Policy Article for Spinal Manipulation Treatments and Chiropractic Services Medical Policy

Article # A250-0021

Coverage for spinal manipulation treatments and chiropractic services varies across plans. Refer to the member's benefit plan document for coverage details.

Medical records for Spinal Manipulation Treatments and Chiropractic services can be reviewed for medical necessity at any time but will specifically be reviewed after the 8th visit.

Reimbursement for treatment visits is limited to a maximum of one hour (4 units/timed codes) for each date of service. (1 hour per specialty per day)

**This policy applies to chiropractor/musculoskeletal care within the scope of a provider's practice, regardless of the rendering provider.

Medically necessary Spinal Manipulation Treatments and Chiropractic services are reasonable and necessary, based on generally accepted standards of Practice, for the evaluation, diagnosis, and treatment of a condition that is neuromusculoskeletal in origin to restore lost function resulting from an injury or illness. **A medically necessary service is also not more costly than a service or supply that is at least as likely to produce equivalent therapeutic or diagnostic results to the applicable illness, injury, disease or symptoms. The fact that a provider has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility medically necessary.**

Services are ***not*** generally indicated for the management of pain alone when there is no functional limitation.

Maintenance Spinal Manipulation Treatments and Chiropractic Services are those that are performed to maintain the individual's current condition or to prevent or slow deterioration of the individual's condition. Maintenance care is considered to be services provided after maximum therapeutic benefit has been achieved, that is, the point at which a patient's condition has plateaued and is unlikely to improve further. Maintenance care is not covered, as there are no benefits for such under the health plan.

Preventive Spinal Manipulation Treatments and Chiropractic Services include management of an asymptomatic or stable condition. This type of care (maintenance or preventive) is not covered as there are no benefits under the health plan.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Definitions

Manipulative Therapy: Manipulative therapy, osteopathic manipulative treatment (OMT), osteopathic manipulative medicine (OMM), manipulative and body-based practice, manual therapy, or physical touch methods is defined as a therapeutic application of manual pressure or force in which the practitioner moves or manipulates one or more parts of the patient's body to achieve and maintain patient health as part of a whole system of evaluation and treatment. Manipulative therapy can be used to treat structural and functional issues in the bones, joints, tissues, and muscles of the body. Examples include chiropractic treatments, physical therapy, and massage therapy

Musculoskeletal Disorders: For the purposes of this policy, Musculoskeletal Disorders (MSDs) are injuries or conditions originating from joints, muscles, ligaments, discs, or other soft tissues in the spine or limbs, and produce clinically relevant symptoms (e.g., pain, numbness, etc.) and functional limitations (e.g., ability to perform daily activities)

General Guidelines:

--The service is aimed at diagnosis, and treatment of musculoskeletal and related disorders and the effects of these on the nervous system and general health.

--The service is for conditions that require the unique knowledge, skills, and judgement of a chiropractor for education and training that is part of an active skilled plan of care.

--The program is individualized, and there is documentation outlining qualifiable, attainable treatment goals.

--The individual's condition has the potential to improve or is improving (and has not reached maximum improvement).

--Improvement is evidenced by successive objective measurements over a defined time frame.

--The services are delivered by a qualified provider of chiropractic services.

Duplicative or redundant services expected to achieve the same therapeutic goal are considered not medically necessary. For example:

• Multiple modalities procedures that have similar or overlapping physiologic effects (e.g., multiple forms of superficial or deep heating modalities)

• Same or similar rehabilitative services provided as part of an authorized therapy program through another therapy discipline.

¬ When an individual receives rehabilitation from a physical therapist, occupational therapist, chiropractor or other rehabilitation professional, each practitioner should provide different treatments that reflect each discipline's unique perspective on the individual's impairments and functional deficits and not duplicate the same treatment. They must also have separate evaluations, treatment plans, and goals. When an individual receives manual therapy services from a physical therapist and chiropractic or osteopathic manipulation, the services must be documented as separate and distinct and must be justified as non-duplicative.

¬ The medical necessity of neuromuscular reeducation, therapeutic exercises, and/or therapeutic activities, performed on the same day, must be documented in the medical record.

Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) for treatment of non-musculoskeletal conditions are considered not medically necessary.

Active Treatment-The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectations of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam.

Most spinal joint problems fall into the following categories:

Acute subluxation-A patient's condition is considered acute when the patient is being treated for a new injury identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in or arrest of progression of the patient's condition.

