al., 2006) found 10 clinical trials that met inclusion criteria. All of these trials were for chronic neck pain. The overall quality of these trials was judged to be poor. They found that for short term follow-up, acupuncture was more effective than inactive controls. And they found limited evidence that acupuncture was more effective than massage therapy. Also, for neck pain with radiculopathy there was moderate evidence that acupuncture was more effective than waiting list control.

Green et al. reviewed the evidence for acupuncture for the treatment of shoulder pain in a 2008 Cochrane review (Green et al., 2008). Nine trials of varying quality met the inclusion criteria. Acupuncture was found to improve shoulder function more than placebo at four weeks, but this benefit (a 3.53 point difference in a 100 point scale) was no longer considered clinical significant at four months. The authors concluded that there was insufficient evidence to either support or refute the use of acupuncture for shoulder pain.

Liu et al. examined the set of systematic reviews of acupuncture for low back pain (Liu et al., 2015). They identified 16 systematic reviews, the overall quality of which they judged to be low. They found inconclusive evidence of a benefit for acupuncture compared to a sham for acute low back pain. For chronic low back pain there was consistent evidence of a benefit for short term pain relief and functional improvement when compared to sham or to no treatment. This benefit was found both when acupuncture was used in isolation and when used as an adjunct treatment.

Under the aegis of the Agency for Healthcare Research and Quality (AHRQ), Furlan et al. evaluated the entire range of complementary and alternative therapies, including acupuncture, for back and neck pain (Furlan et al., 2010). For acupuncture, a total of 105 clinical trials were evaluated. Acupuncture was found to be superior to placebo for chronic nonspecific low back pain, but only immediately post-treatment. But acupuncture was not different from placebo in post-treatment disability, pain medication intake, or global improvement in chronic nonspecific low back pain. Acupuncture and sham acupuncture were similar in reducing chronic non-specific neck pain immediately after treatment. Both were superior to no treatment in improving pain intensity, disability, well-being (SF-36), and range of motion immediately after the treatment. In general, trials that applied sham-acupuncture tended to produce negative results (i.e., statistically non-significant) compared to trials that applied other types of placebo (e.g., TENS, medication, laser). This can be interpreted as sham acupuncture having greater treatment effects than the other comparators. In another AHRQ publication by Chou et al. (2016) titled *Noninvasive Treatments for Low Back Pain*, noted the following key points:

- For acute low back pain, a systematic review found acupuncture associated with lower pain intensity versus sham acupuncture using nonpenetrating needles; three other trials reported effects consistent with these findings. One trial of sham acupuncture using penetrating needles to nonacupuncture points found no effect on pain. These were no clear effects on function in 5 trials (Strength of Evidence (SOE): low for pain and function).
- For chronic low back pain, a systematic review found acupuncture associated with lower pain intensity

versus sham acupuncture (superficial needling at acupuncture or nonacupuncture points, or nonpenetrating pressure at acupuncture points) immediately at the end of treatment and at up to 12 weeks, but there were no differences in function. Four additional trials reported results consistent with these findings (SOE: moderate for pain and function).

- For chronic low back pain, a systematic review found acupuncture associated with lower pain intensity and better function immediately after treatment versus no acupuncture. Mean effects on pain ranged from 7 to 24 points on a 0- to 100-point scale; for function one trial reported a difference of 8 points on a 0- to 100-point scale and the other two trials; two trials showed small or no clear differences at longer-term followup (SOE: moderate for pain and function).
- For acute low back pain, a systematic review found acupuncture associated with slightly greater likelihood of overall improvement versus NSAIDs at the end of treatment (SOE: low).
- For chronic low back pain, a systematic review found acupuncture associated with better pain relief and improvement in function immediately postintervention (SOE: low).
- Harms of acupuncture were poorly reported in the trials, though no serious adverse events were reported (SOE: low).

Zeng and Chung (2015) aimed to summarize and evaluate the available systematic reviews on the clinical effectiveness and cost-effectiveness of acupuncture for the management of chronic nonspecific low back pain (cnLBP), and to identify the safety of acupuncture for the management of cnLBP. Seventeen systematic reviews were included. Five found that acupuncture was more effective when compared with a no treatment/waiting list control, as there were eight systematic reviews and meta-analysis providing positive and consistent findings. Seven systematic reviews providing positive findings of the comparison of acupuncture to sham acupuncture/passive modality treatment. Three systematic reviews of multiple RCTs also indicated positive and consistent findings of the comparison of acupuncture plus an intervention vs an intervention alone. Overall, findings on the effectiveness of acupuncture for cnLBP were consistent.

Qaseem et al. (2017) provided clinical recommendations on noninvasive treatment of low back pain: Recommendation 1: Given that most patients with acute or subacute low back pain improve over time regardless of treatment, clinicians and patients should select nonpharmacologic treatment with superficial heat (moderate-quality evidence), massage, acupuncture, or spinal manipulation (low-quality evidence). (Grade: strong recommendation). Recommendation 2: For patients with chronic low back pain, clinicians and patients should initially select nonpharmacologic treatment with exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction (moderate-quality evidence), tai chi, yoga, motor control exercise, progressive relaxation, electromyography biofeedback, low-level laser therapy, operant therapy, cognitive behavioral therapy, or spinal manipulation (low-quality evidence). (Grade: strong recommendation).

