

**Subject:** Neural Therapy  
**Document #:** MED.00097  
**Status:** Reviewed

**Publish Date:** 01/03/2024  
**Last Review Date:** 11/09/2023

## Description/Scope

This document addresses neural therapy, a treatment approach based on the concept that energy flows freely through the body of a healthy person. Proponents claim that injury, disease, malnutrition, stress and even scar tissue disrupt this flow creating energy imbalances called interference fields. Neural therapy purports to manage chronic disease and disorders by considering four components: the structural component, the electromagnetic component, the biochemical component and the psychological component. Treatments include anesthetic injections, including those to areas distant from the site of the pain, medication and nutritional support, electromagnetic stimulation and psychological intervention.

**Note:** Please see the following document for additional information on related topics:

- [CG-ANC-03 Acupuncture](#)

## Position Statement

### Investigational and Not Medically Necessary:

Neural therapy is considered **investigational and not medically necessary** for all indications.

## Rationale

Neural therapy (NT) is based on electrical disturbance and restricted lymph system theories. It is based on the belief that a distortion in the connective tissue of the body, interference in structure, lymph flow or electrical conduction can cause illness. The goal of NT is to correct the interference and heal the illness or symptoms. However, even those who practice NT acknowledge that the process is not well understood.

Published evidence from a nonrandomized, comparative trial (n=60) compared the short-term effects of NT with physical therapy for the treatment of chronic low back pain (LBP) (Atalay, 2013). NT consisted of anesthetic injections into scars, trigger points, and acupuncture points, and physical therapy, which consisted of various exercises, use of superficial and deep heating and analgesic stimulation using transcutaneous electrical nerve stimulation (TENS). Outcome measures included pain (visual analogue scale [VAS]); function (Roland Morris Disability Questionnaire [RMDQ]); quality of life (QOL), Nottingham Health Profile (NHP); and anxiety and depression (Hospital Anxiety and Depression Scale [HADS]). When differences of the pre- and post-treatment scores between two treatment groups were compared, subjects in the NT group demonstrated significantly better improvement relative to the physical therapy group for RMDQ (p=0.021), NHP-pain (p=0.027), NHP-physical activity (p=0.004), and NHP-social isolation (p=0.045). Other comparisons between the two groups were not significant. Preliminary findings of this study suggested that NT may be effective for pain management in individuals with LBP. However, the study was characterized by several methodological limitations, including lack of placebo controls, lack of follow-up assessment, and varying degrees of disease severity among all subjects at baseline. As a result, no definitive conclusions could be made regarding the safety and effectiveness of NT for this particular indication.

In 2021, Yilmaz reported the results of a randomized trial to determine the effectiveness of NT in individuals with chronic LBP who were resistant to medical and physical therapies. A total of 50 individuals were randomly divided into 2 groups: Group 1, having a single trigger point injection into the lumbar region or gluteal muscle and Group 2, NT. NT consisted of local-segmental treatment (intradermal injections) from T10 to S4 on the lumbosacral region, 5 M injection (intradermal injections of the projections of the pelvic organs on the suprapubic region), deep pelvic plexus injection, and intravenous injection for 5 sessions in a week. Injections into the umbilicus for all subjects and injections into scars resulting from vaccination and surgical operations such as cesarean section, if any, were also applied at only the first session. Scores were recorded using a visual analogue scale (VAS) of pain intensity and the Roland Morris Disability Questionnaire (RMDQ) at baseline and 1, 3, and 6 months post-injection. The VAS and RMDQ scores at 3 and 6 months were significantly lower in Group 2 versus Group 1 (p < 0.05) meaning less pain and disability in the NT group. However, this study had significant design weaknesses including absence of a placebo control group, lack of blinding, and lack of long-term follow-up that make it difficult to interpret the validity of this work.

