Spinal Manipulation Treatments and Chiropractic Services Medical Policy

Service: Spinal Manipulation Treatments and Chiropractic Services

PUM 250-0021

Medical Policy Committee Approval	Q2-06/2025
Effective Date	01/01/2026
Prior Authorization Needed	No

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

Description:

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.

Indications of Coverage:

A. Spinal Manipulation treatments and Chiropractic services are considered medically necessary when **ALL** of the following criteria are met:

1. The member has a neuromusculoskeletal disorder. Headache may be considered a neuromusculoskeletal disorder.

2. There are objective findings of dysfunction in any involved joints (such as hypomobility, subluxation, or fixation) resulting in functional loss.

3. Treatment plan including planned duration and frequency of visits; specific, objectively measurable (such as Oswestry index) achievable, relevant and functional goals to the member's specific activity of daily living requirements/deficiencies and have a stated timeframe within which the provider expected the patient to achieve the goals.

- **Note:** Treatments **MUST** correlate with the location of symptoms and with physical exam findings provided for each visit.

B. Spinal Manipulation is considered medically necessary when **ALL** the following criteria are met:

1.Spinal pain as indicated by **ONE or more** of the following:

i. Back pain when **ALL** the following are present:

a) Absence of signs and symptoms associated with other serious pathologic conditions.

b) Acute low back pain **OR**

c) Recent worsening of symptoms in an individual with chronic (lasting more than 12 weeks) or stable low back pain

ii. Coccydynia (Coccyx pain) and **ALL** the following:

a) Duration less than 1 year

b) Stress x-rays show stable coccyx

c) Traumatic mechanism of injury

iii. Neck Pain and **ALL** the following:

a) Absence of signs and symptoms associated with other serious pathologic conditions.

b) Absence of signs and symptoms of cord compression, such as lower extremity weakness

c) Absence of signs and symptoms of impending vertebrobasilar artery stroke

1. No evidence of acute fracture, dislocation, or rupture
2. No evidence of acute infection
3. No evidence of active tumor at the site being manipulated.
4. No evidence of Cauda Equina syndrome
5. No evidence of progressive neurological disorders
6. No evidence of active flare of Rheumatoid Arthritis or Severe Osteoporosis at the level of spinal manipulation **OR** documentation that supports using the modality in spite of this relative contraindication.
7. Spinal manipulation is a component of a comprehensive multimodal treatment plan.
8. Symptoms significantly impact ADLs.

***Note**: Spinal manipulation treatments or chiropractic services must have the AT modifier (for Active Treatment) otherwise will be denied as Maintenance care.

C. Re-evaluation of the treatment plan must:

1. Must be performed every 4 weeks for visit frequency for 2-3 visits per week, or every 8 visits for a treatment plan of 1 time a week, whichever applies to the specific member.
2. Goals must be objectively measurable (such as Oswestry index), achievable, relevant to the member's specific activity of daily living requirements/deficiencies and have a stated timeframe within which the provider expects the patient to achieve the goals.
3. Objective evidence of progress toward clearly documented and individualized, measurable goals.
4. Include assessment of change in patient condition since last evaluation.
5. Include appropriate standardized outcome tool/measurements as compared to the previous evaluation/reevaluation, such as a revised disability index, or updated physical examination findings, updated with the new treatment plan.
6. Include Evidence to support the need for continued skilled care.
7. Include assessment of the member's ability to participate in home care measures and plans to transition to such a (**an independent**) home exercise program.
8. Identify appropriate services to achieve new or existing treatment goals.
9. Include revision in treatment plan (updated goals)
10. Include correlation to meaningful change in function.

D. Exacerbations, flare-ups or recurrence may require additional supervised treatment to facilitate return to maximum therapeutic benefit status. Treatment is expected to result in a return to pre-exacerbation ability to perform ADLs. For each and every reported exacerbation or flare-up, there must be a documented complete, revised physical exam **with noted objective and functional deficits as a result of any exacerbation,** as well as a revision of the treatment plan, or else the continued treatments will be deemed not medically necessary.

