MASSACHUSETTS

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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**.

	Outpatient
Commercial Managed Care (HMO and POS)	This is **not** a covered service.
Commercial PPO and Indemnity	This is **not** a covered service.

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 <u>Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:</u>

HCPCS Codes

HCPCS codes:	Code Description
M0076	Prolotherapy

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

Date	Action
1/2025	Annual policy review. References updated. Policy statements unchanged.
1/2024	Annual policy review. References updated. Policy statements unchanged.
1/2023	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
12/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2018	New references added from Annual policy review.
11/2015	New references added from Annual policy review. Added coding language.
12/2013	New references from Annual policy review.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.

6/2011	Reviewed - Medical Policy Group – Orthopedics, Rehabilitation and Rheumatology. No changes to policy statements.
7/2010	Reviewed - Medical Policy Group – Orthopedics, Rehabilitation Medicine and Rheumatology. No changes to policy statements.
5/1/2010	Medical Policy 183 effective 5/1/2010 describing ongoing non-coverage
4/2010	Annual policy review. No changes to policy statements.
9/2008	Annual policy review. No changes to policy statements.
8/2007	Annual policy review. No changes to policy statements.

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

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