Chronic subluxation-A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition) but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

An acute exacerbation is a temporary but marked deterioration of the patient's condition that is causing significant interference with activities of daily living (ADLs) due to an acute flare-up of the previously treated condition. The patient's clinical record must specify the date of occurrence, nature of the onset or other pertinent factors that would support the medical necessity of treatment. As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time.

Maintenance therapy includes services that attempt to avert disease, facilitate health and extend and improve the quality of life; or therapy that is implemented to preserve or avoid deterioration of a chronic condition. The treatment is considered maintenance therapy when additional clinical advancement cannot logically be expected from constant ongoing care and the chiropractic treatment becomes auxiliary rather than curative in nature.

Improvement is documented within the initial 2 weeks of chiropractic care. If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified. If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary. Once the maximum therapeutic benefit has been achieved, continued chiropractic care is considered not medically necessary.

Spinal Manipulation Treatments or Chiropractic services must have the AT modifier (for Active Treatment) otherwise will be denied as Maintenance therapy.

Modalities:

Extracorporeal shock wave therapy (ESWT) consists of acoustic shock waves generated by electrohydraulic, electromagnetic, or piezoelectric methods for treatment of chronic musculoskeletal disorders. Shock waves are focused on a specific area, using anatomic, ultrasound, or patient findings to guide location of treatment. The mechanism of action is not fully understood.

Documentation Requirements:

The patient's medical record must contain documentation that fully supports the medical necessity for services). This documentation includes but is not limited to relevant medical history, physical examination and results of pertinent diagnostic tests or procedures. Chiropractic care is focused on the treatment goals outlined in the plan of care (POC).

A POC should be individualized for each patient and should include the following:

- Recommended level of care (duration and frequency of visits)
- Specific treatment goals (with documentation of progress or lack thereof within the clinical records)
- Objective measures to evaluate treatment effectiveness (with qualitative and/or quantitative measures)

The use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Therefore, treatment effectiveness must be assessed at appropriate intervals during subsequent visits (measurable goals).

Specific recommendations (e.g., 'home program', life style modifications, etc.) for ongoing amelioration of musculoskeletal complaints should be provided as early in the course of treatment as possible and should be reinforced at each visit and documented in the medical record.

For patients who have not achieved the goals documented in the POC, the practitioner should conclude the episode of chiropractic care in the last visit by documenting the clinical factors that contributed to the inability to meet the stated goals in the treatment plan.

The precise level of subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine.

The level of spinal subluxation must bear a direct causal relationship to the patient's symptoms and the symptoms must be directly related to the level of the subluxation that has been diagnosed.

Dynamic thrust is the therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust but does not rule out the use of dynamic thrust. The doctor must discuss this risk with the patient and record this in the chart.

The need for a prolonged course of treatment must be clearly documented in the medical record. Treatment should result in improvement or arrest of deterioration of subluxation within a

reasonable and generally predictable period of time.

The word “correction” may be used in lieu of “treatment.” Also, a number of different terms composed of the following words may be used to describe manual manipulation:

- Spine or spinal adjustment by manual means
- Spine or spinal manipulation
- Manual adjustment
- Vertebral manipulation or adjustment

Documentation Requirements: History

The history recorded in the patient record should include the following:

- Symptoms causing patient to seek treatment,
- Family history if relevant,
- Past health history (general health, prior illness, injuries or hospitalizations, medications, surgical history),
- Mechanism of trauma,
- Quality and character of symptoms/problem,
- Onset, duration, intensity, frequency, location and radiation of symptoms; Aggravating or relieving factors, and
- Prior interventions, treatments, medications, secondary complaints.

Documentation Requirements: Initial Visit

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History as stated above

2. Description of the present illness including:

- Mechanism of trauma,

- Quality and character of symptoms/problem,
- Onset, duration, intensity, frequency, location, and radiation of symptoms,
- Aggravating or relieving factors,
- Prior interventions, treatments, medications, secondary complaints and symptoms causing patient to seek treatment.

These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (itis) or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general, other symptoms must relate to the spine as such. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. Evaluation of musculoskeletal/nervous system through physical examination.

4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.

5. Treatment Plan: The treatment plan should include the following:

- Recommended level of care (duration and frequency of visits),
- Specific treatment goals, and
- Objective measures to evaluate treatment effectiveness.

