Clinical Policy Title: Acupuncture

Clinical Policy Number: 03.02.03

**Effective Date:** April 1, 2015  
**Initial Review Date:** January 21, 2015  
**Most Recent Review Date:** March 15, 2017  
**Next Review Date:** March 2018

**Related policies:**

None.

**ABOUT THIS POLICY:** Keystone First has developed clinical policies to assist with making coverage determinations. Keystone First’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by Keystone First when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. Keystone First’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. Keystone First’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, Keystone First will update its clinical policies as necessary. Keystone First’s clinical policies are not guarantees of payment.

**Coverage policy**

Keystone First considers the use of acupuncture to be clinically proven and, therefore, medically necessary when all of the following criteria are met:

- Patient is age 18 years or older.
- Patient needs treatment for one of the following medical conditions:
  - Postoperative-related nausea and vomiting.
  - Chemotherapy-induced nausea and vomiting (CINV).
  - Chronic non-specific low back pain (CNSLBP) (i.e., more than three months).
  - Chronic migraine.
  - Chronic pain caused by osteoarthritis (OA) of the knee.
- As adjunctive treatment when either:
  - Other standard treatment options inadequately control symptoms.
  - Patient refuses treatment or experiences adverse effects from such treatment.
- When performed by a qualified practitioner who is both:
  - Appropriately trained and licensed in acupuncture.
Limitations:

All other uses of acupuncture are not medically necessary. Please note:

- Maintenance treatment, where the member’s symptoms are neither regressing nor improving, is not medically necessary.
- Treatments beyond five visits without meaningful improvement in symptoms require review by a Medical Director.

For Medicare members only:

Keystone First considers the use of acupuncture to be investigational and, therefore, not medically necessary.

Alternative covered services:

Standard medical management of chronic pain syndromes or nausea and vomiting due to chemotherapy or anesthesia.

Background

According to the National Center for Complementary and Integrative Health (NCCIH), acupuncture is one of the practices of traditional Chinese medicine (TCM) (NCCIH, 2014). According to TCM, energy known as “qi” flows throughout the body along patterns known as meridians. Disturbances in the flow of “qi” are thought to result in disease. Acupuncture is based on the belief that stimulating specific points on the body corrects imbalances in the flow of “qi.” The technology has four components:

- Acupuncture needle(s).
- Target location defined by TCM.
- Depth of needle insertion.
- Stimulation of the inserted needle.

Traditional acupuncture uses thin needles, but it may also apply manual pressure, electrical stimulation, magnets, low-power lasers, heat, and ultrasound. The U.S. Food and Drug Administration (FDA) regulates acupuncture needles as Class II medical devices with special controls. Acupuncture needles must be labeled for single use only, biocompatible and sterile, and be administered by qualified practitioners only (21CFR880.5580).

The professional credentials of an acupuncture practitioner can range from none to licensed medical doctor. Licensure laws and scope-of-practice guidelines regulating acupuncture practitioners vary by state. Currently, 43 states and the District of Columbia require the passage of the National Certification
Commission for Acupuncture and Oriental Medicine (NCCAOM) examinations, or NCCAOM certification as a prerequisite for licensure (NCCAOM, 2015). Board certification in medical acupuncture is granted by the American Board of Medical Acupuncture (ABMA) (ABMA, 2015). Certification entails (ABMA, 2015):

- Meeting minimum general requirements.
- Meeting education and training requirements.
- Meeting experience requirements.
- Successfully passing the ABMA examination.

**Searches**

Keystone First searched PubMed and the databases of:

- UK National Health Services Centre for Reviews and Dissemination.
- Agency for Healthcare Research and Quality’s National Guideline Clearinghouse and other evidence-based practice centers.
- The Centers for Medicare & Medicaid Services (CMS).

We conducted searches on January 12, 2017. Search terms were: "acupuncture" (MeSH) and "acupuncture therapy" (MeSH), as well as free text “acupuncture” for articles published in English.

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.

- **Guidelines based on systematic reviews.**

- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

Given the substantial volume of literature on this topic, Keystone First considered only the most comprehensive systematic reviews of acupuncture published in the last five years. More than 100 systematic reviews and meta-analyses were identified, the majority of which found evidence for various clinical uses of acupuncture to be of low quality. Conflicting results were also evident.