E. Modalities used must indicate reasoning for the use, for how long it is used in a session, and how many sessions are planned with the modality. The following modalities may be considered medically necessary if **ALL** of these criteria above are met for the following (a. and b. **must** be met):

1. **Extracorporeal shock wave therapy (ESWT)** is considered medically necessary when **ALL** of the following are documented:

    a. Diagnosis includes **1 or more** of the following:

        I. **Achilles tendinopathy**, with **ALL** of the following:
            a) Pain lasting 3 or more months
            b) Unresponsive to other nonoperative treatments, including **3 or more** of the following:
                - ❖ Anti-inflammatory medication
                - ❖ Eccentric Achilles-strengthening exercises
                - ❖ Heel lift orthoses
                - ❖ Physical therapy
                - ❖ Rest, including brief immobilization

II. **Calcific tendinitis of shoulder**, with **ALL** of the following:
   a) Radiologically verified calcification, as indicated by **1 or more** of the following:
      - ❖ Gartner type 1 or 2 calcification
      - ❖ Mole type A or B calcification

   b) Unresponsive to other nonoperative treatments, including **1 or more** of the following:
      - ❖ Exercise
      - ❖ Oral course of nonsteroid anti-inflammatory drug
      - ❖ Percutaneous needling and aspiration of calcification
      - ❖ Physical therapy
      - ❖ Physical therapy physical modalities
      - ❖ Subacromial steroid injection

III. **Plantar fasciitis**, with **ALL** of the following:
   a) Pain lasting 3 or more months
   b) Unresponsive to other nonoperative treatments, as indicated by **1 or more** of the following:
      - ❖ Corticosteroid injection
      - ❖ Modified footwear
      - ❖ Night splints
      - ❖ Oral course of nonsteroidal anti-inflammatory drug
      - ❖ Orthotics
      - ❖ Physical therapy
      - ❖ Stretching of Achilles tendon and plantar fascia
      - ❖ Tape immobilization (low dye strapping)

b. **None** of the following are present:

   a) Active infection in treatment area
   b) Anticoagulant use
   c) Coagulation disease
   d) Implantable device (e.g., cardiac pacemaker)
   e) Metabolic or endocrine disease (e.g., diabetes)
   f) Neuropathy
   g) Peripheral vascular disease
   h) Systemic inflammatory disease
   i) Pregnancy

Extracorporeal shock wave therapy (ESWT) is considered experimental, investigational, and unproven to affect health outcomes for any condition not listed above, but not limited to:

a. Greater trochanteric pain syndrome
b. Hamstring tendinopathy
c. Interdigital neuroma
d. Lateral epicondylitis
e. Medial tibial stress syndrome
f. Non-calcific rotator cuff tendonitis
g. Patellar tendinopathy
h. Post-traumatic myositis ossificans
i. Shoulder pain
j. Spasticity associated with cerebral palsy.

2. X ray/CT/MRI is considered medically necessary when:

    a. History and physical exam supports the rationale for imaging, any suspected pathology, or what is being ruled out

    b. Full spine radiograph is considered medically necessary for scoliosis only.

- **For orthotics** refer to certificate of benefits for coverage. If covered in certificate, refer to MCG for medical necessity criteria.

Limitations of Coverage:

Benefit Limitations: Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

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.

A. Review health plan and endorsements for exclusions and prior authorization or benefit requirements.

B. If used for a condition/diagnosis other than as listed in the Indications of Coverage, it will be denied as experimental, investigational, and unproven to affect health outcomes.

C. If used for a condition/diagnosis that is listed in the Indications of Coverage, but the criteria are not met, it will be denied as not medically necessary.

D. Most member health plans exclude (have no benefits for) health care services provided in connection with any injury or illness arising out, or sustained in the course, of any occupation, employment, or activity of compensation, profit or gain, for which an employer is required to carry workers' compensation insurance. This exclusion applies regardless of whether benefits under workers' compensation laws or any similar laws have been claimed, paid, waived, or compromised.

E. If no improvement is documented within the initial 2 weeks, additional spinal manipulation or chiropractic treatment services are considered not medically necessary unless the chiropractic treatment is modified.

F. If no improvement is documented within 30 days, despite modification of spinal manipulation or chiropractic services, continued chiropractic treatment is considered not medically necessary.

G. Once the maximum therapeutic benefit has been achieved, continuing spinal manipulation or chiropractic services is considered not medically necessary.

H. Spinal Manipulation Treatments or Chiropractic services in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.

I. Spinal Manipulation Treatments or Chiropractic services in persons whose condition is neither regressing nor improving, is considered not medically necessary.

