Complementary and Alternative Medicine

Number: 0388

Policy

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.

Aetna considers alternative medicine interventions medically necessary if they are supported by adequate evidence of safety and effectiveness in the peer-reviewed published medical literature. The following are some of the alternative medicine interventions that Aetna considers medically necessary for properly selected members, subject to applicable benefit plan limitations and exclusions.

- Acupuncture - see CPB 0135 - Acupuncture (.html)
- Biofeedback - see CPB 0132 - Biofeedback (.html)
- Chiropractic Services - see CPB 0107 - Chiropractic Services (.html)
- Electrical stimulation - see CPB 0011 - Electrical Stimulation for Pain (.html).

Aetna considers the following alternative medicine interventions experimental and investigational, because there is

Policy History

Last Review 04/14/2016
Effective: 03/08/2000
Next Review: 04/13/2017

Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes
inadequate evidence in the peer-reviewed published medical literature of their effectiveness:
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<td>Atherosclerosis -- see CPB 0234 - Chelation Therapy ([..200_299/0234.html] Chung Moo Doe  therapy Coley's toxin Colonic irrigation (colonic cleansing, colonic lavage) Color therapy Conceptual mind-body techniques Craniosacral therapy Crystal healing Cupping Dance/Movement therapy Digital myography Ear Candling Egoscue method Electrodermal stress analysis Electrodiagnosis according to Voll (EAV) Equestrian therapy -- see CPB 0151 - Hippotherapy ([..100_199/0151.html]) Essential Metabolics Analysis (EMA) Essiac Faith healing Feldenkrais method of exercise therapy (also known as awareness through movement) Flower essence Fresh cell therapy</td>
<td>Pilates Polarity therapy (Poon's) Chinese blood cleaning Primal therapy Psychodrama Purging Qigong longevity exercises Ream's testing Reflexology (zone therapy) Reflex Therapy Regenokine therapy Reiki Remedial massage Revici's guided chemotherapy Rife therapy/Rife machine Rolfing (structural integration) Rubenfeld synergy method (RSM) 714-X (for cancer) Salt room therapy Sarapin injections Shark cartilage products SonoKinesthesia treatment Telomere testing Therapeutic Eurythmy-movement therapy Therapeutic touch Thought field therapy (TFT) (Callahan Techniques Training) Thermogenic therapy Trager approach Trager approach</td>
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* Functional intracellular analysis is also known as essential metabolic analysis, intracellular micronutrient analysis, leukocyte nutrient analysis, as well as micronutrient testing.

**Glutathione infusion is considered experimental and investigational for chemotherapy-induced neuropathy, chronic fatigue syndrome, common variable immune deficiency, contrast media-induced nephropathy, and functional diarrhea.

Aetna does not cover medical marijuana because it is not an FDA-approved prescription medication. Please check benefit plan descriptions for details.
Aetna considers Airrosti (Applied Integration for the Rapid Recovery of Soft Tissue Injuries) as proven nonpreferentially for physical therapy, as there is a lack of reliable published evidence that Airrosti is superior to other physical therapy providers.

**Note:** Aetna standard benefit plans exclude coverage of nutritional supplements. Please check benefit plan descriptions. Nutritional supplements that would be excluded under these standard benefit plans include bilberry, black cohosh, bovine cartilage, cat’s claw, Coriolus versicolor mushroom, Echinacea, fish oil, Ginkgo biloba, glucosamine, kava, milk thistle, saw palmetto, shark cartilage, St. John’s wort, valerian, and yohimbine (not an all-inclusive list).

**Background**

"Alternative medicine" is a term used for a broad range of treatments and practices that have not gained wide acceptance in the traditional medical community and so are not considered standard medical treatment. Other terms used to describe such procedures include "holistic", "unconventional", and "complementary".

Alternative therapies are based on no common or consistent ideology, therapy of illness, or treatment. They derive from a variety of sources: ethnic and folk traditions, mainstream medical practices, established religions or semi-religious cults, philosophies or metaphysical movements, and health- and-wellness groups. The National Institutes of Health's Office of Alternative Medicine classified alternative therapies into the following 7 categories:

- Alternative systems of medical practice -- use of medicine from another culture (e.g., Ayurvedia, Chinese medicine)
- Bioelectromagnetic therapies -- use of electrical currents or magnetic fields to promote healing (e.g., bone repair, electroacupuncture)
- Diet and nutrition -- use of specific foods, vitamins, and minerals to prevent illness and to treat disease
- Herbal medicine -- use of plants as medicine
- Manual healing methods -- use of the hands to promote healing (e.g., massage, chiropractic)
- Mind-body interventions -- use of the mind to enhance health (e.g., hypnosis, meditation, yoga)
- Pharmacologic and biologic treatments -- use of various substances (e.g., drugs, serums) to treat specific medical problems.

The efficacy of various alternative medicine regimens is generally unproven, and some alternative therapies have been shown to be ineffective or even harmful.

Active release technique (ART) is a patented soft tissue system that treats problems with muscles, tendons, ligaments, fascia and nerves (e.g., headaches, back pain, carpal tunnel syndrome, shin splints, shoulder pain, sciatica, plantar fasciitis, knee problems, and tennis elbow). These conditions have one important commonality -- they often result from injury to overused muscles. Each ART session is a combination of examination and treatment. The ART provider uses his/her hands to evaluate the texture, tightness and movement of muscles, fascia, tendons, ligaments and nerves. Abnormal tissues are treated by combining precisely directed tension with very specific patient movements. These treatment protocols -- over 500 specific moves -- are unique to ART. They supposedly allow providers to identify and correct the specific problems that are affecting each individual patient. Active release technique is similar to some massage techniques, albeit more aggressive.

While ART may be utilized by some chiropractors, it is different from conventional chiropractic manipulation. Furthermore, Drover et al (2004) reported that ART protocols did not reduce inhibition or increase strength in the quadriceps muscles of athletes with anterior knee pain. Further study is required.

Airrosti (applied integration for the rapid recovery of soft tissue injuries) centers are primarily concentrated in Texas, and focus
on management of soft tissue injuries and chronic pain. Airrosti uses standard physical therapy modalities. There is a lack of published scientific evidence that Airrosti is superior to other physical therapy providers.

Bioidentical hormones (e.g., estrogen, testosterone, dehydroepiandrosterone [DHEA], etc.) are manufactured to have the same molecular structure as the hormones made by one's own body, and have been used in conjunction with laboratory tests of salivary hormone levels. These preparations can be custom-made for patients according to a physician's specifications. Based on test results, providers prescribe dosages of bioidentical hormones that are compounded at a pharmacy. Proponents of bioidentical hormones state that they are better than synthetic hormones in that they are "natural" and that they are more easily metabolized by the body, minimizing side effects. They state that synthetic hormones are stronger than bioidentical hormones and often produce intolerable side effects.