Chou et al. (2017) updated the 2007 American College of Physicians guideline that addressed nonpharmacologic treatment options for low back pain. New evidence was available. Authors systematically reviewed the current evidence on nonpharmacologic therapies for acute or chronic non radicular or radicular low back pain. Randomized trials of 9 nonpharmacologic options versus sham treatment, wait list, or usual care, or of 1 nonpharmacologic option versus another were included. New evidence indicated that tai chi (strength of evidence [SOE], low) and mindfulness-based stress reduction (SOE, moderate) are effective for chronic low back pain and strengthens previous findings regarding the effectiveness of yoga (SOE, moderate). Evidence continues to support the effectiveness of exercise, psychological therapies, multidisciplinary rehabilitation, spinal manipulation, massage, and acupuncture for chronic low back pain (SOE, low to moderate). Limited evidence shows that acupuncture is modestly effective for acute low back pain (SOE, low). The magnitude of pain benefits was small to moderate and generally short term; effects on function generally were smaller than effects on pain.

Wong et al. (2017) authored a systematic review for the Ontario Protocol for Traffic Injury Management (OPTIMa) Collaboration. According to high-quality guidelines: (1) all patients with acute or chronic LBP should receive education, reassurance and instruction on self-management options; (2) patients with acute LBP should be encouraged to return to activity and may benefit from paracetamol, nonsteroidal anti-inflammatory drugs

(NSAIDs), or spinal manipulation; (3) the management of chronic LBP may include exercise, paracetamol or NSAIDs, manual therapy, acupuncture, and multimodal rehabilitation (combined physical and psychological treatment); and (4) patients with lumbar disc herniation with radiculopathy may benefit from spinal manipulation. According to Tice et al. (2017), the strength of evidence appears adequate to support coverage of acupuncture, CBT, MBSR, and yoga for chronic low back pain. Evidence-based boundaries on duration of therapy and on repetitive courses of therapy are reasonable given the potential for inappropriate overuse of services. Authors reported that there was no evidence on the concurrent use of multiple modalities, so concurrent treatment should be treated on a case-by-case basis.

Xiang et al. (2017) sought to establish whether sham acupuncture (SA) or placebo acupuncture (PA) was more efficacious for reducing low back pain (LBP) than other routine treatments and to discuss whether SA or PA is appropriate for randomized controlled trials of acupuncture for LBP. Review identified 7 trials (1768 participants); all were included in the meta-analysis. They found statistically significant differences in pain reduction post-intervention between SA or PA and routine care or a waiting list, however, no significant difference was observed between SA or PA and routine care or no treatment for post-intervention function. Authors concluded that compared with routine care or a waiting list, SA or PA was more efficacious for pain relief post-intervention. Concluding that SA or PA is appropriate for acupuncture research would be premature. Guidelines evaluating SA or PA control methods are needed to determine the specific effect of acupuncture over placebo.

AHRQ published a systematic review by Skelly et al. (2018) on Noninvasive Nonpharmacological Treatment for Chronic Pain. Acupuncture that improved function and/or pain for at least 1 month was found for chronic low back, chronic neck pain, and fibromyalgia. Skelly et al. (2020) updated the evidence from their 2018 report assessing persistent improvement in outcomes following completion of therapy for noninvasive nonpharmacological treatment for selected chronic pain conditions. For chronic low back pain, function improved over short and/or intermediate term for acupuncture (SOE low). Improvements in pain at short term were seen for acupuncture (SOE: moderate). For chronic neck pain, acupuncture improved function short and intermediate term, but there was no pain improvement compared with sham acupuncture (SOE: low). Functional improvements for fibromyalgia were seen with acupuncture (SOE: moderate) short term compared with usual care, attention control, or sham treatment. At intermediate term, there was functional improvement with acupuncture (SOE: moderate).

A 2013 Cochrane Review examined acupuncture for the treatment of fibromyalgia (Deare et al., 2013). Nine trials with 395 subjects were included. These included both needle acupuncture and electro-acupuncture therapies. The overall conclusion was that there was low to moderate quality evidence that acupuncture improves pain and stiffness in people with fibromyalgia. Sham acupuncture had similar effects. The effects of electro-acupuncture are somewhat greater than needle acupuncture and both are considered safe. These findings are qualified due to the low number and quality of studies.

In 2009 BMJ published a systematic review of acupuncture for pain that came to a largely negative conclusion (Madsen et al., 2009). The review focused on trials that included both sham acupuncture and no acupuncture controls. Thirteen trials with 3025 patients were identified. Conditions included OA of the knee, tension-type headaches, migraine headache, low back pain, fibromyalgia, abdominal scar pain, and postoperative pain. A small difference was found between acupuncture and placebo acupuncture, comparable to 4 mm on a 100 mm visual analog scale. A larger effect equal to 10 mm was found between placebo acupuncture and no acupuncture. This 10 mm difference is considered to be at the margin of clinical significance. They find that overall the analgesic effects of acupuncture are small and that methodological limitations of the trials make it impossible to determine whether any of these results can be attributed to specific treatment effects rather than placebo. They conclude, "Whether needling at acupuncture points, or at any site, reduces pain independently of the psychological impact of the treatment ritual is unclear."

Hopton and Macpherson (2010) conducted a systematic review of meta-analyses of acupuncture compared to placebo for acute and chronic pain. The review criteria yielded eight studies, two for low back pain, four on knee pain, and two for headaches. The review found that for osteoarthritis of the knee and headache, acupuncture was more effective than placebo both in the short term and in the long term. For low back pain short term treatment effects were greater than placebo, but for the longer term there was an inconclusive finding. The authors conclude that acupuncture has specific effects beyond placebo for a wide range of pain syndromes. They further note that

this conclusion is now broadly reflected in the scientific literature and that more salient research should shift focus from placebo-related questions to more practical questions about whether the overall benefit is clinically meaningful and cost-effective.

