

POLICY BRIEF

Licensed Acupuncture in Connecticut Workers' Compensation

A reasonable basis for early authorization, measurable care, and payment

Prepared for: Connecticut Workers' Compensation Commissioners and Administrative Law Judges; claimant and respondent counsel; insurance carriers; self-insured employers; and utilization-review professionals

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POSITION Licensed acupuncture should be routinely available as an early conservative option for appropriate work-related pain and musculoskeletal conditions. Initial authorization should be bounded, function-centered, and continued only when objective improvement is documented.

The case in brief

Connecticut already licenses acupuncturists and permits state-licensed providers who comply with Workers' Compensation Commission fee schedules and guidelines to participate in the system. The remaining issue is not whether acupuncture belongs outside conventional claims administration, but whether an individual request is reasonable, necessary, proportionate, and supported by measurable benefit. For chronic nonspecific low-back pain—and for selected neck pain, knee osteoarthritis pain, chronic headache, and musculoskeletal pain claims—the evidence supports a limited conservative trial under ordinary utilization controls.

A defensible policy does not require unrestricted care. It authorizes an initial 6–12 visits over approximately 6–12 weeks, establishes baseline disability and work-function measures, requires reassessment, and permits further treatment only when clinically meaningful improvement and additional attainable goals are documented. Nonresponse, regression, plateau, or a new safety concern warrants modification, discharge, or further evaluation.

This structure gives claimants access to a comparatively low-risk, nonpharmacologic option while preserving payer control over diagnosis, treatment dose, documentation, duplication, medical necessity, and duration. It also avoids a blanket requirement that opioids, injections, surgery, or prolonged medication treatment fail before a conservative acupuncture trial may be considered.

Executive position

Connecticut can authorize acupuncture without weakening medical-necessity review or inviting indefinite treatment. The available evidence supports a limited course for selected conditions, particularly chronic nonspecific low-back pain. Evidence also supports consideration for neck pain, knee osteoarthritis pain, chronic headache, and broader chronic musculoskeletal pain, although strength and expected effect vary by diagnosis.[1–8]

The proposed standard is straightforward: authorize an initial 6–12 visits over approximately 6–12 weeks; require baseline pain-interference, disability, work-capacity, and patient-specific functional measures; reassess no later than the end of the block; and authorize additional care only when clinically meaningful improvement and further attainable goals are documented. Treatment should be reduced, changed, or discontinued for nonresponse, regression, plateau, or safety concerns.

This approach is consistent with the structure of Medicare's chronic-low-back-pain benefit, which covers 12 visits in 90 days, permits up to 8 additional sessions for a patient who improves, and requires discontinuation for nonresponse. Medicare's supervision and billing rules are program-specific; its staged medical-necessity model is nevertheless directly relevant to utilization control.[9]

REQUESTED ACTION Connecticut decision-makers and payers should evaluate acupuncture on diagnosis, evidence, proportionality, documented function, and objective response—not on a categorical “alternative medicine” label or a blanket requirement that opioids, injections, surgery, or prolonged medication treatment fail first.

Why early authorization is reasonable

- It places a low-risk, nonpharmacologic option within conservative care rather than after more invasive or pharmacologic treatment.
- It permits an individual response to be tested at limited financial exposure.
- It creates a reviewable record of diagnosis, baseline function, treatment dose, progress, work status, and reason for continuation or discharge.
- It preserves payer authority to deny unsupported diagnoses, excessive frequency, undocumented maintenance care, or treatment without meaningful benefit.

1. Connecticut's administrative foundation

Connecticut licenses acupuncturists through the Department of Public Health. The Workers' Compensation Commission states that any provider licensed by Connecticut and willing to comply with the Commission's fee schedules and guidelines may practice within the workers' compensation system. The Commission publishes practitioner fee schedules and medical/work-status documentation resources. Its practitioner-fee-schedule regulation governs recognized charges and payment for practitioners permitted to render care under the Act.[10–14]

These provisions establish regulatory feasibility. They do not make every acupuncture request medically necessary, and they do not require unlimited treatment. They support applying ordinary utilization standards to a licensed provider and a covered conservative service.