According to a committee opinion by the American College of Obstetricians and Gynecologists (ACOG, 2005), there is no scientific evidence to support claims of increased safety or effectiveness for individualized estrogen or progesterone regimens prepared by compounding pharmacies. Furthermore, hormone therapy does not belong to a class of drugs with an indication for individualized dosing. The opinion by ACOG also pointed out that salivary hormone level testing used by proponents to 'tailor' this therapy isn't meaningful because salivary hormone levels vary within each woman depending on her diet, the time of day, the specific hormone being tested, and other variables.

According to ACOG, most compounded products, including bioidentical hormones, have not undergone rigorous clinical testing for either safety or efficacy. Also, there are concerns regarding the purity, potency, and quality of compounded products. In 2001, the United States Food and Drug Administration (FDA) analyzed a variety of 29 product samples
from 12 compounding pharmacies and found that 34% of them failed one or more standard quality tests. Additionally, 9 of the 10 failing products failed assay or potency tests, with all containing less of the active ingredient than expected. In contrast, the testing failure rate for FDA-approved drug therapies is less than 2%. The FDA requires manufacturers of FDA-approved products that contain estrogen and progestogen to include a black box warning that reflects the findings of the Women's Health Initiative. However, compounded products, including bioidentical hormones, are not approved by the FDA and therefore, compounding pharmacies are exempt from including warnings and contraindications required by the FDA in class labeling for hormone therapy.

Given the lack of well-designed and well-conducted clinical trials of these compounded hormones, ACOG recommended that all of them should be considered to have the same safety issues as those hormone products that are approved by the FDA and may also have additional risks unique to the compounding process.

In a position statement, the Endocrine Society (2006) stated that it is concerned that patients are receiving potentially misleading or false information about the benefits and risks of bioidentical hormones. It stated that the efficacy of bioidentical hormone therapy is unproven.

There are few, if any, carefully designed studies on the use of hypnotherapy in the treatment of mental health problems (Kirsch et al, 1995; Mamtani and Cimino, 2002; Fromm and Shor, 2006). Based on the current research literature, there is insufficient evidence to support the use of hypnosis in the treatment of psychiatric and psychological disorders, such as depression and anxiety. Furthermore, there also has been no experimental validation of the effectiveness of hypnosis in controlling the symptoms of attention deficit disorder (Baumgartel, 1999).

Proponents of neural therapy believe that (i) the nervous
system influences all bodily functions, (ii) energy flows freely through the body of a healthy person, and (iii) illness and chronic pain disrupt this flow of energy. It involves the injection of anesthetics into various places of the body to eliminate pain and cure illness. This method is not to be confused with nerve blocks and local anesthesia used in conventional medicine. In neural therapy, anesthetics such as lidocaine and procaine, are injected into areas of the body that may be located far from the pain source. These injections are meant to eliminate "interference fields" and restore the body's natural energy flow. The injections may be given into nerves, acupuncture points, glands, scars, and trigger points. A course of treatment may involve 1 or more injections spread over several weeks. A few practitioners use electrical current and lasers instead of injected drugs. Research into neural therapy has been done mainly in Germany where it is widely used; however, there is insufficient evidence on the effectiveness of neural therapy for pain management or for any other health problems (American Cancer Society, 2007).

Griffiths et al (1998) examined the role of the T-lymphocytic cell cycle as well as an autogenous lymphocytic factor (ALF) in the diagnosis and regulation of immunological incompetence. A total of 315 individuals (chemically sensitive immunocompromised patients, n = 290; controls, n = 25) were investigated. Each patient had been on a standard therapy of avoidance of pollutants, nutritional supplementation, and injections of antigens for foods, and biological inhalants, but did not achieve immunological competence. Peripheral lymphocytes were collected and DNA histograms were constructed. The flow cytometer was used to evaluate the cell cycle, hematological, and other immunological profiles. From the other portion of the blood specimen, lymphocytes were propagated in-vitro, harvested, and a lysate, termed ALF, was prepared. When treated with ALF, 88% of these individuals showed a significant (p < 0.001) clinical improvement that correlated with laboratory findings, involving regulation of abnormal cell cycles, increase in total lymphocytes and subsets T4, T8, (p < 0.05) and cell-mediated immunity (CMI) response (p
< 0.001). The authors stated that ALF presumably acts as a biological response modifier. More research is needed to determine the role of ALF in clinical medicine.

The Juvent 1000 Dynamic Motion Therapy (DMT) Platform is advocated as a non-drug, non-invasive treatment for osteoporosis. It provides very small vertical movements of about 50 micrometers that repeat at a rate of approximately 34 times/second. This repetition rate is automatically varied to correspond to an individual's body mass. Consequently, the vertical motion transmitted to the musculoskeletal system by the Juvent Platform is barely noticeable. The user supposedly can obtain the full benefits of the Juvent therapy by standing on the Juvent 1000 Platform for 20 minutes each day. However, there is a lack of evidence regarding the effectiveness of this device.

MEDEK, a form of physiotherapy, refers to Metodo Dinamico de Estimulacion Kinesica or Dynamic Method for Kinetic Stimulation. It was developed by a Chilean physical therapist in the 1970s. MEDEK is used for developing gross motor skills in children with physical disabilities and movement disorders (e.g., cerebral palsy, Down syndrome, hypotonia, muscular dystrophy, and developmental motor delay). It does not focus on modifying muscle tone, primitive reflexes or abnormal patterns of movement. It focuses on training movements leading to sitting, standing, and walking. Muscles are trained in postural and functional tasks rather than in isolation. Tight muscles are stretched in dynamic situations. The motor developmental sequence is not used. MeDEK assumes that different skills require different movement strategies. Unlike other interventions, tasks are performed without the child’s attention, conscious thought or co-operation. It is assumed that motivation will increase temporary performance only but will not create a permanent change. The therapist’s task is to provoke automatic postural reactions that contribute to the postural control needed for functional tasks. Well-designed clinical studies are needed to ascertain the effectiveness of MEDEK.
In a review on autism, Levy and colleagues (2009) stated that popular biologically based treatments include anti-infectives, chelation medications, gastrointestinal medications, hyperbaric oxygen therapy, and intravenous immunoglobulins. Non-biologically based treatments include auditori integration therapy, chiropractic therapy, cranio-sacral manipulation, facilitated communication, interactive metronome, and transcranial stimulation. However, few studies have addressed the safety and effectiveness of most of these treatments.

According the American Cancer Society, there is no scientific evidence that hydrogen peroxide is a safe, effective or useful cancer treatment. Current mainstream medical applications of hydrogen peroxide are limited to 1.5 % to 3 % solutions used as surface disinfectants and wound cleansers.