An evidence map of acupuncture (not a formal systematic review) produced for the Veterans Health Administration (VHA), which identified 183 systematic reviews published since 2005, found inconsistency in the quality and findings of systematic reviews (Hempel, 2014). Inconsistency in results appeared to be related to the selection of the comparator to which the treatment effects of acupuncture were compared. Controls included no treatment, waiting list assignment, acupuncture as
add-on treatment to a treatment plan received by both treatment groups, placebo control (such as sham acupuncture), and active controls, such as exercise and usual care. Typically, trials included a placebo arm and a no-treatment arm to explore variations in the impact of the different types of placebo. There is currently no universal standard for what constitutes an appropriate method or procedure for a sham acupuncture control, and this may contribute to the discrepancy between observed clinical effectiveness of acupuncture and the lack of rigorous research supporting these observations for many indications (Hempel, 2014).

Therefore, this policy will focus on those indications for which there is high-quality and consistent evidence demonstrating improvement in health outcomes with acupuncture; nine systematic reviews are listed in the summary table. Eight evidence-based guidelines and two economic analyses pertaining to the topics of these syntheses were identified.

There is sufficient evidence to support the use of acupuncture as adjunctive treatment for certain types of chronic pain and nausea and vomiting. Included were individual syntheses for the following indications:

- Postoperative- and CINV.
- CNSLBP.
- Chronic migraine.
- OA of the knee.

The benefits of acupuncture are limited mostly to immediate and short-term post-treatment periods in patients ages 18 or older using sham or no-acupuncture controls. Evidence of its effectiveness over other conventional treatment modalities is conflicting or of low quality. Evidence-based guidelines listed in the references recommend acupuncture as an adjunct to standard treatment for the specific indications in the summary table, when other treatment options inadequately control symptoms, or when patients refuse treatment or experience adverse effects from such treatment. One guideline did not recommend acupuncture for the management of OA of the knee (Jevsevar, 2013).

While acupuncture is generally a safe procedure, reporting of harms was poor across studies, so a comparison of the rate of adverse events between acupuncture and other treatments cannot be made. Where reported, adverse events were generally localized, minor, transient, and infrequent when performed by an appropriately trained practitioner using clean technique and single-use needles. When not delivered properly, acupuncture can cause serious adverse effects, including infections, punctured organs, collapsed lungs, injury to the central nervous system, and even death (Ernst, 2011; NCCAM, 2015).

- There is insufficient evidence to draw conclusions regarding the optimal frequency of administration, duration of each session, number, depth of needle penetration, or needle location.
There is insufficient evidence to support the cost-effectiveness of acupuncture for any indication. The few cost-effectiveness analyses that have been conducted in the United States found either a lack of effectiveness or sufficient rigor needed to further inform practice (Kim, 2012; Pinto, 2012).

**Policy updates:**

We identified 26 new systematic reviews and meta-analyses and one new clinical practice guideline published in the last year for this policy. Seven systematic reviews and meta-analyses reported significant short-term or intermediate-term positive effects of acupuncture treatment for several conditions, but significant study design flaws and small numbers of studies limited the validity of the evidence included in these analyses (Feng, 2015; Zhou, 2015; Yuan, 2015; Law, 2015; Gutke, 2015; Dong, 2015; Chan, 2015). One clinical practice guideline stated acupuncture could be a non-pharmacologic option for allergic rhinitis based on moderate evidence from two large randomized controlled trials (RCTs) reporting improvement in symptoms and quality of life with acupuncture, but stopped short of issuing a firm recommendation for its use (Seidman, 2015). The new information would not alter the conclusions of the original policy. Therefore, no changes to the policy are warranted.

In 2017, we identified 15 new systematic reviews and meta-analyses and one new evidence-based guideline for this policy. New evidence confirms previous policy findings of acupuncture’s safety and efficacy in TTH (Linde, 2016a), migraine (Linde, 2016b), and palliation of CINV (Lau, 2016), as well as insufficient demonstration of safety and efficacy in chronic pain syndromes (Qin, 2016), and post-operative pain (Wu, 2016).

The results of several systematic reviews and meta-analyses suggested acupuncture had a limited treatment effect on a number of new clinical indications, but the evidence of safety and efficacy was inconclusive due to poor methodological quality, insufficient quantity, or conflicting findings (Cui, 2016; del Pino-Sedeno, 2016; He, 2016; Kim, 2016; Lim, 2016; Mangese, 2016; Smith, 2016; Su, 2016; Van den Heuvel, 2016; Yang, 2016). A guideline by the American College of Physicians on treatments (including acupuncture) for major depressive disorder in adults issued strong evidence-based recommendations for cognitive behavioral therapy and antidepressants, but made no specific recommendation for acupuncture (Qaseem, 2016). The new information does not change the original findings. Therefore, no policy changes are warranted.