Bölük Şenlikci and colleagues (2021) published results of a prospective, randomized controlled study on the effects of NT on pain and hand function in individuals with De Quervain tenosynovitis, a common cause of lateral wrist pain. A total of 36 individuals were randomly assigned to either NT or control groups. Treatment with a thumb splint and rest was assigned to both groups. NT sessions occurred twice a week for 2 weeks and consisted of local injection of procaine anesthetic in the wrist, paraspinal intradermal injections at C5-T8, injection of the trigger points of the forearm muscles and stellate ganglion injections. Subjects were evaluated with the VAS for current pain and the Duruöz Hand Index (DHI) of hand function at the beginning of the study, then at 1 and 12 months after the end of NT. Both VAS and DHI are self-reported scales. In both the NT and control groups, VAS and DHI scores were significantly lower (meaning decreased pain and increased function, respectively) at 1 and 12 months of follow-up compared to baseline. VAS scores at both follow-up times were lower in the NT group than those of the control group. DHI scores at 1 month follow-up were lower in the NT group than in the control group, but by the 12 month follow-up DHI scores were the same in NT and control. The authors concluded that NT is a safe and effective method for the treatment of De Quervain tenosynovitis. Nevertheless, there are some important limitations to this study including lack of blinding, lack of placebo controls and self-reported results. The DHI hand function results were no better than control at 1 year which calls into question the value of NT versus standard of care.

Overall, there is insufficient published literature that demonstrates the clinical utility and effectiveness of this treatment modality for any indication (Atalay, 2013; Hui, 2012; Lorentzen, 2012).

## Background/Overview

NT is promoted mainly to relieve chronic pain, reduce disability, and improve QOL. It is also thought to help individuals with allergies, hay fever, headaches, arthritis, asthma, hormone imbalances, sports or muscle injuries, gallbladder, heart, liver disease, dizziness,

depression, menstrual cramps, skin and circulation problems. NT originated in Germany in the late 1800s with the idea that the nervous system influences all bodily functions. Later, in the 1940s, practitioners believed that injecting local anesthetics could affect distant, unrelated parts of the body. This theory was based on a clinical anecdote describing the relief of shoulder pain in an individual following the injection of an anesthetic drug into an existing scar on the leg. From this experience arose the notion of interference fields and the development of NT.

NT is not to be confused with nerve blocks, local anesthesia injections, or acupuncture. Nerve blocks involve injections of medication to relieve pain caused by stimulation of a peripheral nerve. Local anesthesia is the injection of an anesthetic agent at a local site to relieve localized pain. Acupuncture, a form of traditional Chinese medicine, stimulates certain points on the body associated with energy channels (referred to as “meridians”) with the insertion and manipulation of fine needles. Proponents of NT propose that local injections of anesthetic agents into areas of the body, such as scars, *that are unrelated to the site of pain*, may interfere with the electrical activity of the nervous system and relieve pain.

## Coding

*The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.*

### When services are Investigational and Not Medically Necessary:

When the code describes a procedure indicated in the Position Statement section as investigational and not medically necessary.

#### CPT

99199 Unlisted special service, procedure or report [when specified as ‘neural therapy’]  
Note: if specific components are coded separately, these services are considered to be investigational and not medically necessary