Traumeel injection solution is an anti-inflammatory, anti-edematous, anti-exudative combination formulation of 12 botanical substances and 1 mineral substance. It is classified as a homeopathic combination remedy.

**Botanical ingredients:**

- Aconitum napellus (monkshood)
- Arnica montana, radix (mountain arnica)
- Belladonna (deadly nightshade)
- Bellis perennis (daisy)
- Calendula officinalis (marigold)
- Chamomilla (chamomile)
- Echinacea angustifolia (narrow-leafed cone flower)
- Echinacea purpurea (purple cone flower)
- Hamamelis virginiana (witch hazel)
- Hypericum perforatum (St. John's wort)
- Millefolium (milfoil)
- Symphytum officinale (comfrey)

**Mineral ingredient:**

- Hepar sulphuris calcareum (calcium sulfide)
In a Cochrane review, Kassab and colleagues (2009) evaluated safety and effectiveness of homeopathic medicines used to prevent or treat adverse effects of cancer treatments. Randomized controlled trials (RCTs) of homeopathic medicines in participants with a clinical or histological diagnosis of cancer where the intervention was aimed at preventing or treating symptoms associated with cancer treatments were included in this review. All age groups, and all stages of disease were included. Two review authors independently assessed studies for inclusion and 2 review authors extracted data. Three review authors independently assessed trial quality using the Delphi List and the Cochrane Collaboration's tool for assessing risk of bias. Disagreements were resolved by consensus. Where available, data were extracted for analysis. A total of 8 controlled trials (7 placebo controlled and 1 trial against an active treatment) with a total of 664 participants met the inclusion criteria. Three studied adverse effects of radiotherapy, 3 studied adverse effects of chemotherapy and 2 studied menopausal symptoms associated with breast cancer treatment. Two studies with low-risk of bias demonstrated benefit: one study with 254 subjects demonstrated superiority of topical calendula over trolamine (a topical agent not containing corticosteroids) for prevention of radiotherapy-induced dermatitis, and another study with 32 subjects demonstrated superiority of Traumeel S (a proprietary complex homeopathic medicine) over placebo as a mouthwash for chemotherapy-induced stomatitis. Two other studies reported positive results, although the risk of bias was unclear, and 4 further studies reported negative results. No serious adverse effects or interactions were reported attributable to the homeopathic medicines used. The authors concluded that this review found preliminary data in support of the efficacy of topical calendula for prophylaxis of acute dermatitis during radiotherapy and Traumeel S mouthwash in the treatment of chemotherapy-induced stomatitis. Moreover, they stated that these trials need replicating. There is no convincing evidence for the efficacy of homeopathic medicines for other adverse effects of cancer treatments. Further research is required.
In a randomized controlled trial, Singer et al (2010) evaluated the effectiveness of the homeopathic preparation Traumeel S in minimizing post-operative pain and analgesic consumption following surgical correction of hallux valgus. A total of 80 consecutive patients were randomized to receive either Traumeel tablets or an indistinguishable placebo, and took primary and rescue oral analgesics as needed. Maximum numerical pain scores at rest and consumption of oral analgesics were recorded on day of surgery and for 13 days following surgery. Traumeel was not found superior to placebo in minimizing pain or analgesic consumption over the 14 days of the trial, however a transient reduction in the daily maximum post-operative pain score favoring the Traumeel arm was observed on the day of surgery, a finding supported by a treatment-time interaction test ($p = 0.04$). The authors concluded that Traumeel was not superior to placebo in minimizing pain or analgesic consumption over the 14 days of the trial. A transient reduction in the daily maximum post-operative pain score on the day of surgery is of questionable clinical importance.

Biomagnetic therapy is an approach to pain-relief that employs the use of magnets to generate an electro-magnetic field (EMF) to areas of musculo-skeletal discomfort or injuries. This approach can reportedly reduce the discomfort arising from various degenerative diseases (e.g., osteoarthritis) and help in the recovery of joint or tendon injury. However, the exact mechanism(s) of these recuperative effects remain elusive. Further ambiguity also stems from the fact that the reported effectiveness of this intervention is based largely on subjective experiences of participants in clinical trials that display a significant investigators' bias as well as placebo-effect. Thus, the effectiveness of biomagnetic therapy for pain-relief has yet to be established.

Lorentzen et al (2012) stated that neural tension technique (NTT) is a therapy believed to reduce spasticity and to increase range of motion (ROM). These investigators compared the ability of NTT and random passive movements (RPMs) to
reduce spasticity in the knee flexors in 10 spastic patients with brain injury. An RCT study with cross-over design evaluated muscle tone measured by: (i) hand-held dynamometer; (ii) Modified Ashworth Scale (MAS); and ROM by angles of resistance onset "catch" (R1) compensatory movement (R2) and "subjectively perceived reduction in muscle tone". Outcome measures were recorded by 3 raters before and after a single treatment session. Objective stiffness measured with the hand-held device showed no significant changes for the NTT or RPM (p ≥ 0.09 to 0.79). The subjective measures showed significant changes after the NTT for the non-blinded rater (MAS: p < 0.05: R1: p < 0.05; R2: p < 0.05), but for the blinded rater a significant reduction was found only for R1 (p < 0.05) and R2 (p < 0.05). For the non-blinded rater, intervention effects were found for R1 (p < 0.01), R2 (p < 0.01) and subjectively perceived tone reduction (p < 0.01). For the blinded rater, no intervention effect was found. The authors concluded that an objective evaluation of NTT demonstrated that it does not reduce spasticity. However, it does increase ROM with the same effect as RPM.

Hivamat therapy (deep oscillation therapy) utilizes an intermittent electrostatic field via a Hivamat machine. It supposedly penetrates deeper into the body tissue than manual methods, allowing previously “untreatable” injuries to be manipulated with a minimum of physical pressure. Electrostatic waves create a kneading effect deep within the damaged tissues, restoring flexibility and blood supply to the affected area.