A Cochrane Review by Paley et al. reviewed the trials of acupuncture for cancer pain in adults (Paley et al., 2011). Three RCTs with 204 patients met the inclusion criteria. One study compared traditional auricular acupuncture with auricular acupuncture at non-acupuncture points and with a control using non-invasive “ear seeds,” at non-acupuncture points. The remaining two studies compared acupuncture with pain medication. The reviewers concluded that while there was some evidence of acupuncture effectiveness there was a high risk of bias in all studies and no conclusions could be reached regarding acupuncture effectiveness.

The Cochrane Review of acupuncture for low back pain (Furlan et al., 2005) has not been updated and is considered obsolete at this point. There are several Cochrane Reviews of acupuncture for pain that are inconclusive due to the small number of studies and/or the low quality of studies. Conditions reviewed include menstrual pain (Smith et al., 2011), elbow pain (Green et al., 2002), cancer pain (Paley et al., 2011), rheumatoid arthritis (Casimiro et al., 2005) and acute ankle sprain (Kim et al., 2014). Ju et al. (2017) assessed the analgesic efficacy and adverse events of acupuncture treatments for chronic neuropathic pain in adults. Randomized controlled trials (RCTs) with treatment duration of eight weeks or longer comparing acupuncture (either given alone or in combination with other therapies) with sham acupuncture, other active therapies, or treatment as usual, for neuropathic pain in adults were included in this review. The primary outcomes were pain intensity and pain relief. The secondary outcomes were any pain-related outcome indicating some improvement, withdrawals, participants experiencing any adverse event, serious adverse events and quality of life. Authors included six studies involving 462 participants with chronic peripheral neuropathic pain (442 completers (251 male), mean ages 52 to 63 years). Most studies included a small sample size (fewer than 50 participants per treatment arm) and all studies were at high risk of bias for blinding of participants and personnel. Authors concluded that due to the limited data available, there was insufficient evidence to support or refute the use of acupuncture for neuropathic pain in general, or for any specific neuropathic pain condition when compared with sham acupuncture or other active therapies.

Yuan et al. (2015) reviewed and analyzed the existing data about pain and disability in TCM treatments for NP and LBP. Seventy five randomized controlled trials (n = 11077) were included. Almost all of the studies investigated individuals experiencing chronic NP (CNP) or chronic LBP (CLBP). Authors concluded that acupuncture, acupressure, and cupping could be efficacious in treating the pain and disability associated with CNP or CLBP in the immediate term. Zeng and Chung (2015) aimed to summarize and evaluate the available systematic reviews on the clinical effectiveness and cost-effectiveness of acupuncture for the management of chronic nonspecific low back pain (cnLBP), and to identify the safety of acupuncture for the management of cnLBP. Seventeen systematic reviews were included. Five found that acupuncture was more effective when compared with a no treatment/waiting list control, as there were eight systematic reviews and meta-analysis providing positive and consistent findings. Seven systematic reviews providing positive findings of the comparison of acupuncture to sham acupuncture/passive modality treatment. Three systematic reviews of multiple RCTs also indicated positive and consistent findings of the comparison of acupuncture plus an intervention vs an intervention alone. Overall, findings on the effectiveness of acupuncture for cnLBP were consistent.

MacPherson et al. (2017) aimed to determine the trajectory of pain scores over time after acupuncture, using a large individual patient data set from high-quality randomized trials of acupuncture for chronic pain. The available individual patient data set included 29 trials and 17,922 patients. The chronic pain conditions included musculoskeletal pain (low back, neck, and shoulder), osteoarthritis of the knee, and headache/migraine. Authors used meta-analytic techniques to determine the trajectory of posttreatment pain scores. Data on longer term follow-up were available for 20 trials, including 6376 patients. The central estimate suggests that approximately 90% of the benefit of acupuncture relative to controls would be sustained at 12 months. Authors suggest that the effects of a course of acupuncture treatment for patients with chronic pain do not seem to decrease importantly over 12 months.

Cox et al. (2016) assessed the effectiveness and safety of acupuncture therapies for musculoskeletal disorders of the extremities. The search revealed 5180 articles; 15 were included (10 with a low risk of bias, 5 with a high

risk of bias). Authors concluded that the evidence for the effectiveness of acupuncture for musculoskeletal disorders of the extremities was inconsistent. Traditional needle acupuncture may be beneficial for CTS and Achilles tendinopathy, but not for nonspecific upper extremity pain and patellofemoral syndrome. Electroacupuncture may be effective for shoulder injuries and may show similar effectiveness to that of night wrist splinting for CTS. The effectiveness of dry needling for plantar fasciitis is equivocal. Leggit (2018) summarized the consensus on acupuncture as a musculoskeletal therapy. Evidence regarding efficacy in the management of musculoskeletal conditions is heterogeneous and subject to several limitations. Despite these limitations, acupuncture consistently has been shown to be more effective than no treatment and is relatively safe. For chronic back pain, it is recommended as a first-line noninvasive therapy. For neck pain, acupuncture provides benefits when it is combined with other treatments.

Noteworthy Recent Clinical Trials

Hinman et al. conducted a randomized clinical trial of acupuncture for knee pain (Hinman, 2014). In total 282 patients, over 50 years of age, with chronic knee pain were randomized into one of four groups: 1. No treatment control; 2. Traditional needle acupuncture; 3. Laser acupuncture; 4. Sham laser (very low power). Subjects in the last three groups were treated once or twice a week for twelve weeks. Primary outcome measures were knee pain (0-10) and function as measure by the McMaster Universities Osteoarthritis Index (0-68). End points were 12 weeks and one year. There was no difference in pain at twelve weeks between needle acupuncture or laser acupuncture and sham laser. There was a small difference between needle and laser treatment and the no treatment control at 12 weeks but not at one year. Needle acupuncture resulted in modest improvement in function compared with control at 12 weeks, but was not significantly different from sham and was not maintained at 1 year. The authors conclude, "In patients older than 50 years with moderate or severe chronic knee pain, neither laser nor needle demonstrate that acupuncture conferred benefit over sham for pain or function. Our findings do not support acupuncture for these patients."

