BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy

Prolotherapy

Policy Number: OCA 3.707
Version Number: 16
Version Effective Date: 12/01/21

Product Applicability	☐ **All Plan+ Products**
WellSense Health Plan ☐ NH Medicaid ☐ NH Medicare Advantage	**Boston Medical Center HealthNet Plan** ☒ MassHealth ACO ☒ MassHealth MCO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers prolotherapy **experimental and investigational** or NOT medically necessary when used for the treatment of chronic musculoskeletal pain and/or instability, temporomandibular joint disorders, and/or for any other condition. Prior authorization is required.

Clinical Criteria

Prolotherapy is considered experimental and investigational or NOT medically necessary due to limited evidence demonstrating the clinical utility and clinical validity of prolotherapy to treat chronic musculoskeletal pain and/or instability, temporomandibular joint disorders, and/or for ANY other indication.

Limitations and Exclusions

See the Clinical Criteria section.

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Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at www.bmchp.org for BMC HealthNet Plan members.

HCPCS Code	Description: Code Considered Experimental and Investigational or NOT Medically Necessary
M0076	Prolotherapy

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 01/27/09: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 01/27/09: Utilization Management Committee (UMC) 02/25/09: Quality Improvement Committee (QIC)	05/01/09 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC, QIC, and UMC

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12

Policy title was *Prolotherapy for the Treatment of Chronic Musculoskeletal Pain* until 09/30/17. Policy title changed to *Prolotherapy* as of 10/01/17.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
01/26/10	No changes.	Version 2	01/26/10: MPCTAC

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Policy Revisions History			
			02/24/10: QIC
12/13/10	Updated references.	Version 3	01/19/11: MPCTAC 02/23/11: QIC
08/01/12	Review with effective date of 10/01/12. Updated references. Revisions made to the following sections: Summary, Description of Item or Service, Medical Policy Statement, and Applicable Coding. Deleted redundant text in Clinical Background Information section.	10/01/12 Version 4	08/15/12: MPCTAC 09/26/12: QIC
07/01/13	Review for effective date 09/01/13. Reformatted text in Clinical Background Information section. Updated references.	09/01/13 Version 5	07/17/13: MPCTAC 08/15/13: QIC
03/01/14	Review for effective date 05/01/14. Updated references. Revised Description of Item or Service and Clinical Background Information sections.	05/01/14 Version 6	03/19/14: MPCTAC 04/16/14: QIC
02/01/15	Review for effective date 04/01/15. No changes to the code list or criteria. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available.	04/01/15 Version 7	02/18/15: MPCTAC 03/11/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 8	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
02/01/16	Review for effective date 04/01/16. Updated Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	04/01/16 Version 9	02/17/16: MPCTAC 03/09/16: QIC
01/01/17	Review for effective date 03/01/17. Updated Description of Item or Service and References sections. Plan note added to the Applicable Coding section without revising the code list.	03/01/17 Version 10	01/18/17: MPCTAC 02/08/17: QIC
09/01/17	Review for effective date 10/01/17.	10/01/17	09/20/17: MPCTAC

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Policy Revisions History			
	Revised policy title. Updated Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Other Applicable Policies sections. Administrative changes made to the Medical Policy Statement and Limitations sections.	Version 11	
09/01/18	Review for effective date 10/01/18. Updated References and Other Applicable Policies sections.	10/01/18 Version 12	09/19/18: MPCTAC
09/01/19	Review for effective date 10/01/19. Administration changes made to the Policy Summary, References, and References to Applicable Laws and Regulations sections.	10/01/19 Version 13	09/18/19: MPCTAC
07/01/20	Review for effective date 08/01/20. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Clinical Background Information, and References sections.	08/01/20 Version 14	07/15/20: MPCTAC
08/01/21	Review for effective date 09/01/21. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, Other Applicable Policies, and References sections.	09/01/21 Version 15	08/27/21: MPCTAC (electronic vote)
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitation and Exclusions section. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 16	11/17/21: MPCTAC

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Next Review Date

07/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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