Corporate Medical Policy

Neural Therapy

File Name: neural_therapy
Origination: 4/2012
Last Review: 4/2024

Description of Procedure or Service

Neural therapy, an alternative medicine modality, involves the injection of a local anesthetic such as procaine or lidocaine into various tissues such as scars, trigger points, acupuncture points, tendon and ligament insertions, peripheral nerves, autonomic ganglia, the epidural space, and other tissues to treat chronic pain and illness. When the anesthetic agent is injected into traditional acupuncture points, this treatment may be called neural acupuncture.

The practice of neural therapy is based on the belief that energy flows freely through the body. It is proposed that injury, disease, malnutrition, stress, and scar tissue disrupt this flow, creating disturbances in the electrochemical function of tissues and energy imbalances called "interference fields." Injection of a local anesthetic is believed to reestablish the normal resting potential of nerves and flow of energy. Alternative theories include fascial continuity, the ground (matrix) system, and the lymphatic system.

There is a strong focus on treatment of the autonomic nervous system, and injections may be given at a location other than the source of the pain or location of an injury. Neural therapy is promoted mainly to relieve chronic pain. It has also been proposed to be helpful for allergies, hay fever, headaches, arthritis, asthma, hormone imbalances, libido, infertility, tinnitus, chronic bowel problems, sports or muscle injuries, gallbladder, heart, kidney, or liver disease, dizziness, depression, menstrual cramps, and skin and circulation problems.

Related Policies:
Intravenous Anesthetics for the Treatment of Chronic Pain
Prolotherapy

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

Neural Therapy is considered investigational for all applications. BCBSNC does not provide coverage for investigational services or procedures.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When Neural Therapy is covered

Not applicable.

When Neural Therapy is not covered

Neural therapy is considered investigational for all indications.

Policy Guidelines

For individuals who have chronic pain or illness (eg, pain, allergies, hay fever, headaches, arthritis, asthma, hormone imbalances, libido, infertility, tinnitus, chronic bowel problems, sports or muscle injuries, gallbladder, heart, kidney, or liver disease, dizziness, depression, menstrual cramps, skin and circulation problems) who receive neural therapy, the evidence includes small randomized trials and a large case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. There are few English-language reports assessing the use of neural therapy for pain, and the available studies have methodologic limitations that preclude conclusions on efficacy. The evidence is insufficient to determine the effects of the technology on health outcomes.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: *There is no specific code for this service. The procedure would be reported using applicable CPT codes for therapeutic injections.*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.85, 12/8/2011

Medical Director – 3/2012

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.85, 12/13/2012

Specialty Matched Consultant Advisory Panel – 1/2013

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.85, 12/12/2013

Specialty Matched Consultant Advisory Panel – 1/2014

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.85, 12/11/2014

Specialty Matched Consultant Advisory Panel – 1/2015

Medical Director review – 1/2015

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.85, 12/10/2015

Specialty Matched Consultant Advisory Panel 1/2016

Medical Director review 1/2016

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.85, 11/9/2017

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.85, 11/8/2018

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.85, 11/14/2019

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American Association of Orthopaedic Medicine. Neural Therapy. 2013; http://www.aaomed.org/Neural-therapy. Accessed September, 2019

BCBSA Medical Policy Reference Manual [Electronic Version]. 2.01.85, 11/12/2020

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North American Spine Society. Diagnosis and treatment of low back pain. 2020. Accessed October 25, 2021

American Association of Orthopaedic Medicine. Neural Therapy. 2013; http://www.aaomed.org/Neural-therapy. Accessed October 25, 2021.

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Frank BL. Neural therapy. Phys Med Rehabil Clin N Am. Aug 1999; 10(3): 573-82, viii. PMID 10516978

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Medical Director review 4/2024

Policy Implementation/Update Information

4/17/12 New policy. Neural therapy is considered investigational for all indications. Notification given 4/17/12. Policy effective 7/24/12. (btw)

1/29/13 Specialty Matched Consultant Advisory Panel review 1/16/2013. No change to policy intent. Reference added. (btw)

2/11/14 Specialty Matched Consultant Advisory Panel review 1/28/2014. No change to policy. Reference added. (btw)

2/24/15 References updated. Specialty Matched Consultant Advisory Panel review 1/2015. Medical Director review 1/2015. Policy Statement unchanged. (td)

2/29/16 Policy Guidelines section revised References updated. Specialty Matched Consultant Advisory Panel review 1/27/2016. Medical Director review 1/2016. (td)

12/30/16 Specialty Matched Consultant Advisory Panel review 11/30/2016. No change to policy statement. (an)

5/26/17 Specialty Matched Consultant Advisory Panel review 4/26/2017. No change to policy statement. (an)

6/8/18 Minor changes to Description and Policy Guidelines sections. Specialty Matched Consultant Advisory Panel review 5/23/2018. No change to policy statement. (an)

4/30/19 Minor changes to Policy Guidelines section. Reference added. Specialty Matched Consultant Advisory Panel review 4/17/2019. No change to policy statement. (an)

4/28/20 References added. Specialty Matched Consultant Advisory Panel review 4/15/2020. No change to policy statement. (eel)

5/18/21 References added. Specialty Matched Consultant Advisory Panel review 4/2021. Medical Director review 4/2021. No change to policy statement. (bb)

5/3/22 References added. Specialty Matched Consultant Advisory Panel review 4/2022. Medical Director review 4/2022. No change to policy statement. (tt)

5/2/23 Related policies updated. References added. Specialty Matched Consultant Advisory Panel review 4/2023. Medical Director review 4/2023. No change to policy statement. (tt)

5/1/24 References added. Specialty Matched Consultant Advisory Panel review 4/2024. Medical Director review 4/2024. No change to policy statement. (tt)