Cho et al. evaluated the effects of acupuncture for chronic low back pain (Cho et al., 2013). One hundred thirty adults aged 18 to 65 years with chronic, nonspecific low back pain (cLBP) of at least three months duration were randomized to either individualized, traditional acupuncture, or to a sham needling procedure. The sham consisted of using non-penetrating, semi-blunt needles at non-acupuncture points. The primary outcome measure was a visual analog scale (VAS) for bothersomeness, and the secondary outcome measure was function (Oswestry). Patients were treated twice weekly for six weeks. VAS for "bothersomeness" scores for the real acupuncture groups decreased by 3.36 points, compared with 2.27 points for participants receiving sham acupuncture at the primary end point. There were no significant differences in disability scores and other secondary outcomes measures between the two treatment groups.

NAUSEA AND VOMITING: Systematic Reviews and Meta-Analyses

A 2009 Cochrane Review (Lee and Fan, 2009) evaluated studies of the stimulation of wrist acupuncture point P6 for the prevention of postoperative nausea and vomiting. Forty trials were identified with 4858 individual subjects. Overall, acupuncture was found to be equally effective as anti-emetic drugs. This was true for both adults and children. It was also found equally effective whether using invasive needles or non-invasive stimulation of the acupuncture point.

A second Cochrane Review (Matthews et al., 2015) evaluated a range of treatments, including acupuncture to treat nausea and vomiting in early pregnancy. Overall the reviewers found that the low quality of evidence precluded any definitive conclusions. In addition they noted that, "Acupuncture (P6 or traditional) showed no significant benefit to women in pregnancy."

Zhang et al. performed a meta-analysis (Zhang et al., 2015) on the use of wristband at acupuncture points for postoperative nausea and vomiting. They found a significant reduction in post-operative vomiting through the use of the wrist band compared to controls. However, they found no difference in the rates of nausea between wrist band and control.

Ezzo et al. conducted a Cochrane Review on the effects of acupuncture point stimulation for chemotherapy-induced nausea and vomiting (Ezzo et al., 2006). Eleven trials met the inclusion criteria. Different acupuncture modalities were used, and overall, acupuncture-point stimulation by all modalities reduced the incidence of acute vomiting, but not acute or delayed nausea severity compared to control. Electro-acupuncture reduced acute

nausea, but manual acupuncture did not. Acupressure reduced acute nausea severity, but not acute vomiting or delayed nausea. Non-invasive electro-stimulation showed no benefits for any outcome. A more recent update of this review has been withdrawn for failure to complete on time.

Garcia et al. (2013) conducted a systematic review of the use of acupuncture in cancer care for the relief of multiple different symptoms. They identified 41 RCTs that met inclusion criteria. In total, eight different symptoms were evaluated: pain, nausea, hot flashes, fatigue, radiation-induced xerostomia, prolonged postoperative ileus, anxiety/mood disorders, and sleep disturbance. They found evidence that acupuncture was an effective treatment for nausea and vomiting, but the evidence was inconclusive or negative for the remaining symptoms.

Noteworthy recent clinical trials

The effectiveness of acupuncture in preventing chemotherapy-related nausea and vomiting in patients with gynecological cancers was tested in a 2014 randomized clinical trial (Rithirangsiroj et al., 2014). Seventy patients were randomized to either acupuncture at P6 prior to chemotherapy infusion, or to the anti-emetic drug ondansetron. All patients received dexamethasone orally twice daily. The acupuncture group had a statistically significantly higher rate of complete absence of nausea and vomiting; 52.6% compared to 35.7% in the medication group. Overall the acupuncture group had lower rates of nausea, less severe nausea and fewer side effects than the ondansetron group.

Shen et al. (2015) completed a trial of 103 liver cancer patients tested the effectiveness of acupuncture at point K1 to prevent chemotherapy induced nausea and vomiting. Fifty one patients were randomized to receive electrostimulation at K1 acupoint for twenty minutes prior to the first administration of chemotherapy and then daily for the next five days. They also received anti-emetic drugs. The control group underwent the same regimen except that they received electrostimulation at a presumed placebo point in their heel. Outcome measures included the rate, intensity and duration of nausea and frequency of vomiting. There were no significant differences between the two groups on any of the outcome measures.

Lee et al. conducted a clinical trial testing the effectiveness acupuncture to prevent opioid-induced nausea. They randomized 178 patients to one of three groups: 1. Pre-operative electro-acupuncture at P6; 2. Post-operative electro-acupuncture at P6; 3. A no-treatment control. The incidence of nausea and vomiting was significantly lower in the pre-operative group than in the control group. Vomiting was also lower in the pre-operative group than in the post-operative group. Overall, pre-operative, but not post-operative electro-acupuncture was more effective than the control group.

Acupuncture Point Injection Therapy

There is insufficient evidence in the peer-reviewed published scientific literature to support safety and efficacy of acupuncture point injection therapy. Data comparing the effectiveness of different products, methods of stimulation and overall clinical utility is lacking.

