## Reimbursement Policy

<table>
<thead>
<tr>
<th><strong>Title:</strong></th>
<th>Acupuncture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy Number:</strong></td>
<td>RP-P-095X</td>
</tr>
<tr>
<td><strong>Application:</strong></td>
<td>Government Products – Medicare Advantage, Medicare Prime Solution (Cost), Minnesota Health Care Programs (MHCP)</td>
</tr>
<tr>
<td><strong>Last Updated:</strong></td>
<td>5/14/2020</td>
</tr>
<tr>
<td><strong>Effective Date:</strong></td>
<td>9/1/2020</td>
</tr>
<tr>
<td><strong>Related Policies:</strong></td>
<td>N/A</td>
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</tbody>
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**Disclaimer:** This reimbursement policy is intended to provide general guidance regarding Medica’s policy for the services described, and does not constitute a guarantee of payment. You are responsible for submitting accurate claims. Factors affecting claims reimbursement may include, but are not limited to, state and federal laws, regulations and accreditation requirements, along with administrative services agreements, provider contracts, and benefit coverage documents. Coding methodology and industry standards are also considered in developing reimbursement policy.

Medica routinely updates reimbursement policies, and new versions are published on this website. If you print a copy of this policy, please be aware that the policy may be updated later, and you are responsible for the information contained in the most recent online version. Medica communicates policy updates to providers via Medica’s monthly e-newsletter, Medica Connections®, as well as through Medica Provider Alerts.

All content included on the provider portion of medica.com is an extension of providers’ administrative requirements, which all Medica network providers are contractually obligated to follow.

**Summary:**
This policy describes reimbursement for acupuncture services submitted on a CMS 1500 claim form or its electronic equivalent submitted with Current Procedural Terminology (CPT®) codes.

**Policy Statement:**

Acupuncture is reported based on 15-minute increments of personal (face-to-face) contact with the member, not the duration of the acupuncture needle(s) placement.

Acupuncture is covered only when provided by a licensed acupuncturist or by another licensed practitioner for whom acupuncture is within the practitioner’s scope of practice and who has specific acupuncture training or credentialing.

Per the Centers for Medicare and Medicaid Services (CMS) guidelines and CMS Medicaid National Correct Coding Initiative (NCCI) established Medically Unlikely Edits (MUE) values for the maximum number of units allowed per date of service:
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- 97810 – 1 unit
- 97811 – 3 units
- 97813 – 1 unit
- 97814 – 2 units

The cost of needles (A4212 and A4215) are included in the service and will be denied if submitted with an acupuncture service.

For Minnesota Health Care Programs (MHCP) enrollees, this policy will follow the Minnesota Department of Health and Human Services Guidelines. Acupuncture is covered for the following conditions:

- Acute pain
- Chronic pain
- Depression
- Anxiety
- Schizophrenia
- Post-traumatic stress disorder
- Insomnia
- Smoking cessation
- Restless legs syndrome
- Menstrual disorders
- Xerostomia (dry mouth) associated with:
  - Sjogren’s syndrome
  - Radiation therapy
- Nausea and vomiting associated with:
  - Post-operative procedures
  - Pregnancy
  - Cancer care

Items that fall within an acupuncturist scope of practice, such as breathing techniques, dietary guidelines and exercise based on Oriental principles, are considered part of an acupuncturist’s visit and are not reimbursed separately.

A maximum number of units allowed per calendar year for treatment is 20 units. Any claims submitted beyond 20 units is subject to post pay review.

Medica does not cover maintenance treatment where symptoms are not regressing or not showing improvement. Acupuncture treatment is not considered medically necessary if the recipient does not show improvement in symptoms.
For Medicare Advantage and Medicare Prime Solution members, Medica will reimburse according to the decision from The Centers for Medicare and Medicaid Services (CMS). Up to 12 visits are covered for chronic low back pain.

Chronic low back pain is defined as:

- Back pain lasting 12 weeks or longer
- Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease);
- Not associated with surgery; and
- Not associated with pregnancy

An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Claims submitted beyond the 12 visits are subject to post pay review.

**Definitions:**

**Acupuncture Practice**

"Acupuncture practice" means a comprehensive system of health care using Oriental medical theory and its unique methods of diagnosis and treatment. Treatment techniques include the insertion of acupuncture needles through the skin and use of other biophysical methods of acupuncture point stimulation, including the use of heat, Oriental massage techniques, electrical stimulation, herbal supplemental therapies, dietary guidelines, breathing techniques, and exercise based on Oriental medical principles.

**Procedure Codes:**

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>97810</td>
<td>Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient</td>
</tr>
<tr>
<td>97811</td>
<td>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)</td>
</tr>
<tr>
<td>97813</td>
<td>Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient</td>
</tr>
<tr>
<td>97814</td>
<td>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)</td>
</tr>
</tbody>
</table>
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<table>
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<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>A4212</td>
<td>Non-coring needle or stylet with or without catheter</td>
</tr>
<tr>
<td>A4215</td>
<td>Needle, sterile, any size, each</td>
</tr>
</tbody>
</table>

**Resources:**
- Centers for Medicare and Medicaid Services (CMS) section 1862 (a)(1)(A) of the Social Security Act
- CMS Medicaid National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUE) and Procedure to Procedure Coding Edits (PTP)
- Medicare (NCCI) Procedure to Procedure Coding Edits
- Minnesota Department of Health and Human Services (DHS)
- Optum 360, Encoder Pro for Professionals

**Effective Date:** 9/1/2020

**Revision Updates:**
- 03/09/2020 Initial policy creation
- 05/14/2020 Updated Medicare and Minnesota Health Care Program (MHCP) guidelines

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