n05697

# Complementary and Alternative Medicine

## *Values*

**Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration**


## Abstract Purpose:

The purpose of this policy is to provide guidance for Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC's (NHP/NHIC/NHAS/NH TPA) utilization management team in rendering medical necessity decisions related to the use of complementary and alternative medicine.


## Policy Detail:

Refer to the appropriate Certificate of Coverage, Evidence of Coverage, Summary Plan Description, or Individual and Family Policy because employer group and government contracts may vary. Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services LLC follows Medicare's National/Local (Wisconsin area) Coverage Determinations for its Medicare Advantage membership. This policy applies to NHP/NHAS/NH TPA commercial lines of business.

I. Description
   - A. Complementary and Alternative Medicine is a broad category applied to medical products and practices that are not part of standard medical care. These products and practices are used along with, or in place of, standard medical care but are not considered by themselves to be standard treatment. NHP/NHIC/NHAS may consider some complementary or alternative medicine/techniques to be medically necessary when the safety and effectiveness is supported through current peer-reviewed medical literature.

II. Medical Indications
   - A. The following are some complementary or alternative medicine interventions that NHP/NHIC/NHAS/NH TPA may consider medically necessary when coverage criteria and/or medical policy indications have been met:
     1. Acupuncture
     2. Biofeedback
   - B. Coverage of Chiropractic services includes treatment by means of manual manipulation of the spine to correct subluxation, adjunctive services, massage therapy, physiotherapy treatment and preliminary patient history.
     1. NHP/NHAS/NH TPA utilizes MCG 30th edition Ambulatory Care Guidelines Spinal Manipulation Therapy (SMT), Chiropractic and Other ACG: A-0331 (AC) for medical necessity determinations for chiropractic services.

2. Chiropractic services will also be covered in accordance with 632.87, Wis. Stat and Chir 4.04, 10.01 which defines chiropractic science, including examination and imaging of the body (limited to x-ray).
3. Network Health non-Medicare contracts with Chiropractors is an agreed upon contractual case rate, therefore any services provided will apply to the case rate payment methodology.

III. Coverage

A. Chiropractic services are a covered benefit and may be considered medically necessary when meeting the coverage indication(s) and MCG criteria outlined above.
B. NHP/NHAS follows n03717 Medical Policy- Acupuncture for coverage determinations regarding acupuncture services for commercial members.
C. NHIC follows CMS National Coverage Determinations (NCD) and Local Coverage Determinations (LCD) for application to its Medicare Advantage membership. Local Coverage Article A57889 is referenced for chiropractic services.

IV. Limitations/Exclusions

A. NHP/NHIC/NHAS/NH TPA considers Nutraceuticals: An injection contained of a blend of vitamins, minerals and various other products (such as stem cells), sometimes called nutra-pharmaceutical blend, to be an experimental treatment.
B. Maintenance therapy is not considered to be reasonable and necessary. Therapy is considered maintenance when clinical improvement cannot be expected from continuous ongoing care and the chiropractic becomes supportive instead of corrective.
C. NHP/NHIC/NHAS/NH TPA may consider the use of electrical stimulation in a clinical setting to be experimental and investigational.
D. H-WAVE electrical stimulation devices or Interferential stimulation (IFT) are considered experimental/investigational or unproven for the treatment of any condition including but not limited to; relief of pain associated with soft tissue injury, musculoskeletal disorders, or to enhance wound or fracture healing.
E. NHP/NHIC/NHAS considerers complimentary or alternative medicine devices, interventions, pharmaceuticals, or services not listed below to be experimental/investigational or unproven.

## Regulatory Citations:

UM 2

## Related Policies:

n03717 Acupuncture Medical Policy

## Related Documents:

### CPT Codes*

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| 98940 | Chiropractic manipulative treatment (CMT); spinal 1-2 regions |
| 98941 | Chiropractic manipulative treatment (CMT); spinal 3-4 regions |
| 45399 | Unlisted procedure, colon** |
| 66999 | Unlisted procedure, anterior segment of eye** |
| 69399 | Unlisted procedure, external ear** |
| 84999 | Unlisted chemistry procedure** |
| 85999 | Unlisted hematology and coagulation procedure** |
| 88182 | Flow cytometry, cell cycle or DNA analysis** |

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| 88184 | Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker** |
| 88185 | Flow cytometer, cell surface, cytoplasmic, or nuclear marker technical component only; each additional marker (List separately in addition to first code marker)** |
| 96379 | Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion** |
| 96549 | Unlisted chemotherapy procedure** |
| 97039 | Unlisted modality (specify type and time if constant attendance)** |
| 97799 | Unlisted physical medicine/rehabilitation service or procedure** |
| 99199 | Unlisted special service, procedure or report** |
| *CPT codes are subject to change as codes are retired or new ones developed. The CPT code list may not be all inclusive. | |
| **Not covered if used to report complementary and alternative medicine | |

V. References


A. Blum, K., Chen, A.L., Chen, T.J. *et al.* The H-Wave® device is an effective and safe non-pharmacological analgesic for chronic pain: a meta-analysis. *Adv Therapy* **25,** 644–657 (2008). https://doi.org/10.1007/s12325-008-0073-3.