**Summary of clinical evidence:**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
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<tbody>
<tr>
<td>Nausea and vomiting</td>
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<tr>
<td>Cheong (2013)</td>
<td>Prevention and treatment of postoperative nausea and Key points:</td>
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<tr>
<td></td>
<td>Systematic review and meta-analysis of 30 RCTs (n=1,276 patients [acupuncture], n=1,258 patients [no acupuncture or sham]).</td>
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<tr>
<td></td>
<td>Overall quality: three of low quality, nine of moderate quality, and four of high quality for Nei Guan acupuncture point (PC6)-only studies; six of low quality for PC6 + other acupoints; one of</td>
</tr>
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</table>
**Citation**

| Vomiting (PONV) | moderate quality, and seven of low quality for other acupoints. Insufficient emphasis of the details of blinding and allocation concealment in most studies. |
| At early postoperative 0 – 6 hours: PC6 acupuncture significantly reduced the number of cases of early vomiting (Relative Risk [RR]=0.36, 95% confidence interval [CI] 0.19 to 0.71; P=0.003), but not early nausea (RR=0.64, 95% CI 0.34 to 1.19; P=0.150). |
| At postoperative 0 – 24 hours: |
| - PC6 acupuncture significantly reduced number of cases of nausea (RR=0.25, 95% CI 0.10 to 0.61; P=0.002), and vomiting (RR=0.82, 95% CI 0.48 to 1.38; P=0.450). |
| - PC6 acupressure significantly reduced the number of cases of nausea (RR=0.71, 95% CI 0.57 to 0.87; P=0.001) and vomiting (RR=0.62, 95% CI 0.49 to 0.80; P=0.000). |
| - PC6 electro-acupoint stimulation significantly reduced the number of cases of nausea (RR=0.49, 95% CI 0.38 to 0.63; P<0.000) and vomiting (RR=0.50, 95% CI 0.36 to 0.70; P<0.000). |
| - Stimulation of PC6 with other acupoint(s) significantly reduced the number of cases of PONV (RR=0.29, 95%CI 0.17 to 0.49; P<0.000). |
| - Stimulation of other acupoint(s)(non-PC6) significantly reduced the number of cases of NV (RR=0.63, 95%CI 0.49 to 0.81; P=0.000). However, the quality of study was generally low in studies of PC6 combined with other acupoint(s) and other acupoint(s). |
| Safety: overall safe but few reports of local erythema with electro-acupuncture; and redness, erythema, swelling, tenderness and paraesthesia with acupressure bands. No major adverse events followed. |
| Some studies reported significant reduction in anti-emetic use, others reported no difference. |
| No conclusions regarding optimal timing or technique. |

**Key points:**

| Garcia (2013) | Key points: |
| Cancer care | - Systematic review of 41 RCTs involving eight symptoms (pain, nausea, hot flashes, fatigue, radiation-induced xerostomia, prolonged postoperative ileus, anxiety/mood disorders, and sleep disturbance). Eleven RCTs addressed CINV. |
| Overall quality = low. Eight studies with high risk of bias, two unclear, one low. |
| The strongest evidence for the use of acupuncture in patients with cancer was for control of CINV. One positive trial had low risk of bias with a large between-group effect size (0.80) in patients with breast cancer on high-dose chemotherapy. A second multicenter blinded trial published reported positive outcomes, but had an unclear risk of bias. |
| Among studies for which an effect size could be estimated, the between group effect size for acupuncture vs. usual care ranged from 0.94 to 1.10. The within-group effect size estimates ranged from 0.35 to 2.35 for active acupuncture and from -0.45 to 1.26 for sham acupuncture. This suggests there are nonspecific aspects contributing to acupuncture, yet the specific effects are larger. |
| Acupuncture for CINV can relieve discomfort and may be an option for patients who do not experience effective symptom control with pharmaceuticals. |