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

K. Extraspinal manipulation is considered experimental, investigational, and unproven to affect health outcomes. The 5 extraspinal regions are: head (including temporomandibular joint, excluding atlanto-occipital) region, lower extremities, upper extremities, rib cage (excluding costotransverse and costovertebral joints) and abdomen.

L. Long term therapy and maintenance therapy, maintenance care, and or supportive care are usually exclusions of the member's health plan.

M. Maintenance Spinal Manipulation Treatments or Chiropractic services and Preventive Spinal Manipulation Treatments or Chiropractic services are considered not medically necessary.

N. Chiropractic or Spinal Manipulation visits greater than three sessions in a week are considered excessive and not medically necessary.

O. Work hardening, vocational rehabilitation, and industrial rehabilitation may be exclusions of the member's health plan.

P. Documentation that does not support the services billed will be denied.

Q. Manipulation is considered experimental, investigational, and unproven to affect health outcomes when it is rendered for internal or non-neuromusculoskeletal conditions including, but not limited to, autism, asthma, attention-deficit hyperactivity disorder, dysmenorrhea, depression, dizziness/vertigo, epilepsy, infant colic (or other non-neuromuscular indications), female infertility, otitis media, improvement of brain function, menopause-associated vasomotor symptoms, prevention of falls, and gastro-intestinal disorders.

R. There is insufficient evidence that manual therapy (spinal manipulation, extra-spinal manipulation, and mobilization) results in improved health outcomes, particularly functional outcomes, related to the treatment of both musculoskeletal and non-musculoskeletal **infant** conditions, and fetal manipulation in pregnant women.

S. Repeat imaging is considered not medically necessary, unless there is documentation of unexpected lack of progression from treatments or worsening of symptoms despite treatments.

T. Full spine radiographs for any condition other than scoliosis is considered not medically necessary.

U. Dynamic spinal visualization (including digital motion x-ray and video fluoroscopy, also known as cineradiography) is considered not medically necessary.

V. Any laboratory services for which the office is not CLIA (Clinical Laboratory Improvement Amendments) certified or falls outside of the scope of practice, including, but not limited to drug testing, therapeutic drug assays, genetic testing, and organ or disease-oriented panels is considered experimental, investigational, and unproven to affect health outcomes.

W. A treatment plan of once per month or treatments provided on an as needed basis, are not consistent with evidence-based guidelines and standards for acute treatment of conditions and are deemed maintenance care, and thus, not covered.

X. As per the Office of Inspector General, in a Medicare population, when chiropractic care extends beyond 24 treatments in a year, the likelihood is approximately 100% that those services are medically unnecessary, and more likely to be maintenance in nature at higher service volumes. Thus, any services exceeding 24 sessions in a rolling 12-month period are deemed not medically necessary, and likely maintenance.

Y. Some of the following services may be exclusions of the member's health plan. In the absence of a specific member certificate exclusion or limitation, the following procedures are also considered experimental, investigational, and unproven to affect health outcomes:

1. Active Therapeutic Movement (ATM2)
2. Advanced Biostructural Correction (ABC) Chiropractic Technique
3. Applied Kinesiology
4. Applied Spinal Biomechanical Engineering