Public Connecticut sources reviewed for this brief did not reveal a statewide comparative outcomes dataset specific to acupuncture. That gap weighs in favor of monitored authorization with standardized reporting, not categorical exclusion. Connecticut can permit evidence-supported care and generate local evidence at the same time.

2. Clinical evidence

Chronic nonspecific low-back pain

This is the strongest indication. The American College of Physicians includes acupuncture among initial nonpharmacologic options for chronic low-back pain. VA/DoD suggests acupuncture for chronic low-back pain while finding evidence insufficient for acute low-back pain. AHRQ found small improvements in pain or function for acupuncture in chronic pain conditions. The 2020 Cochrane review found advantages over no treatment and some usual-care outcomes, while differences from sham were generally small or did not meet the review's threshold for clinical importance. Taken together, the evidence supports access with realistic expectations and outcome monitoring.[1–5]

A 2025 U.S. pragmatic randomized trial enrolled 800 adults age 65 or older across four health systems. Standard acupuncture (8–15 sessions over 12 weeks) and an enhanced course improved back-related disability relative to usual medical care, and the relative benefit persisted at 12 months. At six months, clinically meaningful Roland–Morris improvement occurred in 39.1% of standard-course participants, 43.8% of enhanced-course participants, and 29.4% of usual-care participants. Serious adverse events were uncommon; fewer than 1% were considered possibly related to the acupuncture intervention. The age distribution limits direct generalization to all injured workers, but the community-practitioner and multisystem design supports real-world relevance.[6]

Other conditions

Individual-patient meta-analysis and federal evidence summaries support a reasonable trial for selected patients with neck pain, knee osteoarthritis pain, and chronic headache. Evidence for shoulder pain, myofascial pain, and repetitive-strain disorders is less uniform and supports individualized, time-limited review rather than either automatic approval or categorical denial.[3,7,8]

Neuropathy, complex regional pain syndrome, post-concussion or traumatic-brain-injury symptoms, anxiety, and PTSD should not carry the general policy. Evidence is too limited or heterogeneous for broad endorsement. A symptom-specific adjunctive trial may be considered in an individual record when the target, coordination, and reassessment standard are clear.

Safety

Acupuncture is generally low risk when performed by a properly trained, licensed practitioner using sterile, single-use needles. Minor soreness, bruising, or bleeding can occur; rare serious

injuries have been reported. Appropriate coverage conditions include licensure, infection-control compliance, informed consent, documentation, and referral for red-flag findings.[8]

3. Economic and claims value

The supportable economic argument is value, not guaranteed savings. Trial-based economic evaluations have often found acupuncture cost-effective for chronic pain at conventional willingness-to-pay thresholds, although many studies are international and do not transfer directly to Connecticut workers' compensation.[15–17]

The 2026 economic evaluation accompanying the U.S. BackInAction trial is more directly relevant. Enhanced acupuncture produced a 0.037 QALY gain (95% CI 0.013 to 0.062) and an 18.5-percentage-point increase in clinically meaningful disability improvement relative to usual medical care. Mean annual back-pain-related health-sector costs were \$491 lower, but the confidence interval ranged from a \$2,861 reduction to a \$1,144 increase. Standard acupuncture cost more, with an estimated incremental ratio of \$52,897 per QALY; its QALY difference was not statistically significant. The evidence supports a reasonable opportunity to demonstrate value, not a prediction that every claim will cost less.[18]

For workers' compensation, the relevant economic unit is the episode, not the individual visit. Appropriate evaluation includes allowed medical expense, medication use, imaging, injections, surgery, emergency care, disability duration, modified-duty capacity, and sustained return to work. Published evidence does not establish that acupuncture halves healing time, prevents a fixed percentage of procedures, or uniformly reduces opioid exposure. Those results should be measured rather than assumed.

