Policy Statement
This policy will be used to provide a listing of procedures considered experimental, investigational by any network practitioner. Services listed in the policy are not eligible for reimbursement.

Purpose
To provide a listing of procedures considered experimental, investigational or unproven services by any practitioner.

Scope

Coverage
Coverage is subject to the terms of an enrollee’s benefit plan. To the extent there is any inconsistency between this medical policy and the terms of an enrollee’s benefit plan, the terms of the enrollee’s benefit plan documents will always control. Investigational services are not covered under enrollee’s health plan.

Definition
- Advanced BioStructural Correction (ABC)
- Alphabiotics
- Applied Kinesiology or any of its derivations
- Applied Spinal Biomechanical Engineering
- BioEnergetic Synchronization Technique (B.E.S.T)
- Chiropractic Biophysics (CBP, Clinical Biomechanics of Posture, CBP Mirror Image Technique)
- Coccygeal Meningeal Stress Fixation
- Cold Laser Therapy
- Computerized muscle testing or analysis
- Craniosacral Therapy (CST)
- Directional Non-force Technique
- Spinal Diagnostic Ultrasound
- Hako-Med electrotherapy (horizontal electrotherapy)
- Hippotherapy
- Impulse adjusting instrument
- Intersegmental traction and Autotraction
- Kinesio taping (Elastic Therapeutic Taping)
- Live Cell Analysis or hair analysis
- Manipulation under Anesthesia (MUA)
• Moire Contourographic Analysis
• Nambudripad’s Allergy Elimination Technique (NAET)/ other Allergy Testing
• National Upper Cervical Chiropractic Association (NUCCA technique)/ Grostic technique
• Network Chiropractic, NeuroEmotional Technique (NET)
• Neurocalometer, Nervoscope, Nerve Conduction Velocity, Surface EMG, Paraspinal Electromyography, Spinoscopy or other nerve conduction testing
• Neural Organizational Technique, Contact Reflex Analysis (CRA), Whole System Scan
• Nimmo Receptor-Tonus method
• Pettibon and wobble chair/board treatment
• Preventive Care, Maintenance Care, Corrective Care
• Pro-Adjuster
• Sacro Occipital Technique, Neurocranial Restructuring (NCR), Cranial Manipulation
• Sound Assisted Soft Tissue mobilization
• Chiropractic services directed at controlling progression and/or reducing scoliosis, including but not limited to the SpineCor brace and CLEAR scoliosis treatment
• Repeat imaging to determine the progress of conservative treatment
• Thermography
• Upledger Technique
• Vascular Studies, including, but not limited to, Doppler ultrasound analysis and plethysmography
• VAX-D, Lordex, LTX3000, DRX-9000, DRS (Decompression Reduction Stabilization System), or other back traction devices charged at a higher rate than mechanical traction (97012)
• Whole Body Vibration (WBV), Vibration Plate, Vibration Therapy
• Any lab work for which the office is not CLIA Certified or falls outside of the scope of practice, including, but not limited to drug testing, therapeutic drug assays, and organ or disease oriented panels
• Treatment for brachioradial pruritis
• Dry Needling

Procedure:

1. Guidelines:
   a. If such services are to be provided, the practitioner will inform the member, in writing, that such services will be the member’s responsibility. None of these services are to be performed in lieu of an appropriate examination or without consideration of an appropriate referral.
   b. There is limited scientific evidence that the use of experimental, investigational and unproven services provides an improved or more accurate diagnosis, nor do they result in an improved clinical outcome.
   c. Scientific literature will continue to be reviewed and any significant changes in published literature will be taken into consideration for modification of this policy.

2. Exclusions/Limitations (not limited to):
Refer to enrollee’s Certificate of Coverage or Summary Plan Description.

3. **Removal of a service from the Experimental and Investigations Policy**
   At least annually, a review of the current literature will be evaluated to determine if there is additional research in support of any of the services listed under this policy. This evaluation will include the following criteria:
   - **Safety** – Is the potential benefit superior to the potential harm?
   - **Health Outcomes** – Is there evidence the service will provide, at minimum, equal outcomes and, at best, superior outcomes to currently available services?
   - **Patient Management** – Will the service improve clinical decision making?
   - **Clinical Performance** – Is the reliability as well as predictive value of the service equal or superior to the current “gold standard” for such services?
   - **Cost-effectiveness** – Is the service equal to or lower cost than currently utilized services for similar diagnosis and treatment?

   All criteria will be based on peer-reviewed scientific literature and internationally and nationally accepted and published guidelines. Peer-reviewed scientific studies must be published in or accepted for publication by medical journals meeting national requirements for scientific publication (http://www.icmje.org). The medical literature must meet the National Institutes of Health Library of Medicine for indexing (http://www.nlm.nih.gov). Medical journals that publish most of their scientific manuscripts by the editorial staff of a journal will not be considered for review. If the majority of funding for research is published by the device manufacturer or organization sponsoring a technique the results will not be considered for review.

   If the service appears to be safe and cost-effective Magellan Healthcare will present these results to our health plan partners for consideration of coverage and/or payment. Final authority for such coverage determinations rests with the health plan.
REFERENCES


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