Aliyev (2009) noted that in Germany approximately 2 million sports injuries occur per year. Most common are distortions and ligamentous injury going along with post-traumatic lymphedema. Deep oscillation therapy provided very good results in lymph drainage and in other indications. In an experimental study, these researchers evaluated the effects of deep oscillation therapy in immediate therapy and after-care of different sports injuries in addition to usual care (complex physical and medical therapy). Two soccer teams were
supported by a sports medicine section of a rehabilitation hospital. In 14 people (mean age of 23.9 years), 49 sports injuries of different kind were treated. Subjective rating of the symptoms by visual analog scale (VAS) improved significant (p = 0.001) from 8.7 (baseline) to 2.1 points (post-treatment). Objective rating by the attending physician according to different clinically relevant parameters lead to "very good" or "good" results in 90 % of the patients. The authors concluded that deep oscillation therapy is an easy to use and comparably cost-effective adjuvant therapy option. These investigators already had good experience with it in other indications concerning re-absorption of edema, reducing pain, anti-inflammatory effect, promotion of motoricity, promotion of wound healing, anti-fibrotic effect and improvement in trophicity and quality of the tissue. All these mentioned effects can be confirmed in the treatment of patients with acute sports injury and trauma. The soft mode of action is the reason that in contrast to other electric and mechanical therapies it is no contraindication in immediate therapy. In general, the authors noted no side effects; patients were highly compliant and rated this therapy as very good. Limitations of this small study (n = 14) were its retrospective and uncontrolled nature; findings were also confounded by the concomitant use of usual care.


There is a lack of reliable evidence to support the use of insulin potentiation therapy. The American Cancer Society (2008) described insulin potentiation therapy as the use of insulin along with lower doses of chemotherapy to treat cancer. The American Cancer Society concluded that “Despite supporters' claims that insulin potentiation therapy has been well
researched, no scientific studies that show safety and effectiveness have been published in available peer-reviewed journals. These claims cannot be verified”.

Mora-Ripoll (2011) noted that scientific research has shown that laughter may have both preventive and therapeutic values. Health-related benefits of laughter are mainly reported from spontaneous laughter interventional studies. While the human mind can make a distinction between simulated and spontaneous laughter, the human body cannot. Either way health-related outcomes are deemed to be produced. Simulated laughter is thus a relatively under-researched treatment modality with potential health benefits. The aim of this review was firstly to identify, critically evaluate and summarize the laughter literature; secondly to assess to which extent simulated laughter health-related benefits are currently sustained by empirical evidence; and lastly to provide recommendations and future directions for further research. A comprehensive laughter literature search was performed. A list of inclusion and exclusion criteria was identified. Thematic analysis was applied to summarize laughter health-related outcomes, relationships, and general robustness. Laughter has shown different physiological and psychological benefits. Adverse effects are very limited and laughter is practically lacking in counter-indications. Despite the limited number of publications, there is some evidence to suggest that simulated laughter has also some effects on certain aspects of health, though further well-designed research is warranted. The author concluded that simulated laughter techniques can be easily implemented in traditional clinical settings for health and patient care. Their effective use for therapeutic purposes needs to be learned, practiced, and developed as any other medical strategy. They stated that practical guidelines and further research are needed to help health care professionals (and others) implement laughter techniques in their health care portfolio.

Lebowitz et al (2011) stated that little is known about the physical and psychological effects of sense of humor and
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laughter among patients with chronic obstructive pulmonary disease (COPD). These investigators examined the effects of humor and laughter on psychological functioning, quality of life, health status, and pulmonary functioning among patients with COPD (n = 46; mean age ± SD, 66.9 ± 9.9 years). Subjects completed assessments of sense of humor, depression, anxiety, quality of life, and recent illness. A subset of patients (n = 22) completed a laughter induction study and were randomly assigned to view either a humorous or a neutral video. Pulmonary function, mood state, and dyspnea were assessed before and after the video. Sense of humor was associated with fewer symptoms of depression and anxiety and an enhanced quality of life. However, the induction of laughter led to lung hyper-inflation. The authors concluded that sense of humor among patients with COPD is associated with positive psychological functioning and enhanced quality of life, but laughing aloud may cause acute deterioration in pulmonary function secondary to worsened hyper-inflation.

Mistletoe (Iscador) is an extract that is used mainly in Europe as a treatment for cancer. The extract is injected subcutaneously near a tumor to slow and possibly reverse tumor growth. Ostermann et al (2009) examined the survival of cancer patients treated with mistletoe extract. These investigators searched several databases such as Cochrane, EMBASE, NCCAM, NLM, DIMDI, CAMbase, and Medline. Inclusion criteria were controlled clinical studies on parameters associated with survival in cancer patients treated with Iscador. Outcome data were extracted as they were given in the publication, and expressed as hazard ratios (HR), their logarithm, and the respective standard errors using standard formulas. These researchers found 49 publications on the clinical effects of Iscador usage on survival of cancer patients that met selection criteria. Among them, 41 studies and strata provided enough data to extract HR and their standard errors (Iscador versus no extra treatment). The majority of studies reported positive effects in favor of the Iscador application. Heterogeneity of study results was moderate (I² = 38.3 %, p < 0.0001). The funnel plots were considerably skewed, indicating
a publication bias, a notion which is corroborated by statistical means (AC = -1.3, CI: -1.9 to -0.6, p <= 0.0001). A random effect meta-analysis estimated the overall HR = 0.59 (CI: 0.53 to 0.66, p < 0.0001). Randomized studies showed less effects than non-randomized studies (ratio of HRs: 1.24, CI: 0.79 to 1.92, p = 0.35), and matched-pair studies gave significantly better results than others (ratio of HRs: 0.33; CI: 0.17 to 0.65, p = 0.0012). The authors concluded that pooled analysis of clinical studies suggested that adjuvant treatment of cancer patients with the mistletoe extract Iscador is associated with a better survival. Despite obvious limitations, and strong hints for a publication bias that limited the evidence found in this meta-analysis, one cannot ignore the fact that studies with positive effects of VA-E on survival of cancer patients are accumulating. They stated that future studies evaluating the effects of Iscador should focus on a transparent design and description of endpoints in order to provide greater insight into a treatment often being depreciated as ineffective, but highly valued by cancer patients.

Ritter et al (2010) reported the case of a 43-year old woman who was diagnosed with pancreatic adenocarcinoma spreading into the regional lymph nodes and into multiple liver segments (pT3, pN1, pM1). Upon diagnosis, she underwent a pylorus-preserving pancreatic head resection, including dissection of regional lymph nodes and atypical resection of a single liver segment, followed by 9 cycles of palliative chemotherapy with gemcitabine and oxaliplatin. At 37 weeks after surgery, the patient demonstrated a sustained partial remission, and the chemotherapy was stopped. Surprisingly, 10 months later, she still showed no evidence of tumor progression. Since the time of pancreatic surgery, the patient had taken mistletoe extracts and this adjunctive treatment has been continued until now. The authors concluded that the cases of sustained long-term remission of metastatic pancreatic cancer are extremely rare. Although this single case observation does not allow for firm conclusions regarding potential mechanisms, the adjunctive therapy with mistletoe extracts might have played a role. Thus, they stated that the clinical effects of such treatment in patients with pancreatic cancer warrant further investigation.
Kirsch and Hajto (2011) presented several favorable clinical responses of patients who had sarcoma and who were treated with immunologically effective mistletoe (Viscum album L) extracts (ME) preparations. In accordance with the bell-shaped dose-response relationship of mistletoe lectins (ML), the patients with sarcoma were treated with ME preparations, standardized for the active sugar-binding lectin contents. Thus, an optimal dose of 0.75 to 1.0 ng/kg ML was given twice a week subcutaneously. In this report, the clinical progress of 6 patients with sarcoma showed remissions of tumor symptoms. The authors concluded that it seems that this disease is beneficially influenced by optimized lectin-oriented ME therapy since patients with sarcoma may react especially well to the improved balance of natural immunological mechanisms. They stated that these case reports require further clinical studies in patients with sarcoma.