Providers of Acupuncture Services

Acupuncture services are delivered by a qualified provider of acupuncture acting within the scope of their license as regulated by the Federal and State governments. Generally, only those healthcare practitioners who hold an active license, certification, or registration with the applicable state board or agency may provide services. Benefits for services provided by these healthcare providers may also be dependent upon the member's benefit contract language.

Coding/Billing Information

Note: 1) This list of codes may not be all-inclusive.

2) Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	Description
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
97811	Acupuncture, 1 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, 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 re-insertion of needle(s) (List separately in addition to code for primary procedure)

ICD-10-CM Diagnosis Codes	Description
G43.001- G43.919	Migraine
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- G44.229	Chronic tension-type headache
G44.301- G44.329	Post traumatic headache
G89.11	Acute pain due to trauma
G89.12	Acute post-thoracotomy pain
G89.18	Other acute postprocedural pain
G89.21	Chronic pain due to trauma
G89.22	Chronic post-thoracotomy pain
G89.28	Other chronic postprocedural pain
G89.29	Other chronic pain
G89.3	Neoplasm related pain (acute) (chronic)
G89.4	Chronic pain syndrome
K91.0	Vomiting following gastrointestinal surgery
M16.0- M16.9	Osteoarthritis of hip
M17.0- M17.9	Osteoarthritis of knee
M18.0- M18.9	Osteoarthritis of first carpometacarpal joint
M19.011- M19.93	Other and unspecified osteoarthritis
M25.511	Pain in right shoulder
M25.512	Pain in left shoulder
M25.519	Pain in unspecified shoulder
M25.521	Pain in right elbow
M25.522	Pain in left elbow
M25.529	Pain in unspecified elbow
M25.531	Pain in right wrist
M25.532	Pain in left wrist
M25.539	Pain in unspecified wrist
M25.541	Pain in joints of right hand
M25.542	Pain in joints of left hand
M25.549	Pain in joints of unspecified hand

M25.551	Pain in right hip
M25.552	Pain in left hip
M25.559	Pain in unspecified hip
M25.561	Pain in right knee
M25.562	Pain in left knee
M25.569	Pain in unspecified knee
M25.571	Pain in right ankle and joints of right foot
M25.572	Pain in left ankle and joints of left foot
M25.579	Pain in unspecified ankle and joints of unspecified foot
M47.11	Other spondylosis with myelopathy, occipito-atlanto-axial region
M47.12	Other spondylosis with myelopathy, cervical region
M47.13	Other spondylosis with myelopathy, cervicothoracic region
M47.16	Other spondylosis with myelopathy, lumbar region
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
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.891	Other spondylosis, occipito-atlanto-axial region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.01	Spinal stenosis, occipito-atlanto-axial region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.07	Spinal stenosis, lumbosacral region
M48.08	Spinal stenosis, sacral and sacrococcygeal region
M50.00	Cervical disc disorder with myelopathy, unspecified cervical region
M50.01	Cervical disc disorder with myelopathy, high cervical region
M50.020	Cervical disc disorder with myelopathy, mid-cervical region, unspecified level
M50.021	Cervical disc disorder at C4-C5 level with myelopathy
M50.022	Cervical disc disorder at C5-C6 level with myelopathy
M50.023	Cervical disc disorder at C6-C7 level with myelopathy
M50.03	Cervical disc disorder with myelopathy, cervicothoracic region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.120	Mid-cervical disc disorder, unspecified level
M50.121	Cervical disc disorder at C4-C5 level with radiculopathy

M50.122	Cervical disc disorder at C5-C6 level with radiculopathy
M50.123	Cervical disc disorder at C6-C7 level with radiculopathy
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.20	Other cervical disc displacement, unspecified cervical region
M50.21	Other cervical disc displacement, high cervical region
M50.220	Other cervical disc displacement, mid-cervical region, unspecified level
M50.221	Other cervical disc displacement at C4-C5 level
M50.222	Other cervical disc displacement at C5-C6 level
M50.223	Other cervical disc displacement at C6-C7 level
M50.23	Other cervical disc displacement, cervicothoracic region
M50.30	Other cervical disc degeneration, unspecified cervical region
M50.31	Other cervical disc degeneration, high cervical region
M50.320	Other cervical disc degeneration, mid-cervical region, unspecified level
M50.321	Other cervical disc degeneration at C4-C5 level
M50.322	Other cervical disc degeneration at C5-C6 level
M50.323	Other cervical disc degeneration at C6-C7 level
M50.33	Other cervical disc degeneration, cervicothoracic region
M51.06	Intervertebral disc disorders with myelopathy, lumbar region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M51.84	Other intervertebral disc disorders, thoracic region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome
M53.3	Sacrococcygeal disorders, not elsewhere classified
M54.2	Cervicalgia
M54.30- M54.32	Sciatica
M54.40- M54.42	Lumbago with sciatica
M54.5	Low back pain (Code invalid 9/30/2021)
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain
M54.6	Pain in thoracic spine
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M77.40	Metatarsalgia, unspecified foot
M77.41	Metatarsalgia, right foot
M77.42	Metatarsalgia, left foot
M79.11	Myalgia of mastication muscle
M79.12	Myalgia of auxillary muscles, head and neck
M79.18	Myalgia, other site