#### ICD-10 Diagnosis

All diagnoses

## References

### Peer Reviewed Publications:

- Altinbilek T, Terzi R, Basaran A, et al. Evaluation of the effects of neural therapy in patients diagnosed with fibromyalgia. *Turk J Phys Med Rehabil.* 2019; 65(1):1-8.
- Atalay NS, Sahin F, Atalay A, Akkaya N. Comparison of efficacy of neural therapy and physical therapy in chronic low back pain. *Afr J Tradit Complement Altern Med.* 2013; 10(3):431-435.
- Batur BE, Atan T. Neural therapy for fibromyalgia: myth or improving quality of life? *Int J Clin Pract.* 2020; e13719.
- Bölük Şenlikci H, Odabaşı ÖS, Ural Nazlıkul FG, Nazlıkul H. Effects of local anaesthetics (neural therapy) on pain and hand functions in patients with De Quervain tenosynovitis: a prospective randomised controlled study. *Int J Clin Pract.* 2021; 75(10):e14581.
- Egli S, Pfister M, Ludin SM, et al. Long-term results of therapeutic local anesthesia (neural therapy) in 280 referred refractory chronic pain patients. *BMC Complement Altern Med.* 2015; 15:200.
- Gibson RG, Gibson SL. Neural therapy in the treatment of multiple sclerosis. *J Altern Complement Med.* 1999; 5(6):543-552.
- Harris GR. Neural therapy and its role in the effective treatment of chronic pain. *Practical Pain Management* site. Available at: <http://www.practicalpainmanagement.com/treatments/complementary/prolotherapy/neural-therapy-its-role-effective-treatment-chronic-pain>. Accessed on September 15, 2023.
- Hui F, Boyle E, Vayda E, Glazier RH. A randomized controlled trial of a multifaceted integrated complementary-alternative therapy for chronic herpes zoster-related pain. *Altern Med Rev.* 2012; 17(1):57-68.
- Huntley A, Ernst E. Complementary and alternative therapies for treating multiple sclerosis symptoms: a systematic review. *Complement Ther Med.* 2000; 8(2):97-105.
- Lorentzen J, Nielsen D, Holm K, et al. Neural tension technique is no different from random passive movements in reducing spasticity in patients with traumatic brain injury. *Disabil Rehabil.* 2012; 34(23):1978-1985.
- Montenegro ML, Braz CA, Rosa-e-Silva JC, et al. Anesthetic injection versus ischemic compression for the pain relief of abdominal wall trigger points in women with chronic pelvic pain. *BMC Anesthesiol.* 2015; 15:175.
- Nazlıkul H, Ural FG, Ozturk GT, et al. Evaluation of neural therapy effect in patients with piriformis syndrome. *J Back Musculoskelet Rehabil.* 2018; 31(6):1105-1110.
- Yılmaz E. The determination of the efficacy of neural therapy in conservative treatment-resistant patients with chronic low back pain. *Spine (Phila Pa 1976).* 2021; 46(14):E752-E759.

### Government Agency, Medical Society and Other Authoritative Publications:

- Learman LA, McHugh KW. Chronic Pelvic Pain: American College of Obstetricians and Gynecologists (ACOG). *Practice Bulletin, Number 218.* *Obstet Gynecol.* 2020; 135(3):e98-e109.
- Yadav V, Bever C, Bowen J, et al. Summary of evidence-based guideline: complementary and alternative medicine in multiple sclerosis: Report of the guideline development subcommittee of the American Academy of Neurology. *Neurology.* 2014; 82(12):1083-1092.

## Index

Electrical Disturbance Theory  
Neural Therapy  
Restricted Lymph System Theory

**The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.**

## Document History

Status	Date	Action
--------	------	--------

Reviewed	11/09/2023	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated References section.
Reviewed	11/10/2022	MPTAC review. Updated Rationale, Background/Overview and References sections.
Reviewed	11/11/2021	MPTAC review. References were updated.
Reviewed	11/05/2020	MPTAC review. References were updated.
Reviewed	11/07/2019	MPTAC review. References were updated.
Reviewed	01/24/2019	MPTAC review. References were updated.
Reviewed	01/25/2018	MPTAC review. The document header wording was updated from "Current Effective Date" to "Publish Date." References were updated.
Reviewed	02/02/2017	MPTAC review. References were updated.
Reviewed	02/04/2016	MPTAC review. References were updated. Removed ICD-9 codes from Coding section.
Reviewed	02/05/2015	MPTAC review. Rationale and References sections were updated.
Reviewed	02/13/2014	MPTAC review. Rationale and references were updated.
Reviewed	02/14/2013	MPTAC review. References were updated.
Reviewed	02/16/2012	MPTAC review. References updated.
Reviewed	02/17/2011	MPTAC review. References updated.
Reviewed	02/25/2010	MPTAC review. References updated.
Reviewed	02/26/2009	MPTAC review. References updated.
New	02/21/2008	MPTAC review. Initial document development.

---

Applicable to Commercial HMO members in California: When a medical policy states a procedure or treatment is investigational, PMGs should not approve or deny the request. Instead, please fax the request to Anthem Blue Cross Grievance and Appeals at fax # 818-234-2767 or 818-234-3824. For questions, call G&A at 1-800-365-0609 and ask to speak with the Investigational Review Nurse.

Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Medical Policy, which addresses medical efficacy, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

© CPT Only – American Medical Association