

Meeting: Utilization Management Committee	Date: 6/20/2024
Title/Topic: Medical Policy – Complementary and Alternative Medicine	Policy Number: n05697
Purpose: Annual Review	Outcome: Approve
Line of Business: Commercial and Medicare	Effective Date: 6/20/2024

INTRODUCTION:

Includes definition of problem or opportunity. Provides background information on the topic. Describes current state. May also include prior state and/or factors that have changed. Includes operational definitions where key terms may have varied interpretation.

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. Some complementary or alternative medicine/techniques may be medically necessary when the safety and effectiveness is supported through current peer-reviewed medical literature.

This medical policy provides guidance for Utilization Management Coordinator Registered Nurses (UMC-RN) regarding determinations involving the medical necessity of complimentary or alternative medicine. This policy is due for annual review.

UMC-RN staff consult the member’s individual coverage document regarding plan coverage prior to applying medical necessity criteria for Commercial lines of business.

ACTION RECOMMENDED:

States recommendations in specific terms. Includes a summary of what should be accomplished, methods, and timetable (if applicable). Recommendations on implementation and follow-up plans may also be included.

Annual review has been conducted and the Complementary and Alternative Medicine medical policy is presented for review and approval with changes as written.

This policy was updated from an exclusionary policy to an inclusionary policy. The description of complementary and alternative medicine was updated to align with current standard medical definitions. An indication was added to include coverage criteria for Chiropractic Services and a coverage reference was added referencing the n03717 Medical Policy- Acupuncture for Commercial lines of business. Limitations/Exclusions were reformatted to align with update to an inclusionary policy. Exclusionary CPT/HCPCS were removed from the CPT Code list and verification with update of CPT/HCPCS codes was performed. References were reviewed and updated. Other updates include formatting and grammar changes.

ANALYSIS/JUSTIFICATION:

Includes information relevant to the recommended action including information used in formulation the recommendations. Information will include reference to any existing Centers for Medicare & Medicaid Services (CMS) coverage determinations as well as any existing established vendor criteria. Information may include financial/cost data, service measures, projections or other key measures or process tools, recommendations from a clinical provider with expertise regarding the topic, and/or information from other widely used treatment guidelines or peer reviewed clinical literature.

No national or local coverage determinations were identified from the Centers for Medicare/Medicaid (CMS) pertaining to the H-wave or interferential therapy.

MCG 28th edition has no guidelines or guidance specific to H-wave or interferential therapy.

Network Health has existing medical policies that are referenced in determination of medical necessity determinations regarding acupuncture.

Biofeedback is addressed through eviCore criteria as a component of physical and occupational therapy services.

The Centers for Medicare/Medicaid (CMS) has guidance and criteria regarding indications for Chiropractic Services under Local Coverage Article (LCA) A57889, Chiropractic services, effective 01/01/2020. There is additional guidance found in the Medicare Benefit Policy Manual, Chapter 15- Covered Medical and other Health Services, 30.5 Chiropractor's Services (Rev. 23, Issued: 10-08-04, effective: 10-01-04, Implementation: 10-04-04) B3-2020.26.

Network Health retired the Chiropractic Medial Policy in 2023 as MCG Ambulatory Care Guidelines provide criteria regarding Chiropractic Services for spinal manipulation therapy. Other Chiropractic Services are not addressed in MCG.

REFERENCES:

Includes detailed description regarding source(s) of information used for development of policy or recommendations via citation.

- 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>. Accessed 4/23/2024
- 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>. Accessed 04/23/2024
- 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. Accessed 04/23/2024

- 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. Accessed 04/23/2024
- Centers for Medicare and Medicaid Services (CMS) Local Coverage Article A57889, Chiropractic services, effective 01/01/2020. Accessed 04/22/2024.
- MCG, Ambulatory Care 28th Edition – Spinal Manipulation Therapy (SMT), Chiropractic and Other, ACG: A-0331(AC). Accessed 04/22/2024
- 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

<p>REVISION REASON:</p>

<p><i>Includes the date changes or updates were made and summary of changes applied.</i></p>
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06/15/2023: Annual review. Minor grammar and formatting changes made. Reference to the retired Physical & Occupational Therapy medical policy were removed. Reference was added to the Chiropractic medical policy. CPT/HCPCS code verification was performed to monitor for changes, with updates made for new or retired codes. References were reviewed and updated.

06/20/2024: Annual review. Policy was reformatted to be an inclusionary policy (i.e., what is covered) verses an exclusionary policy (i.e., what is excluded). Grammar and formatting changes made. The description of complementary and alternative medicine was updated to align with current, standard medical definitions. An indication was added to provide guidance on coverage of Chiropractic services for Commercial lines of business. Coverage reference was added directing to the n03717 Medical Policy- Acupuncture for coverage indications for Acupuncture services for Commercial lines of business. The Limitations and Exclusions were reformatted to align with the update to an inclusionary policy. Excluded services were removed from the CPT/HCPCS grid and CPT/HCPCS review and update was completed. References were reviewed updated.

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.