M79.2	Neuralgia and neuritis, unspecified
M79.601	Pain in right arm
M79.602	Pain in left arm
M79.603	Pain in arm, unspecified
M79.604	Pain in right leg
M79.605	Pain in left leg
M79.606	Pain in leg, unspecified
M79.621	Pain in right upper arm
M79.622	Pain in left upper arm
M79.629	Pain in unspecified upper arm
M79.631	Pain in right forearm
M79.632	Pain in left forearm
M79.639	Pain in unspecified forearm
M79.641	Pain in right hand
M79.642	Pain in left hand
M79.643	Pain in unspecified hand
M79.644	Pain in right finger(s)
M79.645	Pain in left finger(s)
M79.646	Pain in unspecified finger(s)
M79.651	Pain in right thigh
M79.652	Pain in left thigh
M79.659	Pain in unspecified thigh
M79.661	Pain in right lower leg
M79.662	Pain in left lower leg
M79.669	Pain in unspecified lower leg
M79.671	Pain in right foot
M79.672	Pain in left foot
M79.673	Pain in unspecified foot
M79.674	Pain in right toe(s)
M79.675	Pain in left toe(s)
M79.676	Pain in unspecified toe(s)
M79.7	Fibromyalgia
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 sacral region
M99.05	Segmental and somatic dysfunction of pelvic region
M99.06	Segmental and somatic dysfunction of lower extremity
M99.07	Segmental and somatic dysfunction of upper extremity
M99.08	Segmental and somatic dysfunction of rib cage
M99.11	Subluxation complex (vertebral) of cervical region
M99.12	Subluxation complex (vertebral) of thoracic region
M99.13	Subluxation complex (vertebral) of lumbar region
M99.14	Subluxation complex (vertebral) of sacral region
M99.15	Subluxation complex (vertebral) of pelvic region
M99.16	Subluxation complex (vertebral) of lower extremity
M99.17	Subluxation complex (vertebral) of upper extremity
M99.18	Subluxation complex (vertebral) of rib cage
M99.21	Subluxation stenosis of neural canal of cervical region
M99.22	Subluxation stenosis of neural canal of thoracic region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.24	Subluxation stenosis of neural canal of sacral region
M99.25	Subluxation stenosis of neural canal of pelvic region
M99.26	Subluxation stenosis of neural canal of lower extremity
M99.27	Subluxation stenosis of neural canal of upper extremity

M99.28	Subluxation stenosis of neural canal of rib cage
M99.31	Osseous stenosis of neural canal of cervical region
M99.32	Osseous stenosis of neural canal of thoracic region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.34	Osseous stenosis of neural canal of sacral region
M99.35	Osseous stenosis of neural canal of pelvic region
M99.36	Osseous stenosis of neural canal of lower extremity
M99.37	Osseous stenosis of neural canal of upper extremity
M99.38	Osseous stenosis of neural canal of rib cage
M99.41	Connective tissue stenosis of neural canal of cervical region
M99.42	Connective tissue stenosis of neural canal of thoracic region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.44	Connective tissue stenosis of neural canal of sacral region
M99.45	Connective tissue stenosis of neural canal of pelvic region
M99.46	Connective tissue stenosis of neural canal of lower extremity
M99.47	Connective tissue stenosis of neural canal of upper extremity
M99.48	Connective tissue stenosis of neural canal of rib cage
M99.51	Intervertebral disc stenosis of neural canal of cervical region
M99.52	Intervertebral disc stenosis of neural canal of thoracic region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.54	Intervertebral disc stenosis of neural canal of sacral region
M99.55	Intervertebral disc stenosis of neural canal of pelvic region
M99.56	Intervertebral disc stenosis of neural canal of lower extremity
M99.57	Intervertebral disc stenosis of neural canal of upper extremity
M99.58	Intervertebral disc stenosis of neural canal of rib cage
M99.61	Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.62	Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.64	Osseous and subluxation stenosis of intervertebral foramina of sacral region
M99.65	Osseous and subluxation stenosis of intervertebral foramina of pelvic region
M99.66	Osseous and subluxation stenosis of intervertebral foramina of lower extremity
M99.67	Osseous and subluxation stenosis of intervertebral foramina of upper extremity
M99.68	Osseous and subluxation stenosis of intervertebral foramina of rib cage
M99.71	Connective tissue and disc stenosis of intervertebral foramina of cervical region
M99.72	Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
M99.74	Connective tissue and disc stenosis of intervertebral foramina of sacral region
M99.75	Connective tissue and disc stenosis of intervertebral foramina of pelvic region
M99.76	Connective tissue and disc stenosis of intervertebral foramina of lower extremity
M99.77	Connective tissue and disc stenosis of intervertebral foramina of upper extremity
M99.78	Connective tissue and disc stenosis of intervertebral foramina of rib cage
O21.0- O21.9	Excessive vomiting in pregnancy
R07.82	Intercostal pain
R07.9	Chest pain, unspecified
R11.0	Nausea
R11.10	Vomiting, unspecified
R11.11	Vomiting without nausea
R11.12	Projectile vomiting
R11.2	Nausea with vomiting, unspecified
R51	Headache (Code invalid 9/30/2020)
R51.0	Headache with orthostatic component, not elsewhere classified
R51.9	Headache, unspecified
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S13.4XXD	Sprain of ligaments of cervical spine, subsequent encounter