B. Williamson, T.K.; Rodriguez, H.C.; Gonzaba, A.; Poddar, N.; Norwood, S.M.; Gupta, A. H-Wave® Device Stimulation: A Critical Review. *J. Pers. Med.* **2021**, *11*, 1134. https://doi.org/10.3390/jpm11111134.

C. Chou R, Huffman LH; American Pain Society; American College of Physicians. Nonpharmacologic therapies for acute and chronic low back pain: A review of the evidence for an American Pain Society/American College of Physicians clinical practice guideline. Ann Intern Med. 2007;147(7):492-504.

D. Fuentes JP, Armijo Olivo S, Magee DJ, Gross DP. Effectiveness of interferential current therapy in the management of musculoskeletal pain: a systematic review and meta-analysis. Phys Ther. 2010 Sep;90(9):1219-38. doi: 10.2522/ptj.20090335. Epub 2010 Jul 22. PMID: 20651012.

E. Centers for Medicare and Medicaid Services (CMS) Local Coverage Article A57889, Chiropractic services, effective 01/01/2020.

F. MCG, Ambulatory Care 30th Edition – Spinal Manipulation Therapy (SMT), Chiropractic and Other, ACG: A-0331(AC).

G. Medicare Benefit Policy Manual Chapter 15-Covered Medical and other Health Services Table of Contents (Rev. 10880, 08-06-2021), 30.5 Chiropractor's Services (Rev. 23, Issued: 10-08-04, Effective: 10-01-04, Implementation: 10-04-04) B3-2020.26

**Disclaimer:**

Contract language as well as state and federal laws take precedence over any medical policy. Network Health coverage documents (i.e., Certificate of Coverage, Evidence of Coverage, Summary Plan Descriptions) outline contractual terms of the applicable benefit plan for each line of business and will be considered first in determining eligibility. Not all Network Health coverage documents are the same. Coverage may differ. Our Medicare membership follows applicable Centers for Medicare and Medicaid Services (CMS) coverage statements including National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). Please refer to the CMS website at www.cms.gov.

Network Health reserves the right to review and update our medical policies on occasion as medical technologies are constantly evolving. The documentation of any brand name of a test, product and/or procedure in a medical policy is in no way an endorsement of that product; it is for reference only. Network Health's medical policies are for guidance and not intended to prevent the judgment of the reviewing medical director(s) nor dictate to health care providers how to practice medicine.

| **Origination Date:**<br>03/31/2021 | **Approval Date:**<br>06/18/2026 | **Next Review Date:**<br>06/18/2027 |
|---|---|---|
| **Regulatory Body:**<br>OTHER | **Approving Committee:**<br>Utilization Management Committee | |
| **Department of Ownership:**<br>Utilization Management | | **Revision Number:**<br>6 |
| **Revision Reason:**<br>04/21/2022 - annual review, minor grammatical and formatting changes - Approved 04/21/2022 by Medical Policy Committee Approved by Medical Policy Committee on 04/21/2022<br>06/15/2023 – annual review-consent agenda, removed reference to retired PT/OT medical policy, added reference to the chiropractic medical policy, references updated, CPT/HCPCS codes added, minor grammatical and formatting changes. 6/20/2024- annual review, formatting and grammar changes, description of complementary/alternative medicine updated, included indication for chiropractic services, added coverage reference to the NHP Acupuncture Medical Policy for Commercial lines of business, updated from an exclusionary policy to an inclusionary policy, reformatted limitations and exclusions to be in line with inclusionary policy update, removed excluded services from CPT/HCPCS grid, CPT/HCPCS verified and updated, references updated.<br>12/12/2024-amended Chiropractic coverage to include adjunctive services, massage therapy, physiotherapy, and preliminary patient history in accordance with Wisconsin State Statutes and agreed upon contractual case rates for non-Medicare contracts. Approved at Utilization Committee.<br>06/12/2025 annual review, minor grammatical and formatting changes.<br>06/18/2026 annual review, grammar, formatting, and references updated. | | |