The National Cancer Institute (2012) stated that “At present, the use of mistletoe cannot be recommended outside the context of well-designed clinical trials”.

Muscle testing is often referred to as applied kinesiology, although the two are not the same. Muscle testing refers to a non-invasive way of evaluating the body’s imbalances and assessing its needs. It entails testing the body’s responses when applying slight pressure to a large muscle, to provide information on energy blockages, the functioning of the organs, nutritional deficiencies (vitamins and minerals), as well as food sensitivities. Furthermore, muscle testing can also be used to test the body’s responses to herbs and other remedies. However, there is a lack of evidence regarding the clinical value of this type of testing, whether electronically or manually.

In a systematic review with meta-analysis, Lim and colleagues (2011) compared pain and disability in individuals with persistent non-specific low back pain (LBP) who were treated with Pilates exercises compared to minimal or other interventions. Searches of Medline, CINAHL, Embase, Cochrane library, PEDro, and ProQuest Dissertations and Thesis databases
were conducted. Randomized controlled trials were selected and reviewed if they compared pain and disability in individuals with persistent non-specific LBP who were treated with Pilates exercises compared to other treatment approaches. Quality of the trials was evaluated. Data for pain and disability scores were extracted. Narrative synthesis plus meta-analyses were performed with a fixed-effects or random-effects model, standardized mean differences (SMDs), and tests for heterogeneity. A total of 7 RCTs were identified and included in the meta-analyses. Data pooling was performed using RevMan 5. When compared to minimal intervention, Pilates-based exercise provided superior pain relief (pooled SMD, -2.72; 95% CI: -5.33 to -0.11; p = 0.04) but the pooled disability scores were not significantly different (pooled SMD, -0.74; 95% CI: -1.81 to 0.33; p = 0.17). No significant differences were found when comparing Pilates-based exercise to other forms of exercise for pain (pooled SMD, 0.03; 95% CI: -0.52 to 0.58; p = 0.92) or disability scores (pooled SMD, -0.41; 95% CI: -0.96 to 0.14; p = 0.14). The authors concluded that Pilates-based exercises are superior to minimal intervention for pain relief. However, existing evidence does not establish superiority of Pilates-based exercise to other forms of exercise to reduce pain and disability for patients with persistent non-specific LBP. Moreover, the relatively low quality of existing studies and the heterogeneity of pooled studies in this systematic review combine to suggest that these results should be interpreted with caution.

Pereira et al (2012) performed a systematic review with meta-analyses that evaluates the effectiveness of the Pilates method on the pain and functionality outcome in adults with non-specific chronic LBP. The search was performed in the following databases: Medline, Embase, AMED, Cinahl, Lilacs, Scielo, SportDiscus, ProQuest, Web of Science, PEDro, Academic Search Premier and the Cochrane Central Register of Controlled Trials from 1950 to 2011; the following keywords were used: 'Pilates', 'Pilates-based', 'back exercises', 'exercise therapy', 'low back pain', 'back pain' and 'backache'. The inclusion criteria were studies that assessed the effects of the Pilates method on patients with chronic LBP. A total of 5 studies met the inclusion
criteria. The total number of patients was 71 in the Pilates group and 68 in the control group. Pilates exercise did not improve functionality (standardized mean difference (SMD = -1.34; 95 % CI: -2.80 to 0.11; p = 0.07) or pain between Pilates and control groups (SMD = -1.99; 95 % CI: -4.35 to 0.37; p = 0.10). Pilates and lumbar stabilization exercises presented no significant difference in functionality (mean difference (MD) = -0.31; 95 % CI: -1.02 to 0.40; p = 0.39) or pain (MD = -0.31; 95 % CI: -1.02 to 0.40; p = 0.39). The authors concluded that Pilates method did not improve functionality and pain in patients who have LBP when compared with control and lumbar stabilization exercise groups.

Thermogenic therapy refers to the production of artificial fever; it has been in use since 1919 in the treatment of certain types of resistant infectious diseases, rheumatoid arthritis and Sydenham's chorea. There is a lack of evidence regarding the effectiveness of this therapy.

Wesselius et al (2005) noted that bee sting therapy is increasingly used to treat patients with multiple sclerosis (MS) in the belief that it can stabilize or ameliorate the disease. However, there are no clinical studies to justify its use. In a randomized, cross-over study, these investigators assigned 26 patients with relapsing-remitting or relapsing secondary progressive MS to 24 weeks of medically supervised bee sting therapy or 24 weeks of no treatment. Live bees (up to a maximum of 20) were used to administer bee venom 3 times per week. The primary outcome was the cumulative number of new gadolinium-enhancing lesions on T1-weighted MRI of the brain. Secondary outcomes were lesion load on T2*-weighted MRI, relapse rate, disability (Expanded Disability Status Scale, Multiple Sclerosis Functional Composite, Guy's Neurologic Disability Scale), fatigue (Abbreviated Fatigue Questionnaire, Fatigue Impact Scale), and health-related quality of life (Medical Outcomes Study 36-Item Short Form General Health Survey). During bee sting therapy, there was no significant reduction in the cumulative number of new gadolinium-enhancing lesions. The T2*-weighted lesion load further progressed, and there
was no significant reduction in relapse rate. There was no improvement of disability, fatigue, and quality of life. Bee sting therapy was well-tolerated, and there were no serious adverse events. The authors concluded that in this trial, treatment with bee venom in patients with relapsing MS did not reduce disease activity, disability, or fatigue and did not improve quality of life.

Also, the American Academy of Neurology's evidence-based guideline on “Complementary and alternative medicine in multiple sclerosis” (Yadav et al, 2014) stated that bee sting therapy is possibly ineffective for relapses and Cari Loder regimen (lofepramine plus phenylalanine with B12) is possibly ineffective for disability, symptoms, depression, and fatigue.