**Key points:**

| Chronic pain | Chronic pain: back and neck pain, OA, chronic headache, and shoulder pain. |
| Vickers (2012) | Key points: |
| Individual patient data meta-analyses using data from 29 of 31 eligible RCTs (n=17,922 patients). |
| Overall quality of RCTs: high with strict inclusion criteria for allocation concealment. |
| Patients receiving acupuncture had less pain, with scores that were 0.23 (95% CI 0.13 to 0.33), 0.16 (95% CI 0.07 to 0.25), and 0.15 (95% CI 0.07 to 0.24) standard deviations (SDs) lower versus sham controls for back and neck pain, OA, and chronic headache, respectively versus no-acupuncture (i.e., usual care or guideline care) controls were 0.55 (95% CI 0.51 to 0.58), 0.57 (95% CI 0.50 to 0.64), and 0.42 (95% CI 0.37 to 0.46) SDs, respectively. Results were robust to a variety of sensitivity analyses, including those related to publication bias. |

**Chronic pain**
<table>
<thead>
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<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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</thead>
</table>
| Ernst (2011) | Various pain types  

- Acupuncture provides modest benefits over usual care, suggesting that factors in addition to the specific effects of needling are important contributors to the therapeutic effects of acupuncture.

**Key points:**
- Review of 57 systematic reviews regarding the effectiveness of acupuncture for various pain syndromes, and 95 cases for evaluation of adverse events.
- Overall quality of primary studies and systematic reviews was variable.
- Results show numerous contradictions and caveats.
- Four systematic reviews of excellent methodological quality found acupuncture was no better than sham for pain control.
- The majority of high-quality reviews were positive for low back pain (LBP) and OA, but conflicting or negative findings for other pain types.
- Two systematic reviews for neck pain found short-term relief better than sham.
- Severe adverse effects included five fatalities; pneumothorax and infections were most frequently reported.
- Authors’ conclusion: Numerous reviews have produced little convincing evidence that acupuncture is effective in reducing pain. Serious adverse events, including deaths, continue to be reported.

| Lam (2013) | CNSLBP  

- Systematic review of 32 RCTs and meta-analysis of 25 RCTs.
- Acupuncture had a clinically meaningful reduction in levels of self-reported pain (mean difference = -16.76 [95% CI -33.33 to -0.19], P = 0.05, I = 90%) versus sham, and improved function (standard mean difference = -0.94 [95% CI -1.41 to -0.47], P < 0.00, I = 78%) versus no treatment immediately post intervention.
- Levels of function also clinically improved when acupuncture, in addition to usual care, or electro-acupuncture was compared with usual care alone.
- Acupuncture vs. medications (nonsteroidal anti-inflammatory drugs [NSAIDs], muscle relaxants and analgesics) and usual care; statistically significant differences between the control and the intervention groups, but too small to be of any clinical significance.
- Inconclusive evidence of acupuncture vs. transcutaneous electrical nerve stimulation.
- Acupuncture may have a favorable effect on self-reported pain and functional limitations on CNSLBP, but evidence is limited by heterogeneity in the study characteristics and the low methodological quality in many of the included studies.

| Furlan (2012) for AHRQ | LBP and neck pain  

- Systematic review of 33 RCTs of LBP 24 RCTs of neck pain comparing acupuncture to active (i.e., physical modalities and exercise) or inactive treatments (i.e., placebo, no treatment).
- Overall quality: low to moderate with overall medium risk of bias.
- Results of individual trials stratified by spine region (e.g., low back, neck), duration of pain (acute, subacute, chronic, mixed and unknown), and cause of pain (specific or nonspecific).
- For back pain, moderate-quality evidence suggests acupuncture was moderately more beneficial, vs. no treatment or placebo, in reducing pain intensity immediately or in the short term, after treatment in persons with CNSLBP. Acupuncture was cost-effective relative to usual care or no treatment in subjects with chronic LBP, but health gains were small and follow-up was short.
- For neck pain:
  - No evidence of acupuncture vs. no treatment or placebo of neck pain of acute/subacute, chronic, and mixed duration.
  - No significant difference between acupuncture vs. sham-acupuncture in subjects with chronic-specific (two trials) or nonspecific pain (three trials).
  - Inconsistent results for immediate or short-term post-treatment pain intensity between...
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<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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</table>
| Hayes (2009), last reviewed in 2013  | - Acupuncture and pain medication, in subjects with chronic and unknown pain duration.  
- In one study, acupuncture use was associated with significantly higher total costs, compared to usual care ($1,565 versus $1,496).  
- Mixed results regarding comparison of acupuncture to other complementary and alternative medicine (CAM) therapies or active treatments.                                                                 |
| Tension-type headache (TTH) and migraine | **Key points:**  
- Systematic review of six RCTs for prevention of TTH and nine RCTs of migraine.  
- Quality assessment: moderate to high for TTH and migraine.  
- Follow-up ranged from one month to approximately six months.  
- For TTH, conflicting evidence of the efficacy of acupuncture, depending on the comparator. Inconsistent improvement in outcomes vs. sham. Single studies reported acupuncture was superior to usual care or drug treatment, while one study reported relaxation was superior to acupuncture. Needs further validation.  
- For migraine prevention, evidence regarding the efficacy of acupuncture was conflicting. Not consistently different from sham acupuncture on any outcome measures in three studies, but was consistently superior to both usual care and relief therapy in four studies. Conflicting evidence of the efficacy relative to prophylactic drug treatment.  
- Placebo effect of sham procedure may contribute to conflicting results, as might the possibility that the sham is not truly a placebo.  
- Insufficient evidence to establish definitive patient selection criteria. No absolute contraindications for use of acupuncture, but patients taking anticoagulation therapy, pregnant women, and patients with bleeding disorders were excluded from enrollment in several studies.  