4. Proposed authorization standard

Decision point	Required record	Disposition
Initial request	Compensable diagnosis; chronicity; examination; relevant red flags; prior and concurrent care; medications; baseline function and work status; treatment plan.	Generally authorize 6–12 visits over 6–12 weeks when diagnosis and evidence support a conservative trial.
Interim review	Attendance, tolerance, score trend, functional change, work capacity, medication use, self-management, adverse events.	Modify early for regression, poor tolerance, or absence of a plausible response.
Continuation	Clinically meaningful change on a validated measure or clearly documented work-relevant function; ongoing necessity; further attainable goals.	Authorize a defined additional block; taper frequency as gains stabilize.
No response or plateau	No material functional improvement, regression, maintenance without further goals, or new red flag.	Discharge, change the plan, or obtain further evaluation. No indefinite passive maintenance absent exceptional documented circumstances.
Closure	Final scores, work status, residual restrictions, medication status,	Close the episode or transition to independent management.

Decision point	Required record	Disposition
	self-management plan, and reason for discharge.	

The initial range is a policy default, not an inflexible treatment prescription. Diagnosis, acuity, comorbidity, access, travel, guideline, and documented response may justify variation.

Outcome measures

- Low back: Oswestry Disability Index or Roland–Morris Disability Questionnaire.
- Neck: Neck Disability Index. Upper extremity: QuickDASH. Lower extremity: LEFS or another diagnosis-specific instrument.
- Pain interference: Brief Pain Inventory or PROMIS Pain Interference; intensity may supplement but should not stand alone.
- Work: restrictions, sitting/standing/lifting/reaching/walking tolerance, modified-duty capacity, time loss, and sustained return to work.
- Medication and utilization: analgesic use, opioid dose when applicable, unscheduled care, imaging, injections, and surgery referrals.

Published minimal clinically important differences should be used when available. One fixed percentage should not be imposed across instruments that measure different constructs.

5. Acupuncture within coordinated care

Acupuncture and active rehabilitation are not inherently competing services. Acupuncture may be used independently in an appropriate case or coordinated with exercise, physical therapy, education, behavioral care, modified duty, or vocational planning. Duplication of passive treatment should be addressed through the treatment record and distinct functional goals. A general rule limiting physical therapy to once weekly because acupuncture is authorized is not supported by the evidence reviewed.

A blanket requirement to fail physical therapy is also unnecessary. The record may support sequential care, concurrent care, or acupuncture as the initial conservative modality. The relevant questions are whether the proposed combination is reasonable, whether services have distinct purposes, and whether the claimant is improving.

6. Decision framework for contested requests

- Is the diagnosis established and related to the accepted or claimed injury?
- Does the evidence support at least a reasonable conservative trial for that diagnosis?
- Is the proposed frequency and duration proportionate?
- Are baseline function, work capacity, and specific goals documented?
- Does the record address red flags, prior treatment, concurrent care, and medication use?
- For continuation, is improvement clinically meaningful and plausibly attributable in part to the treatment?
- Are further goals attainable, or has the claimant plateaued?
- Is the denial based on patient-specific evidence and disclosed criteria rather than a categorical label?

PRACTICAL RESULT A record satisfying these questions supports authorization. A record that does not can be denied or returned for necessary documentation without adopting a blanket exclusion against licensed acupuncture.

7. Recommended Connecticut action

The Commission and payers should recognize licensed acupuncture as routinely available early conservative care for appropriate work-related pain and musculoskeletal conditions.

Authorization should be based on diagnosis, documented functional goals, proportionality, and objective response rather than mandatory failure of more invasive or pharmacologic therapy.