Ali and colleagues (2009) stated that intravenous micronutrient therapy (IVMT), and specifically the Myers' Cocktail, is a popular approach for treating fibromyalgia syndrome (FMS) among complementary and alternative medicine practitioners, but its effectiveness is uncertain. In a randomized, double-blind, placebo-controlled pilot study, these researchers evaluated the feasibility, safety, and provided insights into the effectiveness of this therapy. Subjects were 34 adults with American College of Rheumatology (ACR)-defined FMS. They were randomly assigned either to treatment (weekly infusions of IVMT) or to placebo (weekly infusions of lactated Ringer's solution) for 8 weeks. Primary outcome was change in the Tender Point Index, assessed 8 and 12 weeks after initiation. Secondary measures included a VAS to assess global pain, and validated measures of physical function (Fibromyalgia Impact Questionnaire), mood (Beck Depression Index), and quality of life (Health Status Questionnaire 2.0). Clinically significant improvements were noted (of a magnitude similar to other effective interventions). However, in part because of the high placebo response and the small sample size, no statistically significant differences were seen between groups, in any outcome measure, at 8 and 16 weeks. Statistically significant within-group differences were seen in both the intervention and placebo groups, demonstrating a treatment effect for both IVMT and placebo. At 8 weeks, the IVMT group experienced significantly improved
tender points, pain, depression, and quality of life directly following treatment (all $p < 0.02$), while the placebo group experienced significantly improved tender points only ($p < 0.05$). The treatment effects of IVMT persisted at 4 weeks post-intervention for tender points, pain, and quality of life, while placebo effects persisted only for tender points. A single minor adverse event was noted in 1 subject in the intervention group. The authors conclude that this pilot study established the safety and feasibility of treating FMS with IVMT. Most subjects experienced relief as compared to baseline, but no statistically significant differences were seen between IVMT and placebo. They stated that the effectiveness of IVMT for fibromyalgia, relative to placebo, is as yet uncertain.

Schencking et al (2012) noted that vitamin C (ascorbic acid) is an immune-relevant micronutrient, which is depleted in viral infections and this deficiency seems to play a critical role in the pathogenesis of herpes infections and in the development of post-herpetic neuralgia (PHN). In an observational multi-center study, these researchers evaluated the utilization, safety and effectiveness of intravenously administrated vitamin C in patients with shingles. Between April 2009 and December 2010, a total of 16 general practitioners recorded data of 67 participants with symptomatic herpes zoster who received vitamin C intravenously (Pascorbin® 7.5 g/50 ml) for approximately 2 weeks in addition to standard treatment. The assessment of pain (VAS) and the dermatologic symptoms of shingles such as hemorrhagic lesions and the number of efflorescences were investigated in a follow-up observation phase of up to 12 weeks. Mean declines of pain scores (VAS), number of affected dermatomes and efflorescences, and the presence of hemorrhagic vesicles between the baseline and follow-up assessments at 2 and 12 weeks were statistically significant. Overall, 6.4 % of the participants experienced PHN. Common complaints such as general fatigue and impaired concentration also improved during the study. The effects and the tolerability of the treatment were evaluated positively by the physicians. The risk of developing PHN was reduced. The authors concluded that these findings provided evidence that...
concomitant use of intravenously administered vitamin C may have beneficial effects on herpes zoster-associated pain, dermatologic findings and accompanying common complaints. Moreover, they stated that randomized, placebo-controlled clinical studies are needed to confirm these findings.

**Buteyko Breathing Technique:**

In a Cochrane review on “Breathing exercises for adults with asthma”, Freitas et al (2013) concluded that “even though individual trials reported positive effects of breathing exercises, no reliable conclusions could be drawn concerning the use of breathing exercises for asthma in clinical practice. This was a result of methodological differences among the included studies and poor reporting of methodological aspects in most of the included studies. However, trends for improvement are encouraging, and further studies including full descriptions of treatment methods and outcome measurements are required”.

Furthermore, an UpToDate review on “Complementary, alternative, and integrative therapies for asthma” (Martin, 2016) states that “Behavioral therapies -- Data are conflicting about the benefit of biofeedback, functional relaxation, and breathing exercises for patients with asthma, although some patients appear to derive benefit .... Breathing techniques designed to prolong exhalation and decrease minute ventilation have been studied as non-pharmacologic therapies for asthma. Pranayama, or yoga breathing exercises, emphasize deep respiration with slow exhalation. Similarly, Buteyko breathing exercises were developed based on the theory that a reduction in minute ventilation might improve asthmatic control. Most studies of these approaches show no significant benefit, but have been limited by small sample size or retrospective analysis. However, data from systematic reviews and randomized controlled trials provide evidence of benefit, although confirmation is needed with additional trials that better specify baseline breathing patterns and are free of methodologic concerns”.

Glutathione Infusion:

Exner et al (2000) stated that reactive oxygen species (ROS), formed in various biochemical reactions, are normally scavenged by antioxidants. Glutathione in its reduced form (GSH) is the most powerful intracellular anti-oxidant, and the ratio of reduced to oxidized glutathione (GSH:GSSG) serves as a representative marker of the anti-oxidative capacity of the cell. Several clinical conditions are associated with reduced GSH levels which as a consequence can result in a lowered cellular redox potential. GSH and the redox potential of the cell are components of the cell signaling system influencing the translocation of the transcription factor NF kappa B which regulates the synthesis of cytokines and adhesion molecules. Therefore, one possibility to protect cells from damage caused by ROS is to restore the intracellular glutathione levels. Cellular GSH concentration can be influenced by exogenous administration of GSH (as intravenous infusion or as aerosol), of glutathione esters or of GSH precursors such as glutamine or cysteine (in form of N-acetyl-L-cysteine, alpha-lipoic acid). The modulation of GSH metabolism might present a useful adjuvant therapy in many pathologies such as intoxication, diabetes, uremia, sepsis, inflammatory lung processes, coronary disease, cancer and immunodeficiency states.

Logan and Wong (2001) noted that chronic fatigue syndrome (CFS) is an illness characterized by persistent and relapsing fatigue, often accompanied by numerous symptoms involving various body systems. The etiology of CFS remains unclear; however, a number of recent studies have shown oxidative stress may be involved in its pathogenesis. The role of oxidative stress in CFS is an important area for current and future research as it suggests the use of anti-oxidants in the management of CFS. Specifically, the dietary supplements glutathione, N-acetylcysteine, alpha-lipoic acid, oligomeric proanthocyanidins, ginkgo biloba, and vaccinium myrtillus (bilberry) may be beneficial. In addition, research on food intolerance was discussed, since food intolerance may be involved in CFS symptom presentation and in oxidation via
Cytokine induction.