5. Atlas Orthogonal Technique
6. Bioenergetic Synchronization Technique (BEST)
7. Biogeometric Integration
8. Blair Technique
9. Bowen Technique
10. Chiropractic Biophysics Technique (CBP, Clinical Biomechanics of Posture, CBP Mirror Image Technique)
11. Spinal Manipulation Treatments or Chiropractic services directed at controlling progression and/or reducing scoliosis, including but not limited to the SpineCor brace and CLEAR scoliosis treatment
12. Coccygeal Meningeal Stress Fixation Technique
13. Computerized muscle testing or analysis
14. Computerized radiographic mensuration analysis for assessing spinal mal alignment.
15. Cranial Manipulation
16. Craniosacral/Cranial sacral therapy (CST) (including the Upledger Technique)
17. Directional Non-Force Technique
18. Dry Needling
19. Far infrared radiation therapy for treatment of pain
20. Gonzalez Rehabilitation Technique
21. Home Biofeedback Units
22. Cryotherapy (or heat therapy), whether provided in the office or home
23. Hako-Med electrotherapy (horizontal electrotherapy)
24. Impulse adjusting instrument (Arthrostim)
25. Kinesio taping (Elastic Therapeutic Taping)
26. Koren Specific Technique
27. Low-Intensity Continuous Ultrasound for treatment of chronic low back pain
28. Low level laser therapy (LLLT, grade III, therapeutic laser, low-power laser, low-energy laser, biostimulating laser, photobiostimulating laser, photobiomodulation therapy [PBM], laser phototherapy, cold laser, non-thermal laser, etc.) for any use
29. Deep laser therapy (grade IV, Light force deep tissue therapy, high-power laser, high-intensity, high-dose laser therapy [HDLT], etc.) for any use
30. Manipulation under Anesthesia (MUA) (consider scope of practice)
31. Moire Contourographic Analysis
32. Nambudripad's Allergy Elimination Technique (NAET) or other Allergy Testing
33. National Upper Cervical Chiropractic Association (NUCCA technique) or Grostic technique
34. Network Chiropractic, NeuroEmotional Technique (NET)
35. Network Technique
36. Neural Organizational Technique, Contact Reflex Analysis (CRA), Whole System Scan
37. Neuro Emotional Technique
38. Neurocalometer, Nervoscope, Nerve Conduction Velocity, Surface EMG, Paraspinal Electromyography, Spinoscopy, or other nerve conduction testing
39. Neurocalometer/Nervoscope
40. Neurocranial Restructuring (NCR)
41. Para-spinal electromyography (EMG) or Surface scanning EMG
42. Pettibon technique, system and Pettibon products including the Wobble chair.

43. Spinoscopy
44. Spinal Diagnostic Ultrasound
45. Thermography
46. Treatment for brachioradial pruritus
47. Webster Technique (for breech babies)
48. Whitcomb Technique
49. Whole Body Vibration (WBV), Vibration Plate, Vibration Therapy
50. All forms of spinal traction or vertebral axial decompression for all indications. This includes VAX D, Lordex LTX3000, DRX 9000, DRS (Decompression Reduction Stabilization System) and any other form of spinal traction device.
51. Other services not on this list may be considered not medically necessary and/or investigational, experimental, and unproven to affect health outcomes based upon medical review of submitted claims and documentation:
    a. Massage therapy
    b. Infrared therapy/services
    c. Transcutaneous electrical nerve stimulation (TENS)

Documentation Required:

- Standard Written Order (SWO), prescribed by a qualified healthcare provider concerning the member's diagnosis.
- Medical record information (including continued need/use if applicable) and medical necessity. Documentation should clearly reflect why the skills of a licensed healthcare provider are needed. Each date of service must include the subjective complaint(s), objective findings, assessment, diagnosis, treatment/ancillary diagnostic studies performed, and any recommendations, instructions, or patient education. All services and level of services must be supported by the documentation and include the clinical rationale for treatment intervention, a time component, and goals, if needed. Assessment of patient's response or non-response to intervention and plan for subsequent treatment sessions, assessments, or updates.
- Correct coding for the service that meets all coding guidelines.

Disclaimer: This policy is for informational purposes only and does not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may or may not provide coverage for all services listed in this policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact customer services as listed on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG Health to assist in administering health benefits. This medical policy and MCG Health guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG, email medical.policies@wpsic.com. Coverage of all services is subject to medical necessity and services deemed experimental, investigational, and/or unproven under the terms of the clinical guidelines will not be covered.

Spinal manipulation treatments and chiropractic services are 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.

Medical Policy Review History:

Implemented	10/01/2015, 08/01/17, 07/01/18, 07/01/19, 06/01/20, 02/01/21, 02/01/22, 01/01/24, 03/01/25, 01/01/26
Medical Policy Committee Approval	06/12/15, 06/03/16, 06/16/17, 03/16/18, 03/15/19, 02/27/20, 01/28/21, 01/27/22, 01/26/23, 11/30/23, 05/30/24, 10/31/24, 06/26/25
Reviewed	06/03/16, 06/16/17, 03/16/18, 03/15/19, 02/27/20, 01/28/21, 01/27/22, 01/26/23, 11/30/23, 05/30/24, 10/31/24, 06/26/25
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Developed	06/12/15

Approved by the Medical Director

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