S13.4XXS	Sprain of ligaments of cervical spine, sequela
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter
S13.8XXD	Sprain of joints and ligaments of other parts of neck, subsequent encounter
S13.8XXS	Sprain of joints and ligaments of other parts of neck, sequela
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
S16.1XXD	Strain of muscle, fascia and tendon at neck level, subsequent encounter
S16.1XXS	Strain of muscle, fascia and tendon at neck level, sequela
S16.8XXA	Other specified injury of muscle, fascia and tendon at neck level, initial encounter
S16.8XXD	Other specified injury of muscle, fascia and tendon at neck level, subsequent encounter
S16.8XXS	Other specified injury of muscle, fascia and tendon at neck level, sequela
S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
S23.3XXD	Sprain of ligaments of thoracic spine, subsequent encounter
S23.3XXS	Sprain of ligaments of thoracic spine, sequela
S23.8XXA	Sprain of other specified parts of thorax, initial encounter
S23.8XXD	Sprain of other specified parts of thorax, subsequent encounter
S23.8XXS	Sprain of other specified parts of thorax, sequela
S29.011A	Strain of muscle and tendon of front wall of thorax, initial encounter
S29.011D	Strain of muscle and tendon of front wall of thorax, subsequent encounter
S29.011S	Strain of muscle and tendon of front wall of thorax, sequela
S29.012A	Strain of muscle and tendon of back wall of thorax, initial encounter
S29.012D	Strain of muscle and tendon of back wall of thorax, subsequent encounter
S29.012S	Strain of muscle and tendon of back wall of thorax, sequela
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.5XXD	Sprain of ligaments of lumbar spine, subsequent encounter
S33.5XXS	Sprain of ligaments of lumbar spine, sequela
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.6XXD	Sprain of sacroiliac joint, subsequent encounter
S33.6XXS	Sprain of sacroiliac joint, sequela
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter
S33.8XXD	Sprain of other parts of lumbar spine and pelvis, subsequent encounter
S33.8XXS	Sprain of other parts of lumbar spine and pelvis, sequela
S39.012A	Strain of muscle, fascia and tendon of lower back, initial encounter
S39.012D	Strain of muscle, fascia and tendon of lower back, subsequent encounter
S39.012S	Strain of muscle, fascia and tendon of lower back, sequela
S39.013A	Strain of muscle, fascia and tendon of pelvis, initial encounter
S39.013D	Strain of muscle, fascia and tendon of pelvis, subsequent encounter
S39.013S	Strain of muscle, fascia and tendon of pelvis, sequela
S43.491A	Other sprain of right shoulder joint, initial encounter
S43.491D	Other sprain of right shoulder joint, subsequent encounter
S43.491S	Other sprain of right shoulder joint, sequela
S43.492A	Other sprain of left shoulder joint, initial encounter
S43.492D	Other sprain of left shoulder joint, subsequent encounter
S43.492S	Other sprain of left shoulder joint, sequela
S43.81XA	Sprain of other specified parts of right shoulder girdle, initial encounter
S43.81XD	Sprain of other specified parts of right shoulder girdle, subsequent encounter
S43.81XS	Sprain of other specified parts of right shoulder girdle, sequela
S43.82XA	Sprain of other specified parts of left shoulder girdle, initial encounter
S43.82XD	Sprain of other specified parts of left shoulder girdle, subsequent encounter
S43.82XS	Sprain of other specified parts of left shoulder girdle, sequela
S46.811A	Strain of other muscles, fascia and tendons at shoulder and upper arm level, right arm, initial encounter
S46.811D	Strain of other muscles, fascia and tendons at shoulder and upper arm level, right arm, subsequent encounter
S46.811S	Strain of other muscles, fascia and tendons at shoulder and upper arm level, right arm, sequela

S46.812A	Strain of other muscles, fascia and tendons at shoulder and upper arm level, left arm, initial encounter
S46.812D	Strain of other muscles, fascia and tendons at shoulder and upper arm level, left arm, subsequent encounter
S46.812S	Strain of other muscles, fascia and tendons at shoulder and upper arm level, left arm, sequela
S53.411A	Radiohumeral (joint) sprain of right elbow, initial encounter
S53.411D	Radiohumeral (joint) sprain of right elbow, subsequent encounter
S53.411S	Radiohumeral (joint) sprain of right elbow, sequela
S53.412A	Radiohumeral (joint) sprain of left elbow, initial encounter
S53.412D	Radiohumeral (joint) sprain of left elbow, subsequent encounter
S53.412S	Radiohumeral (joint) sprain of left elbow, sequela
S53.419A	Radiohumeral (joint) sprain of unspecified elbow, initial encounter
S53.419D	Radiohumeral (joint) sprain of unspecified elbow, subsequent encounter
S53.419S	Radiohumeral (joint) sprain of unspecified elbow, sequela
S53.421A	Ulnohumeral (joint) sprain of right elbow, initial encounter
S53.421D	Ulnohumeral (joint) sprain of right elbow, subsequent encounter
S53.421S	Ulnohumeral (joint) sprain of right elbow, sequela
S53.422A	Ulnohumeral (joint) sprain of left elbow, initial encounter
S53.422D	Ulnohumeral (joint) sprain of left elbow, subsequent encounter
S53.422S	Ulnohumeral (joint) sprain of left elbow, sequela
S53.429A	Ulnohumeral (joint) sprain of unspecified elbow, initial encounter
S53.429D	Ulnohumeral (joint) sprain of unspecified elbow, subsequent encounter
S53.429S	Ulnohumeral (joint) sprain of unspecified elbow, sequela
S53.431A	Radial collateral ligament sprain of right elbow, initial encounter
S53.431D	Radial collateral ligament sprain of right elbow, subsequent encounter
S53.431S	Radial collateral ligament sprain of right elbow, sequela
S53.432A	Radial collateral ligament sprain of left elbow, initial encounter
S53.432D	Radial collateral ligament sprain of left elbow, subsequent encounter
S53.432S	Radial collateral ligament sprain of left elbow, sequela
S53.439A	Radial collateral ligament sprain of unspecified elbow, initial encounter
S53.439D	Radial collateral ligament sprain of unspecified elbow, subsequent encounter
S53.439S	Radial collateral ligament sprain of unspecified elbow, sequela
S53.441A	Ulnar collateral ligament sprain of right elbow, initial encounter
S53.441D	Ulnar collateral ligament sprain of right elbow, subsequent encounter
S53.441S	Ulnar collateral ligament sprain of right elbow, sequela
S53.442A	Ulnar collateral ligament sprain of left elbow, initial encounter
S53.442D	Ulnar collateral ligament sprain of left elbow, subsequent encounter
S53.442S	Ulnar collateral ligament sprain of left elbow, sequela
S53.449A	Ulnar collateral ligament sprain of unspecified elbow, initial encounter
S53.449D	Ulnar collateral ligament sprain of unspecified elbow, subsequent encounter
S53.449S	Ulnar collateral ligament sprain of unspecified elbow, sequela
S53.491A	Other sprain of right elbow, initial encounter
S53.491D	Other sprain of right elbow, subsequent encounter
S53.491S	Other sprain of right elbow, sequela
S53.492A	Other sprain of left elbow, initial encounter
S53.492D	Other sprain of left elbow, subsequent encounter
S53.492S	Other sprain of left elbow, sequela
S63.591A	Other specified sprain of right wrist, initial encounter
S63.591D	Other specified sprain of right wrist, subsequent encounter
S63.591S	Other specified sprain of right wrist, sequela
S63.592A	Other specified sprain of left wrist, initial encounter
S63.592D	Other specified sprain of left wrist, subsequent encounter
S63.592S	Other specified sprain of left wrist, sequela
S63.8X1A	Sprain of other part of right wrist and hand, initial encounter
S63.8X1D	Sprain of other part of right wrist and hand, subsequent encounter

