meridian

Clinical Policy: Chiropractic Care

Reference Number: IL.CP.MP.535 | Coding Implications
Last Review Date: 11/22 | Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Spinal Manipulation	Spinal manipulation is a form of manual therapy that involves the movement of a joint near the end of the clinical range of motion.
Subluxation	A motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact.
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. 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.
Maintenance Therapy	A treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.

Policy/Criteria

I. It is the policy of MeridianHealth affiliated with Centene Corporation® that chiropractic care is **medically necessary** for the following indications:
   A. Requests for up to 18 visits may be approved by a referral specialist. **Requests over the initial 18 visits required prior authorization and must be reviewed by a Medical Director.**
   B. Spinal manipulation is the only covered chiropractic procedure.
   C. **For Beneficiaries Under the Age of 18:**
      i. Providers must submit a prior authorization (PA) request before performing manipulations on patients under the age of 18 years old.
   D. **Required Documentation:** Meridian considers chiropractic services by means of manual manipulation medically necessary when appropriate. **The following clinical documentation should be submitted at time of request:**
      i. Documentation of subluxation by x-ray or physical exam
      ii. Date of onset of current complaint and the frequency of visits to date, including a brief history of complaint, initial symptoms and significant symptom characteristics
      iii. Level of subluxation and associated diagnosis, including complications or predisposing conditions, if present
      iv. Physical and objective findings

v. Radiographic findings, including significant findings in support of diagnosis (If documentation other than x-rays supports the medical necessity of spinal manipulation for children, the x-ray requirement may be waived. MeridianHealth reserves the right to request x-ray documentation if deemed necessary.)
vi. Member's response to current treatment (improvement to date, if any)
vii. Estimate of continued treatment necessary for current complaint
viii. Expected and anticipated benefit of continued treatment
ix. Any additional details, comments, etc. that may be of assistance in the evaluation.

E. **Relative Contraindications:** 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 should discuss this risk with the patient and record this in the chart.

F. The following are **relative contraindications** to dynamic thrust:
i. Articular hyper mobility and circumstances where the stability of the joint is uncertain;
ii. Severe demineralization of bone;
iii. Benign bone tumors (spine);
iv. Bleeding disorders and anticoagulant therapy; ***and***
v. Radiculopathy with progressive neurological signs.

G. Dynamic thrust is **absolutely contraindicated** near the site of demonstrated subluxation and proposed manipulation in the following:
i. Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation; including acute rheumatoid arthritis and ankylosing spondylitis;
ii. Acute fractures and dislocations or healed fractures and dislocations with signs of instability;
iii. An unstable os odontoideum;
iv. Malignancies that involve the vertebral column;
v. Infection of bones or joints of the vertebral column;
vi. Signs and symptoms of myelopathy or cauda equina syndrome;
vii. For cervical spinal manipulations, vertebrobasilar insufficiency syndrome; and
viii. A significant major artery aneurysm near the proposed manipulation.
ix. Risk factors for dissection (eg, a prior history of cervical artery dissection, recent neck trauma, stroke or transient ischemic attack [TIA] symptoms, Ehlers-Danlos syndrome type IV)
x. Down Syndrome (because of risk of Acute atlantoaxial instability)
xi. Upper cervical instability

H. **Absolute Contraindications:**
i. If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary.

ii. Chiropractic maintenance therapy (treatment being supportive in nature and not corrective) is not considered to be medically reasonable or necessary
iii. Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.
iv. Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.
v. Chiropractic care in persons, whose condition is neither regressing nor improving, is considered not medically necessary.
vi. Manipulation is considered experimental and investigational when it is rendered for non-neuromusculoskeletal conditions (examples include, but are not limited to: attention-deficit hyperactivity disorder, dysmenorrhea, epilepsy; and gastro-intestinal disorders) because its effectiveness for these indications is unproven.
vii. Manipulation for children ages 12 and under is considered experimental and investigational for non-neuromuscular skeletal indications. Examples include, but are not limited to: constipation, ear infections, etc.
viii. Chiropractic manipulation has no proven value for treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence, unless the member is presenting pain or spasm, or some other medically necessary indications for chiropractic manipulation are present.

I. **Non-Covered Chiropractic Services:** The following chiropractic services are excluded from Medicaid coverage are all services other than manual manipulation of the spine and spinal x-rays. Medicaid does not cover the following services when rendered by a chiropractor:
   i. Consultations
   ii. Fracture care
   iii. Home visits
   iv. Injections
   v. Laboratory tests
   vi. Maintenance therapy
   vii. Medical supplies
   viii. Evaluation and management services
   ix. Plaster casts
   x. Inpatient hospital visits

J. **Non-Covered Chiropractic Procedures:** MeridianHealth considers the following chiropractic procedures experimental and investigational and therefore are **not covered benefits**:
   i. Active Release Technique
   ii. Active Therapeutic Movement (ATM2)
   iii. Advanced Biostructural Correction (ABC) Chiropractic Technique
   iv. Applied Spinal Biomechanical Engineering
   v. Atlas Orthogonal Technique
   vi. Bioenergetic Synchronization Technique
   vii. Biogeometric Integration
   viii. Blair Technique
   ix. Bowen Technique
   x. Chiropractic Biophysics Technique

xi. Coccygeal Meningeal Stress Fixation Technique
xii. Cranial Manipulation
xiii. Directional Non-Force Technique
xiv. FAKTR (Functional and Kinetic Treatment with Rehab) Approach
xv. Gonzalez Rehabilitation Technique
xvi. Koren Specific Technique
xvii. Manipulation for infant colic
xviii. