Priority Health	BILLING POLICY No. 131
ACUPUNCTURE	
Date of origin: Aug. 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial dependent on rider
- Medicare follows CMS unless otherwise specified in EOC
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Acupuncture is the selection and manipulation of specific acupuncture points through the insertion of needles or "needling," or other "non-needling" techniques focused on these points

POLICY SPECIFIC INFORMATION

Per CMS guidelines:

- **Physicians** may furnish acupuncture in accordance with applicable state requirements.
- **Physician assistants, nurse practitioners/clinical nurse specialists, and auxiliary personnel** may furnish acupuncture if they meet all applicable state requirements and have:
  - A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and
  - 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, physician assistant, or nurse practitioner/clinical nurse specialist required by CMS regulations at 42 CFR §§ 410.26 and 410.27.

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, cLBP 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.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

The time spent in personal (one-on-one) contact must be clearly documented in the medical record. This policy enforces the code description for Acupuncture services which are to be reported based on 15 minute time increments of personal face-to-face contact with the patient and not the duration of the needle(s) placement. A unit of time is attained when the mid-point is passed unless specific CPT guidelines state otherwise. For example, 15 minutes is attained when 8 minutes have elapsed. Incremental intervals of the same treatment at the same visit may be accumulated. If the mid-point of the unit of time is not attained, the code should not be billed.

The following should be documented for all acupuncture services rendered:

- Brief account of chief complaints and results of the previous treatment and any significant changes that have occurred since the last visit, if applicable.
- The acupuncture points used.
- Patient positioning.
- Whether electrical stimulation was used.
- Members response to treatment.
- Progress made (or lack thereof). Note that when Functional Outcome Measures (FOM) are used, they should demonstrate Minimal Clinically Important Difference (MCID) from baseline results through periodic reassessments. If the maximum therapeutic benefit has been reached, this should be documented, and treatment should be stopped.
- Treatment plan, which should:
    - o Be individualized with therapeutic goals that are functionally oriented, realistic, measurable, and evidence-based;
    - o Document frequency and duration of service;
    - o Be appropriately correlated with clinical findings and clinical evidence; and o Be expected to result in significant therapeutic improvement over a clearly defined period of time and identify a proposed date of release/discharge from treatment.

Reimbursement specifics

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the Plan's professional or facility services claims coding policies. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Billing details

CPT® code guidelines state only one initial CPT code, 97810 or 97813, should be reported per day.

Priority Health follows the Centers for Medicare and Medicaid Services (CMS) guidelines and National Correct Coding Initiative (NCCI) established Medically Unlikely Edits (MUE) values.

The cost of needles (A4212 and A4215) is included in the Acupuncture service and will be denied if submitted in addition to the Acupuncture service per the CMS National Physician Fee Schedule (NPFS).

Consistent with the CPT code description and the CMS NCCI Procedure to Procedure Coding Edits (PTP), electrical stimulation services (97014 and 97032) should not be reported in addition to specific Acupuncture services that include electrical stimulation (97813, 97814, and S8930) as these are mutually exclusive procedures. In addition, acupuncture codes 97813, 97814 and S8930 are considered inclusive to G0283.

A modifier may be appropriate when an electrical stimulation service is performed distinctly and separate from the Acupuncture service and the documentation supports the service was not related to the Acupuncture.

Per CPT guidelines, E&M services billed on the same day as an acupuncture procedure may be reimbursed when appended with modifier 25 to indicate that the separate E&M service represents a service above and beyond the usual preservice and post service work associated with the acupuncture services. The documentation must support the significant, separate and distinct nature of the E&M service. The time of the E&M service is not included in the time of the acupuncture service.

When both the time-based acupuncture services AND needle insertion services are billed on the same date of service, the time-based acupuncture services (97810, 97811, 97813, 97814) will be denied as inclusive to the needle insertion services (20560 or 20561), per CMS National Correct Coding Initiative (NCCI) edits. No override modifiers allowed per NCCI criteria.

Coding specifics

- **97810 -** Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

- **97811** - 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)
- **97813** - Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
- **97814** - 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)
- **20560** - Needle insertion(s) without injection(s); 1 or 2 muscle, also known as dry needling or trigger-point acupuncture, does not involve the administration of injectable therapeutic agents
- **20561** - Needle insertion(s) without injection(s); 3 or more muscles, also known as dry needling or trigger-point acupuncture, does not involve the administration of injectable therapeutic agents
- **S8930** - Electrical stimulation of auricular acupuncture points; each 15 minutes of personal one-on-one contact with patient

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

- **25 -** significant and separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.
- **59, XE, XS,XP & XU -** is used to identify procedures/services that are commonly bundled together but are appropriate to report separately under some circumstances. This commonly means a different location, different anatomical site, and/or a different session.
- **KX** - Requirements specified in the medical policy have been met

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

This policy applies to acupuncture services provided in an outpatient setting.

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

Priority Health, in accordance with guidance from the Centers for Medicare and Medicaid Services (CMS) covers the use of acupuncture for Medicare members with chronic low back pain (cLBP). Coverage of this benefit is intended to reduce the use of opioids for cLBP.

cLBP is defined as:

- Lasting 12 weeks or longer
- Non-specific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, or infectious disease, etc.)
- Not associated with surgery
- Not associated with pregnancy

Priority Health Medicare covers up to 12 visits over a 90-day period for members with cLBP. An additional eight sessions will be covered for patients demonstrating improvement. No more than 20 acupuncture treatments may be administered annually.

Treatment must be discontinued if the patient is not improving or regressing.
Most Priority Health Medicare plans also cover up to six non-Medicare-covered acupuncture visits (limited to 6 visits whether done in- or out-of-network) for other conditions, such as; headaches, anxiety, sleep issues, osteoarthritis, chemotherapy side effects and respiratory disorders.

Billing for visits 13 - 20

Priority Health covers an additional eight sessions (beyond the initial 12 sessions), for patient demonstrating improvement. For these additional sessions, the provider must bill using the KX modifier to indicate the patient is improving and that the visits are medically necessary as justified by appropriate documentation in the medical records.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

- Acupuncture, Medicare | Priority Health
- NCD - Acupuncture for Chronic Lower Back Pain (cLBP) (30.3.3)
- Acupuncture CPT Codes for Insurance Billing 2025-2026
- https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and

frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made