Cersosimo (2005) reviewed the incidence, mechanism, signs, symptoms, and management of oxaliplatin-induced neurotoxicity. Data sources included English-language publications from the MEDLINE database (1995 to August 2004), published articles, and meeting abstracts were reviewed. Relevant data were extracted from published reports and abstracts on studies and case reports of humans with cancer who received oxaliplatin chemotherapy and in-vitro studies of oxaliplatin neurotoxicity. Neurotoxicity is a common adverse effect of oxaliplatin that usually presents as peripheral neuropathy. There are 2 forms of oxaliplatin-induced neurotoxicity: (i) acute and (ii) chronic. The acute form occurs in greater than 90% of patients and may begin during the infusion or within hours of completion, is usually self-limited, and may be exacerbated by exposure to cold. Chronic neuropathy is cumulative and is most commonly seen in patients who have received total doses greater than or equal to 540 mg/m². Although it is a sensory neuropathy, the intensity can increase to the point that it impairs physical functions, such as holding objects and writing. Preventive measures include administration of calcium and magnesium solutions, gabapentin, carbamazepine, amifostine, and glutathione. Treatment measures include calcium and magnesium solutions, gabapentin, and alpha-lipoic acid. The authors concluded that peripheral neuropathy is seen in the majority of patients who receive oxaliplatin. The acute form is usually transient and self-limited; however, the chronic form can be dose-limiting. Calcium and magnesium solutions are an effective and convenient means of treating and reducing the severity of neuropathic symptoms. Moreover, they stated that additional studies, including controlled trials, are needed to determine the best way to prevent and treat this complication.

Naziroglu et al (2013) noted that contrast media (CM)-induced nephropathy is a common cause of iatrogenic acute renal failure. These investigators discussed the mechanisms and risk factors of CM, summarized the controlled studies evaluating
measures for prevention and concluded with evidence-based strategies for prevention. They reviewed the relevant literature and results from recent clinical studies as well as critical analyses of published systematic reviews used MEDLINE and the Science Citation Index. The cytotoxicity induced by CM leads to apoptosis and death of endothelial and tubular cells and may be initiated by cell membrane damage together with ROS and inflammation. Cell damage may be aggravated by factors such as tissue hypoxia, properties of individual CM such as ionic strength, high osmolarity and/or viscosity. The authors stated that clinical studies indeed support this possibility, suggesting a protective effect of ROS scavenging with the administration of N-acetylcysteine, ascorbic acid erdosteine, glutathione and bicarbonate infusion.

The Academy of Nutrition and Dietetics’ practice guideline on “Oncology evidence-based nutrition” (2013) stated that “If an adult oncology patient is at risk for or has chemotherapy-induced peripheral neuropathy (CIPN), the RDN should advise the patient that the use of nutrition substances (vitamin E, calcium and magnesium infusions, acetyl-L-carnitine, glutamine, glutathione) may or may not be beneficial as a means of preventing or improving CIPN. Research indicates that these substances have had only limited success in preventing or improving CIPN in oncology patients receiving specific chemotherapeutic agents”.

Salt Room Therapy:

Hedman et al (2006) stated that randomized controlled trials are needed to evaluate the effects of complementary treatments in asthma. This study assessed the effect of salt chamber treatment as an add-on therapy to low-to-moderate inhaled steroid therapy in asthma patients with bronchial hyper-responsiveness (BHR). After a 2-week baseline period, 32 asthma patients who exhibited BHR in the histamine inhalation challenge were randomized: 17 to 2-week active treatment, during which salt was fed to the room by a salt generator, and 15 to placebo. The salt chamber treatment lasted 40 minutes
and was administered 5 times a week. Median provocative
dose causing a decrease of 15% in Fev(1) (PD(15)FEV(1))
[corrected] increased significantly in the active group (p =
0.047) but not in the placebo group. The difference in changes
between the active and placebo groups was significant (p =
0.02); 9 patients (56%) in the active group and 2 patients (17%)
in the placebo group exhibited at least 1 doubling dose decrease
in BHR (p = 0.040); 6 patients (38%) in the active group and
none in the placebo group became non-hyperresponsive (p =
0.017). Neither the peak expiratory flow (PEF) values measured
just before and after the treatment, nor FEV(1) values measured
before the histamine challenges, changed. The reduction in BHR
was not caused by changes in the baseline lung function. The
authors concluded that salt chamber treatment reduced
bronchial hyper-responsiveness as an add-on therapy in
asthmatics with a low-to-moderate dose
of inhaled steroids. They stated that the possibility that salt
chamber treatment could serve as a complementary therapy to
conventional medication cannot be excluded.

While this was a randomized study, the sample size was (n = 17
received salt chamber treatment) and its findings were
confounded by the combinational use of inhaled steroids.
Moreover, these findings do not appear to have been
duplicated.

Vibro-Acoustic Therapy:

Lukasiak et al (2013) stated that the so-called "heel spur" is a
radiological term referring to adaptive bone growth as a result
of chronic over-load enthesopathy of the proximal attachment
of the plantar fascia. The main cause of the pain is continued
localized pressure on the surrounding soft tissues. Vibro-
acoustic wave therapy is a relatively new method gaining
popularity among doctors, physiotherapists and patients.
These researchers examined the effectiveness of vibro-acoustic
therapy compared to laser and ultrasound therapy. The study
enrolled 60 patients treated for plantar heel spurs who were
divided into a study group of 40 patients who underwent vibro-
acoustic therapy and a control group of 20 patients treated with ultrasound and laser therapy. The outcome measure for evaluating the effectiveness of physiotherapy was a subjective assessment of pain intensity by VAS and the modified short-form McGill Pain Questionnaire. The mean pain intensity score in patients undergoing vibro-acoustic therapy decreased by about 2.6 points according to the VAS scale and 17 points according to the McGill questionnaire, compared to reductions of 0.6 and 6 points, respectively, in the ultrasound and laser therapy group. The correlation between subjective assessment of pain according to the VAS scale and palpation-based assessment of pain was significantly positive between the 2 groups, demonstrating similarity of the 2 scales, with a slight dominance of the group undergoing laser and ultrasound therapy. The authors concluded that these findings represented a tentative confirmation of analgesic effectiveness of the vibro-acoustic method in musculoskeletal over-load conditions. They stated that in order to confirm its effectiveness, it is necessary to conduct further prospective randomized studies with blinding and evaluate the long-term results.

