
Subject: Acupuncture
Status: Approved

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Description

This document addresses the use of acupuncture, which is the practice of stimulating specific points on the body using needles for the purpose of treating various health conditions.

Purpose: To establish guidelines for the authorization, delivery, and management of acupuncture services as a supplemental benefit under the Medicare Advantage plan, ensuring access to medically necessary care while maintaining cost-effectiveness and adherence to clinical guidelines.

Eligibility Criteria

Member enrollment into the following eligible plans: EasyCarePlus, EasyCare, Total

Annual Benefit Limit

Routine visits

No authorizations for up to 30 visits per year under EasyCare Plus (HMO D-SNP) and Total (HMO-DSNP)

No authorizations for up to 20 visits per year under EasyCare (HMO)

More than the no prior-auth limit: Authorization is required

Diagnosis of chronic lower back pain ICD-10 M54.5

All visits require authorization with a limit of 12 visits over 90 days

If there is no improvement in pain after the 12 visits over 90 days, 20 additional visits will be authorized

Medical Necessity

When a request exceeds the annual benefit limit, the request will be reviewed using the following criteria:

Evidence Based Guidelines

MCG

Centers for Medicare and Medicaid Services (CMS) National Coverage Determination (NCD) 30.3

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30.3.3

Network and Providers

VNS Medicare Plans offer a range of in-network Acupuncture providers. The Plans accept requests for out-of-network providers and follow the out-of-network authorization process.

Authorization Process

Pre-authorization Requirements:

A pre-authorization process requires submission of documentation detailing the patient's condition, history, and proposed treatment plan.

Providers must submit a detailed treatment plan specifying the number of sessions, frequency, and expected outcomes

Non-Covered Services

The following services are not covered under the acupuncture benefit: herbal supplements, cupping, moxibustion, and any other adjunct therapies not specifically authorized by the plan.

Auditing and Monitoring

Health plans will monitor inappropriate utilization or billing practices, including random audits of treatment records and claims.

Regularly collect and analyze data on utilization, patient outcomes, and provider performance to identify trends and ensure adherence to clinical guidelines.

The policy will be reviewed annually to ensure alignment with the latest clinical guidelines and regulatory requirements.