765 The City Drive South, Orange Ca 92868

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TITLE:	Astiva Health Utilization Management Policy for Acupuncture Services	
APPROVED:	**12/6/2023**	
APPROVED:	Jason Chung MD, Chief Medical Officer	
APPROVED:	Utilization Management Committee	
DEPARTMENT:	Utilization Management	

POLICY:

This policy outlines the Utilization Management guidelines regarding acupuncture benefit administration and criteria for prior authorization for acupuncture service providers for Astiva Health members.

Stakeholder(s)	Line(s) of Business
X Workforce Member	X Medicare
X Contractor/Vendor	❑ Medi-Cal
X Delegate	X Dual

Eligibility:

Only services to treat chronic pain present at least 4 weeks involving the back, neck or shoulders are eligible. No more than 96 total visits in non-Medicare covered visits a year will be authorized for a member.

DEFINITIONS:

CMS The Centers for Medicare & Medicaid Services oversees the federally and state funded insurance programs for seniors, persons with disabilities (Medicare) and low income (Medicaid) who are deemed eligible for these benefits.

NCQA National Committee for Quality Assurance is an accreditation body that is highly respected in the industry and has been appointed by Congress to aid in developing standards for Special Needs Plans (SNPs) including but not limited to the SNP

	Model of Care requirements. Additionally, health plans and providers who voluntarily request NCQA Accreditation undergo an in-depth review and survey of their operations and quality improvement processes and results to prove their value to consumers and other purchasers of insurance. Accreditation may or may not be granted. When granted the accreditation is for specified functional areas and is for a specified timeframe.
FWA	FWA is Fraud, Waste, and Abuse (a term used to reference the entire gamut of inappropriate behavior, activities, practices, etc. related to perpetrating crimes against members or related to government funding)
HHS	The United States Department of Health and Human Services (HHS), is a cabinet-level executive branch department of the U.S. federal government created to protect the health of all Americans and providing essential human services. Its motto is "Improving the health, safety, and well-being of America. Various States also have a Health & Human Services Department for the citizens of their State.

PROCEDURE

Acupuncture and therapeutic massage services cover necessary routine care for pain. You must use contracted Plan providers.

Coverage

Acupuncture is covered for Medicare-covered services and non-Medicare-covered services for eligible members with the supplemental benefit.

Medicare-covered services:

Covered Indications (NCD 30.3.3)

Effective for services performed on or after January 21, 2020, CMS will cover acupuncture for Medicare patients with chronic Lower Back Pain (cLBP). Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstance:

- For the purpose of this decision, Chronic Lower Back Pain is defined as:
  - 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 8 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.

Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.

Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:

- a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,
- a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.

Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.

Non-Medicare-covered services:

For supplemental services, the beneficiary is covered for routine acupuncture and therapeutic massage services up to a maximum of 96 combined visits per year. Coverage is limited to treatment of back, shoulders and neck only. High frequency of treatments or abnormal utilization patterns are subject to audit and provider claims denial.

Authorization Request Documentation:

Acupuncturists offices seeking prior authorization must submit a complete authorization request package. This should include:

1. Patient Information: Provide the patient's full name, date of birth, and member identification number.

2. Treating Acupuncturist Information: Include the name, contact information, and professional credentials of the treating acupuncturist.

3. Clinical Documentation: Submit short description and codes for requested services. Include clinical records supporting the necessity of the requested services, such as:

- Documentation of member and service eligibility as described above.
- Relevant medical history and diagnostic findings, such as imaging tests.
- A detailed treatment plan outlining the procedures to be performed and body sites treated. For continuing treatment, documentation of treatment response and decision-making rationale for either continuing or changing treatment.
- Any alternative treatment options or site(s) for treatment considered.
- Supporting documentation: Any additional documents that may aid in the authorization process, such as specialist consultations, second opinions, or relevant peer-reviewed research articles.

Timely Submission:

Provider offices are responsible for submitting the complete authorization request package and any requested additional documentation in a timely manner. Failure to provide all required documentation may result in delays or denial of the authorization request. Requests with incomplete information will be automatically closed after 60 days without requested information and Waiver of Liability.

Review Process:

The health plan will review the submitted documentation to assess the eligibility and appropriateness of the requested services. The decision will be based on established criteria and guidelines. The Plans' Utilization Management Committee reviews all Prior Authorization Policies based on input from professional UM Committee member(s) prior to public availability and annually thereafter.

Notification:

Upon review, the health plan will promptly communicate its decision to the practitioner office, generally within 14 days. For expedited requests, a decision is rendered within 3 days. If the request is approved, details of the authorization will be provided. If the request is denied, the reasons for denial and information on the appeals process will be included.

Member Rights and Responsibilities: Members retain appeal rights for pre-authorization of services which are denied, and this will be provided in the decision letter to members.

Confidentiality and Privacy: All documentation will be securely stored and solely used for provision of members' care and quality and utilization improvement activities. All relevant confidentiality and privacy laws are in effect.

Policy Review and Updates: This policy will be reviewed at least annually, or more often as needed due to changes in clinical criteria or State/Federal regulation by the Utilization Management Committee.

REFERENCES / CITATIONS:

HISTORY:

Date	Summary of Significant Changes to P&P
11/6/2023	• Initiated
12/6/2023	• Approved by UM Committee