| Linde (2009) Cochrane review Migraine  | **Key points:**  
- Systematic review of 22 RCTs (n=4,419 participants): acupuncture vs. no prophylactic treatment or routine care, only (six RCTS); acupuncture vs. sham (14 RCTs); acupuncture vs. prophylactic drug treatment (four RCTs).  
- After three to four months, patients receiving acupuncture had higher response rates and fewer headaches.  
- Consistent evidence that acupuncture provides additional benefit for treatment of acute migraine attacks, compared to routine care.  
- There is no evidence for an effect of “true” acupuncture over sham interventions, though this is difficult to interpret, as exact point location could be of limited importance.  
- Available studies suggest that acupuncture is at least as effective as, or possibly more effective than, prophylactic drug treatment, and has fewer adverse effects. Acupuncture should be considered a treatment option for patients willing to undergo this treatment.  

| Manyanga (2014) Peripheral joint OA    | **Key points:**  
- Systematic review and meta-analysis of 12 RCTs (n=1,763) comparing acupuncture to sham acupuncture, no treatment or usual care (mostly of the knee).  
- Duration of interventions ranged from 2 – 12 weeks, with total follow-up durations ranging from 4 – 52 weeks.  
- Overall quality: low to moderate. Most trials had unclear (64%) or high (9%) risk of bias.  
- Acupuncture use associated with significant reductions in pain intensity (Mean difference [MD] -0.29, 95% CI -0.55 to -0.02, I² 0%, 10 trials, 1,699 participants), functional mobility (standardized MD -0.34, 95% CI -0.55 to -0.14, I² 70%, nine trials, 1,543 participants), health-related quality of life (standardized MD -0.36, 95% CI -0.58 to -0.14, I² 50%, three trials, 958 participants).  
- Subgroup analysis of pain intensity by intervention duration, suggested greater pain intensity reduction with intervention periods greater than four weeks (MD -0.38, 95% CI -0.69 to -0.06, I² 53%).  


<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
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<tbody>
<tr>
<td>Kim (2012)</td>
<td><strong>Persistant back pain</strong></td>
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<tr>
<td><strong>Key points:</strong></td>
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<tr>
<td></td>
<td>• Systematic review of RCTs with cost-effectiveness analyses (CEA).</td>
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<tr>
<td></td>
<td>• Identified one CEA from the U.S. perspective (Cherkin, 2001):</td>
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<td></td>
<td>- RCT of 262 patients ages 20 – 70 years with LBP to receive TCM acupuncture (n = 94), therapeutic massage (n = 78), or self-care educational materials (n = 90). Intent-to-treat analysis used. Symptom and disability outcomes.</td>
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<td>- Up to 10 massage or acupuncture visits were permitted over 10 weeks.</td>
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<tr>
<td></td>
<td>- Results: Massage was superior to self-care and acupuncture at 10 weeks on disability outcomes, and superior to acupuncture after one year, on both symptom and disability outcomes. The massage group used the least medications (P&lt;.05) and had the lowest costs of subsequent care.</td>
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<tr>
<td></td>
<td>- Conclusions: TCM acupuncture was relatively ineffective for persistent back pain.</td>
</tr>
<tr>
<td>Pinto (2012)</td>
<td><strong>Hip and knee OA</strong></td>
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<tr>
<td><strong>Key points:</strong></td>
<td></td>
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<tr>
<td></td>
<td>• Systematic review of 10 economic evaluations and one RCT reporting health care costs for conservative treatments of knee OA—exercise programs, acupuncture, rehabilitation programs, and lifestyle interventions.</td>
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<td>• Six of 11 studies exhibited high risks of bias for the cost and/or effect components of their cost-effectiveness estimate. Six studies used comparators of unknown cost-effectiveness.</td>
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<td></td>
<td>• Authors’ conclusions: limited evidence for the cost-effectiveness of conservative treatments for management of hip and/or knee OA. More high-quality economic evaluations of conservative interventions are needed to further inform practice.</td>
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</tbody>
</table>

