Medical Policy

Prolotherapy

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Policy Number: 183

BCBSA Reference Number: 2.01.26 (For Plans internal use only)

Related Policies

Diagnosis and Treatment of Sacroiliac Joint Pain, #320

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Prolotherapy is considered INVESTIGATIONAL as a treatment of musculoskeletal pain.

Prior Authorization Information

Inpatient
- For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed INPATIENT.

Outpatient
- For services described in this policy, see below for products where prior authorization might be required if the procedure is performed OUTPATIENT.

<table>
<thead>
<tr>
<th>Commercial Managed Care (HMO and POS)</th>
<th>Outpatient</th>
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<tbody>
<tr>
<td>This is not a covered service.</td>
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<tr>
<th>Commercial PPO and Indemnity</th>
<th>Outpatient</th>
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CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.
The following CPT code is considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:

<table>
<thead>
<tr>
<th>HCPCS codes</th>
<th>Code Description</th>
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<tr>
<td>M0076</td>
<td>Prolotherapy</td>
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**Description**

The goal of prolotherapy is to promote tissue repair or growth by prompting the release of growth factors, such as cytokines, or by increasing the effectiveness of existing circulating growth factors. The mechanism of action is not well understood but may involve local irritation and/or cell lysis. Agents used with prolotherapy have included zinc sulfate, psyllium seed oil, combinations of dextrose, glycerin, and phenol, or dextrose alone, often combined with a local anesthetic. Polidocanol, sodium morrhuate, and vascular sclerosants have also been used to sclerose areas of high intratendinous blood flow associated with tendinopathies. Prolotherapy typically involves multiple injections per session conducted over a series of treatment sessions.

A similar approach involves the injection of autologous platelet-rich plasma, which contains a high concentration of platelet-derived growth factors.

**Summary**

Prolotherapy describes a procedure intended for healing and strengthening ligaments and tendons by injecting an agent that induces inflammation and stimulates endogenous repair mechanisms. Prolotherapy may also be referred to as proliferant injection, prolo, joint sclerotherapy, regenerative injection therapy, growth factor stimulation injection, or nonsurgical tendon, ligament, and joint reconstruction.

For individuals who have musculoskeletal pain (eg, chronic neck, back pain), osteoarthritic pain, or tendinopathies of the upper or lower limbs who receive prolotherapy, the evidence includes small, randomized trials with inconsistent results. Relevant outcomes are symptoms, functional outcomes, and quality of life. The strongest evidence evaluates the use of prolotherapy for the treatment of osteoarthritis, but the clinical significance of the therapeutic results is uncertain. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

**Policy History**

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<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>1/2023</td>
<td>Annual policy review. Description, summary, and references updated. Policy statements unchanged.</td>
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<tr>
<td>1/2022</td>
<td>Annual policy review. Description, summary, and references updated. Policy statements unchanged.</td>
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<tr>
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<tr>
<td>1/2021</td>
<td>Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.</td>
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<tr>
<td>1/2018</td>
<td>New references added from Annual policy review.</td>
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<tr>
<td>11/2015</td>
<td>New references added from Annual policy review. Added coding language.</td>
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<tr>
<td>12/2013</td>
<td>New references from Annual policy review.</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References