### CPT Codes / HCPCS Codes / ICD-10 Codes

**Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":**

**ICD-10 codes will become effective as of October 1, 2015:**

<table>
<thead>
<tr>
<th>CPT codes not covered for indications listed in the CPB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>86353</td>
</tr>
<tr>
<td>90880</td>
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<tr>
<td>96360</td>
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**Other CPT codes related to the CPB:**
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>20974</td>
<td>Electrical stimulation to aid bone healing; noninvasive (nonoperative)</td>
</tr>
<tr>
<td>20975</td>
<td>invasive (operative)</td>
</tr>
<tr>
<td>64550</td>
<td>Application of surface (transcutaneous) neurostimulator</td>
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<tr>
<td>82136</td>
<td>Amino acids, 2 to 5 amino acids, quantitative, each specimen [micronutrient]</td>
</tr>
<tr>
<td>82180</td>
<td>Ascorbic acid (Vitamin C), blood [micronutrient]</td>
</tr>
<tr>
<td>82306</td>
<td>Vitamin D; 25 hydroxy, includes fraction(s), if performed [micronutrient]</td>
</tr>
<tr>
<td>82310</td>
<td>Calcium; total [micronutrient]</td>
</tr>
<tr>
<td>82379</td>
<td>Carnitine (total and free), quantitative, each specimen [micronutrient]</td>
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<tr>
<td>82495</td>
<td>Chromium [micronutrient]</td>
</tr>
<tr>
<td>82525</td>
<td>Copper [micronutrient]</td>
</tr>
<tr>
<td>82607</td>
<td>Cyanocobalamin (Vitamin B-12) [micronutrient]</td>
</tr>
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<td>82652</td>
<td>Vitamin D; 1, 25 dihydroxy, includes fraction(s), if performed [micronutrient]</td>
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<td>82725</td>
<td>Fatty acids, nonesterified [micronutrient]</td>
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<td>Folic acid; serum [micronutrient]</td>
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<td>83735</td>
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<td>83785</td>
<td>Manganese [micronutrient]</td>
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<td>84207</td>
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<td>84252</td>
<td>Riboflavin (Vitamin B-2) [micronutrient]</td>
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<td>Selenium [micronutrient]</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>90875</td>
<td>Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes</td>
</tr>
<tr>
<td>90876</td>
<td>approximately 45-50 minutes</td>
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<tr>
<td>90901</td>
<td>Biofeedback training by any modality</td>
</tr>
<tr>
<td>90911</td>
<td>Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry</td>
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<tr>
<td>96902</td>
<td>Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality</td>
</tr>
<tr>
<td>97014</td>
<td>Application of a modality to one or more areas; electrical stimulation (unattended)</td>
</tr>
<tr>
<td>97032</td>
<td>Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes</td>
</tr>
<tr>
<td>97039</td>
<td>Unlisted modality (specify type and time if constant attendance)</td>
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<tr>
<td>97110</td>
<td>Therapeutic procedures, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
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<td>97124</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)</td>
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<td>97139</td>
<td>Unlisted therapeutic procedure (specify)</td>
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<td>97140</td>
<td>Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes</td>
</tr>
<tr>
<td>97150</td>
<td>Therapeutic procedure(s), group (two or more individuals)</td>
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<td>Description</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>97530</td>
<td>Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes</td>
</tr>
<tr>
<td>97799</td>
<td>Unlisted physical medicine/rehabilitation service or procedure</td>
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<tr>
<td>97810</td>
<td>Acupuncture, one or more needles, without electrical stimulation; initial 15 minutes of personal one-on-one contact with patient</td>
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<tr>
<td>+ 97811</td>
<td>without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)</td>
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<tr>
<td>97813</td>
<td>with electrical stimulation; initial 15 minutes of personal one-on-one contact with patient</td>
</tr>
<tr>
<td>+ 97814</td>
<td>with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)</td>
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<tr>
<td>98940</td>
<td>Chiropractic manipulative treatment (CMT); spinal, one to two regions</td>
</tr>
<tr>
<td>98941</td>
<td>spinal, three to four regions</td>
</tr>
<tr>
<td>98942</td>
<td>spinal, five regions</td>
</tr>
<tr>
<td>98943</td>
<td>extraspinal, one or more regions</td>
</tr>
</tbody>
</table>

**HCPCS codes not covered for indications listed in the CPB:**

**Intravenous micronutrient therapy (Myers' cocktail), Vitamin C infusion - no specific code:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0176</td>
<td>Activity therapy, such as music, dance, art or play therapies not for recreation, related to the care and treatment of patient's disabling mental health problems per session (45 minutes or more)</td>
</tr>
<tr>
<td>J3420</td>
<td>Injection, vitamin B-12 cyanocobalamin, up to 1000 mcg [Cari Loder regimen]</td>
</tr>
<tr>
<td>J3570</td>
<td>Laetrile, amygdalin, vitamin B-17</td>
</tr>
<tr>
<td>M0075</td>
<td>Cellular therapy</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>M0300</td>
<td>IV chelation therapy (chemical endarterectomy)</td>
</tr>
<tr>
<td>P2031</td>
<td>Hair analysis (excluding arsenic)</td>
</tr>
<tr>
<td>S8940</td>
<td>Equestrian/hippotherapy, per session</td>
</tr>
<tr>
<td>S9451</td>
<td>Exercise classes, nonphysician provider, per session [pilates]</td>
</tr>
</tbody>
</table>

**Other HCPCS codes related to the CPB:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4595</td>
<td>Electrical stimulator supplies, 2 lead, per month (e.g., TENS, NMES)</td>
</tr>
<tr>
<td>E0720</td>
<td>Transcutaneous electrical nerve stimulation (TENS) device, two leads, localized stimulation</td>
</tr>
<tr>
<td>E0730</td>
<td>Transcutaneous electrical nerve stimulation (TENS) device, four or more leads, for multiple nerve stimulation</td>
</tr>
<tr>
<td>E0731</td>
<td>Form-fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)</td>
</tr>
<tr>
<td>E0746</td>
<td>Electromyography (EMG), biofeedback device</td>
</tr>
<tr>
<td>G0281</td>
<td>Electrical stimulation, (unattended), to one or more areas, for chronic stage III and stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care</td>
</tr>
<tr>
<td>G0282</td>
<td>Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281</td>
</tr>
<tr>
<td>G0283</td>
<td>Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care</td>
</tr>
<tr>
<td>J1815, J1817, S5550 - S5571</td>
<td>Insulin</td>
</tr>
</tbody>
</table>
The above policy is based on the following references:


   Dallas, TX: AHA; 1996.

38. Sci.Med.AIDS FAQ [website]. Available at:


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Report/Technology Assessment No. 10. Rockville, MD:
Agency for Healthcare Research and Quality (AHRQ);


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165. Lorentzen J, Nielsen D, Holm K, et al. Neural tension technique is no different from random passive movements in reducing spasticity in patients with


185. Academy of Nutrition and Dietetics. Oncology


187. Martin RJ. Complementary, alternative, and integrative therapies for asthma. UpToDate Inc., Waltham, MA. Last reviewed January 2016.
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Amendment to
Aetna Clinical Policy Bulletin:
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There are no amendments for Medicaid.

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