6. Date of the initial treatment.

Documentation Requirements: Subsequent Visits

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History (an interval history sufficient to support continuing need; document substantive changes):

- Review of chief complaint
- Changes since last visit
- System review if relevant

2. Physical exam (interval, document subsequent changes). A full repeat pain, asymmetries, range of motion (ROM) abnormalities, tissue changes (P.A.R.T.) assessment is not expected.

    - Exam of area of spine involved in diagnosis
    - Assessment of change in patient condition since last visit
    - Evaluation of treatment effectiveness

3. Documentation of treatment given on day of visit.

4. Documentation of how the day's treatment fits within the POC (e.g., "visit 4 of planned 7 treatments") and any way the treatment plan is being changed.

Documentation: X-Ray/Computed Tomography (CT)/Magnetic Resonance Imaging (MRI)

An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment.

In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent.

A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

If the diagnostic studies have been taken in a hospital or outpatient facility, a written report, including interpretation and diagnosis by a physician, must be present in the patient's medical record. Documentation of the chiropractor's review of the x-ray (MRI/CT) noting the level of

subluxation must be maintained in the medical record.

Documentation: Demonstrated by Physical Examination (aka "P.A.R.T. Evaluation Process")

The P.A.R.T. evaluation process is recommended as the examination alternative to the previously mandated demonstration of subluxation by x-ray/MRI/CT for services beginning January 1, 2000. The acronym P.A.R.T. identifies diagnostic criteria for spinal dysfunction (subluxation).

P - Pain/tenderness evaluated in terms of location, quality and intensity: The perception of pain and tenderness is assessed. Most primary neuromusculoskeletal disorders manifest primarily by a painful response. Pain and tenderness findings may be identified through 1 or more of the following: observation, percussion, palpation, provocation, etc. Furthermore, pain intensity may be assessed using 1 or more of the following: visual analog scales, algometers, pain questionnaires, etc.

A - Asymmetry/misalignment identified on a sectional or segmental level: observation (posture and heat analysis), static palpation for misalignment of vertebral segments, diagnostic imaging, etc.

R - ROM abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility. ROM abnormalities may be identified through 1 or more of the following: motion palpation, observation, stress diagnostic imaging, ROM, measurement(s), etc.

T - Tissue, tone changes in the characteristics of contiguous or associated soft tissues including skin, fascia, muscle and ligament. Abnormalities in tone, texture and/or temperature may be identified through 1 or more of the following procedures: observation, palpation, use of instrumentation, test of length and strength, etc.

To demonstrate a subluxation based on physical examination, 2 of the 4 (P.A.R.T.) criteria are required, 1 of which must be asymmetry/misalignment or ROM abnormality.

Documentation of changes in the patient's examination, status and progression must be recorded at each visit.

The evaluation process must be ongoing. Signs and certain symptoms must be rechecked during

the course of treatment to determine the extent of the patient progress. Standardized measurement scales (e.g., Visual Analog Scale (VAS), Oswestry Disability Questionnaire and the Quebec Back Pain Disability Scale) may be used to measure improvement or lack thereof. This ongoing evaluation and assessment forming the basis for treatment modification is a key factor in total patient management. The initial examination, no matter how thorough, cannot be expected to provide all the answers. A treatment trial should be instituted with its effects assessed to determine whether it should be continued or a different plan devised. Moreover, it is the examination that forms the foundation for treatment, guiding the doctor in selecting appropriate treatment techniques, frequency and course of treatment.

On receipt of a request for documentation, at a minimum, the practitioner must submit the initial visit's treatment plan, the concluding/discharge visit and subsequent visits that demonstrate any change in the history, physical exam or treatment plan.

Utilization Guidelines:

The frequency and duration of chiropractic treatment must be medically necessary and based on the individual patient's condition and response to treatment. Prolonged or repeated courses of treatment are more likely to undergo medical review.

Spinal manipulation treatments and chiropractic services is considered medically necessary only when indicated per the most current medical references and specialty society guidelines, such as MCG, NCCN, etc.

State mandates, laws or benchmark supersede this medical policy.

Billing and Coding

Limitations:

Spinal Manipulation Treatments or Chiropractic services for Medicare Supplement plans must have the AT modifier (for Active Treatment) otherwise will be denied as Maintenance therapy).