A 12–24-month monitored implementation period would permit Connecticut to evaluate approval and denial rates, visits per episode, function, work status, medication use, adverse events, total episode cost, subsequent procedures, and sustained return to work. Reporting should be deidentified, diagnosis-stratified, and sufficiently standardized to compare modalities without treating billing data alone as clinical outcomes.

This is a limited recommendation. It does not support automatic approval for every diagnosis, unlimited maintenance care, or claims of guaranteed savings. It supports applying ordinary evidence-based utilization principles to a licensed, comparatively low-risk conservative treatment.

References

1. Qaseem A, et al. Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: ACP Clinical Practice Guideline. *Ann Intern Med*. 2017;166:514–530. doi:10.7326/M16-2367.
2. VA/DoD. Clinical Practice Guideline for the Diagnosis and Treatment of Low Back Pain. 2022. <https://www.healthquality.va.gov/guidelines/Pain/lbp/>
3. Skelly AC, et al. Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review Update. *AHRQ Comparative Effectiveness Review No. 227*. 2020.
4. Mu J, et al. Acupuncture for chronic nonspecific low back pain. *Cochrane Database Syst Rev*. 2020;12:CD013814.
5. Dowell D, et al. CDC Clinical Practice Guideline for Prescribing Opioids for Pain—United States, 2022. *MMWR*. 2022;71(3):1–95.
6. Sherman KJ, et al. Acupuncture for Chronic Low Back Pain in Older Adults: A Randomized Clinical Trial. *JAMA Netw Open*. 2025;8(9):e2531348. PMID: 40938602.
7. Vickers AJ, et al. Acupuncture for Chronic Pain: Update of an Individual Patient Data Meta-Analysis. *J Pain*. 2018;19(5):455–474.
8. National Center for Complementary and Integrative Health. Acupuncture: Effectiveness and Safety. <https://www.nccih.nih.gov/health/acupuncture-effectiveness-and-safety>
9. Centers for Medicare & Medicaid Services. NCD 30.3.3: Acupuncture for Chronic Lower Back Pain. <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=373>
10. Connecticut Workers' Compensation Commission. Insurance and Medical Providers. <https://portal.ct.gov/wcc/insurance-and-medical-providers>
11. Connecticut Workers' Compensation Commission. Fee Schedules. <https://portal.ct.gov/wcc/knowledge-base/articles/insurance-and-medical-providers/fee-schedules>
12. Connecticut Workers' Compensation Commission. Forms for Health Care Providers. <https://portal.ct.gov/wcc/knowledge-base/articles/forms-and-publications/forms-for-health-care-providers>
13. Connecticut Workers' Compensation Commission. Administrative Regulation §31-280-3. <https://portal.ct.gov/wcc/statutes-and-regulations/do-not-use-workers-compensation-regulations/31-280-3>
14. Connecticut Department of Public Health. Acupuncturist Licensing Requirements. <https://portal.ct.gov/DPH/Practitioner-Licensing--Investigations/Acupuncture/Acupuncturist-Licensing-Requirements>
15. Ambrósio EMM, et al. Costs and consequences of acupuncture as a treatment for chronic pain: a systematic review. *Complement Ther Med*. 2012;20:364–374.
16. Witt CM, et al. Pragmatic randomized trial evaluating the clinical and economic effectiveness of acupuncture for chronic low back pain. *Am J Epidemiol*. 2006;164:487–496.
17. Thomas KJ, et al. Longer term clinical and economic benefits of offering acupuncture care to patients with chronic low back pain. *Health Technol Assess*. 2005;9(32).
18. Herman PM, et al. Cost-Effectiveness of Acupuncture Needling for Older Adults With Chronic Low Back Pain. *Spine*. 2026;51(3):E65–E75. PMID: 41493335.

Scope note

This brief is policy analysis and advocacy, not medical advice, a utilization-review determination, or a legal opinion. Individual coverage depends on applicable law, the compensability record, diagnosis, documentation, and the governing benefit and payment rules. Evidence and Connecticut requirements should be rechecked before formal adoption.