**References**

**Professional society guidelines/other:**


**Peer-reviewed references:**


**CMS National Coverage Determinations (NCDs):**


Local Coverage Determinations (LCDs):

No LCDs identified as of the writing of this policy.

**Commonly submitted codes**

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comments</th>
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<tbody>
<tr>
<td>97810</td>
<td>Acupuncture, 1 or more needles; without electrical stimulation, initial 14 minutes of personal one-on-one contact with the patient</td>
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<tr>
<td>97811</td>
<td>Acupuncture, 1 or more needles, without electrical stimulation, each additional 15 minutes of personal one-on-one contact, with re-insertion of needle(s)</td>
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<tr>
<td>97813</td>
<td>Acupuncture, 1 or more needles; with electrical stimulation, initial 14 minutes of personal one-on-one contact with the patient</td>
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<tr>
<td>97814</td>
<td>Acupuncture, 1 or more needles, with electrical stimulation, each additional 15 minutes of personal one-on-one contact, with re-insertion of needle(s)</td>
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<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
<th>Comments</th>
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<tbody>
<tr>
<td>G43.701</td>
<td>Chronic migraine without aura, not intractable, with status migrainosus</td>
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<tr>
<td>G43.709</td>
<td>Chronic migraine without aura, not intractable, without status migrainosus</td>
<td></td>
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<tr>
<td>G43.711</td>
<td>Chronic migraine without aura, intractable, with status migrainosus</td>
<td></td>
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<tr>
<td>G43.719</td>
<td>Chronic migraine without aura, intractable, without status migrainosus</td>
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<tr>
<td>G89.28</td>
<td>Other postoperative pain</td>
<td></td>
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<tr>
<td>G89.29</td>
<td>Other chronic pain</td>
<td></td>
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<tr>
<td>K91.0</td>
<td>Vomiting after gastrointestinal surgery</td>
<td></td>
</tr>
<tr>
<td>M54.5</td>
<td>Low back pain</td>
<td></td>
</tr>
<tr>
<td>M17.0</td>
<td>Bilateral primary osteoarthritis knee</td>
<td></td>
</tr>
<tr>
<td>M17.10</td>
<td>Unilateral primary osteoarthritis, unspecified knee</td>
<td></td>
</tr>
<tr>
<td>M17.11</td>
<td>Unilateral primary osteoarthritis, right knee</td>
<td></td>
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<tr>
<td>M17.12</td>
<td>Unilateral primary osteoarthritis, left knee</td>
<td></td>
</tr>
<tr>
<td>M17.2</td>
<td>Bilateral post-traumatic osteoarthritis knee</td>
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<tr>
<td>M17.30</td>
<td>Unilateral post-traumatic osteoarthritis, unspecified knee</td>
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<td>M17.31</td>
<td>Unilateral post-traumatic osteoarthritis, right knee</td>
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<td>M17.32</td>
<td>Unilateral post-traumatic osteoarthritis, left knee</td>
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<tr>
<td>M17.4</td>
<td>Other bilateral secondary osteoarthritis of knee</td>
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</tr>
<tr>
<td>M17.5</td>
<td>Other unilateral secondary osteoarthritis of knee</td>
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<tr>
<td>M17.9</td>
<td>Osteoarthritis of knee, unspecified</td>
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<td>Code</td>
<td>Description</td>
<td>Comments</td>
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<tr>
<td>R11.2</td>
<td>Nausea and vomiting</td>
<td>Add I10 code for adverse effect of type of chemo</td>
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<thead>
<tr>
<th>HCPCS Level II</th>
<th>Description</th>
<th>Comments</th>
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<tbody>
<tr>
<td>N/A</td>
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