The precise level(s) of the subluxation(s) must be specified by the chiropractor to substantiate a claim for manipulation of each spinal region(s).

A statement on a claim that there is "pain" is insufficient.

Only 1 chiropractic manipulation service for a beneficiary can be reimbursed per day.

Codes: ***The following codes for treatments and procedures applicable to this document are included below for informational purposes.***

Code	Description
98925	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 1-2 BODY REGIONS INVOLVED
98926	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 3-4 BODY REGIONS INVOLVED
98927	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 5-6 BODY REGIONS INVOLVED
98928	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 7-8 BODY REGIONS INVOLVED
98929	OSTEOPATHIC MANIPULATIVE TREATMENT (OMT); 9-10 BODY REGIONS INVOLVED
98940	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 1-2 REGIONS
98941	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL 3-4 REGIONS
98942	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 5 REGIONS
98943	CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL, 1 OR MORE REGIONS
	ASSOCIATED PROCEDURE CODES
97010	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; HOT OR COLD PACKS
97012	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; TRACTION, MECHANICAL
97014	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (UNATTENDED)

97016	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; VASOPNEUMATIC DEVICES
97020	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; MICROWAVE
97024	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; DIATHERMY (EG, MICROWAVE)
97026	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; INFRARED
97028	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRAVIOLET
97032	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ELECTRICAL STIMULATION (MANUAL), EACH 15 MINUTES
97035	APPLICATION OF A MODALITY TO 1 OR MORE AREAS; ULTRASOUND, EACH 15 MINUTES
97037	APPLICATION OF A MODALITY, LOW-LEVEL LASER THERAPY
97039	UNLISTED MODALITY (SPECIFIC TYPE AND TIME IF CONSTANT ATTENDANCE)
97760	ORTHOTIC(S) MANAGEMENT AND TRAINING (INCLUDING ASSESSMENT AND FITTING WHEN NOT OTHERWISE REPORTED), UPPER EXTREMITY(IES), LOWER EXTREMITY(IES) AND/OR TRUNK, INITIAL ORTHOTIC(S) ENCOUNTER, EACH 15 MINUTES
0101T	EXTRACORPOREAL SHOCK WAVE INVOLVING MUSCULOSKELETAL SYSTEM, NOT OTHERWISE SPECIFIED
0552T	LOW-LEVEL LASER THERAPY, DYNAMIC PHOTONIC AND DYNAMIC THERMOKINETIC ENERGIES, PROVIDED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
20560	NEEDLE INSERTION(S) WITHOUT INJECTION(S); 1 OR 2 MUSCLE(S)
20561	NEEDLE INSERTION(S) WITHOUT INJECTION(S); 3 OR MORE MUSCLES
28890	EXTRACORPOREAL SHOCK WAVE, HIGH ENERGY, PERFORMED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL, REQUIRING ANESTHESIA OTHER THAN LOCAL, INCLUDING ULTRASOUND GUIDANCE, INVOLVING THE PLANTAR FASCIA
A4595	ELECTRICAL STIMULATOR SUPPLIES, 2 LEAD, PER MONTH, (E.G., TENS, NMES)

G0283	ELECTRICAL STIMULATION (UNATTENDED), TO ONE OR MORE AREAS FOR INDICATIONS) OTHER THAN WOUND CARE, AS PART OF A THERAPY PLAN OF CARE.
L0621	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0622	SACROILIAC ORTHOSIS, FLEXIBLE, PROVIDES PELVIC-SACRAL SUPPORT, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED
L0623	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SACRAL SUPPORT, WITH RIGID OR SEMI-RIGID PANELS OVER THE SACRUM AND ABDOMEN, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
L0624	SACROILIAC ORTHOSIS, PROVIDES PELVIC-SACRAL SUPPORT, WITH RIGID OR SEMI-RIGID PANELS PLACED OVER THE SACRUM AND ABDOMEN, REDUCES MOTION ABOUT THE SACROILIAC JOINT, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PENDULOUS ABDOMEN DESIGN, CUSTOM FABRICATED
S3900	SURFACE ELECTROMYOGRAPHY (EMG)
S8948	APPLICATION OF A MODALITY (REQUIRING CONSTANT PROVIDER ATTENDANCE) TO ONE OR MORE AREAS; LOW-LEVEL LASER; EACH 15 MINUTES
S9090	VERTEBRAL AXIAL DECOMPRESSION, PER SESSION