S63.8X1S	Sprain of other part of right wrist and hand, sequela
S63.8X2A	Sprain of other part of right wrist and hand, initial encounter
S63.8X2D	Sprain of other part of left wrist and hand, subsequent encounter
S63.8X2S	Sprain of other part of left wrist and hand, sequela
S73.191A	Other sprain of right hip, initial encounter
S73.191D	Other sprain of right hip, subsequent encounter
S73.191S	Other sprain of right hip, sequela
S73.192A	Other sprain of left hip, initial encounter
S73.192D	Other sprain of left hip, subsequent encounter
S73.192S	Other sprain of left hip, sequela
S83.411A	Sprain of medial collateral ligament of right knee, initial encounter
S83.411D	Sprain of medial collateral ligament of right knee, subsequent encounter
S83.411S	Sprain of medial collateral ligament of right knee, sequela
S83.412A	Sprain of medial collateral ligament of left knee, initial encounter
S83.412D	Sprain of medial collateral ligament of left knee, subsequent encounter
S83.412S	Sprain of medial collateral ligament of left knee, sequela
S83.421A	Sprain of lateral collateral ligament of right knee, initial encounter
S83.421D	Sprain of lateral collateral ligament of right knee, subsequent encounter
S83.421S	Sprain of lateral collateral ligament of right knee, sequela
S83.422A	Sprain of lateral collateral ligament of left knee, initial encounter
S83.422D	Sprain of lateral collateral ligament of left knee, subsequent encounter
S83.422S	Sprain of lateral collateral ligament of left knee, sequela
S83.511A	Sprain of anterior cruciate ligament of right knee, initial encounter
S83.511D	Sprain of anterior cruciate ligament of right knee, subsequent encounter
S83.511S	Sprain of anterior cruciate ligament of right knee, sequela
S83.512A	Sprain of anterior cruciate ligament of left knee, initial encounter
S83.512D	Sprain of anterior cruciate ligament of left knee, subsequent encounter
S83.512S	Sprain of anterior cruciate ligament of left knee, sequela
S83.521A	Sprain of posterior cruciate ligament of right knee, initial encounter
S83.521D	Sprain of posterior cruciate ligament of right knee, subsequent encounter
S83.521S	Sprain of posterior cruciate ligament of right knee, sequela
S83.522A	Sprain of posterior cruciate ligament of left knee, initial encounter
S83.522D	Sprain of posterior cruciate ligament of left knee, subsequent encounter
S83.522S	Sprain of posterior cruciate ligament of left knee, sequela
S83.8X1A	Sprain of other specified parts of right knee, initial encounter
S83.8X1D	Sprain of other specified parts of right knee, subsequent encounter
S83.8X1S	Sprain of other specified parts of right knee, sequela
S83.8X2A	Sprain of other specified parts of left knee, initial encounter
S83.8X2D	Sprain of other specified parts of left knee, subsequent encounter
S83.8X2S	Sprain of other specified parts of left knee, sequela
S83.91XA	Sprain of unspecified site of right knee, initial encounter
S83.91XD	Sprain of unspecified site of right knee, subsequent encounter
S83.91XS	Sprain of unspecified site of right knee, sequela
S83.92XA	Sprain of unspecified site of left knee, initial encounter
S83.92XD	Sprain of unspecified site of left knee, subsequent encounter
S83.92XS	Sprain of unspecified site of left knee, sequela
S93.401A	Sprain of unspecified ligament of right ankle, initial encounter
S93.401D	Sprain of unspecified ligament of right ankle, subsequent encounter
S93.401S	Sprain of unspecified ligament of right ankle, sequela
S93.402A	Sprain of unspecified ligament of left ankle, initial encounter
S93.402D	Sprain of unspecified ligament of left ankle, subsequent encounter
S93.402S	Sprain of unspecified ligament of left ankle, sequela

Considered Experimental, investigational or unproven when used to report acupuncture for any other indication (including infertility and recurrent pregnancy loss):

ICD-10-CM Diagnosis Codes	Description
	All other codes

Acupuncture Point Injection

Considered Experimental, investigational or unproven when used to report acupuncture point injection therapy:

CPT®*	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)

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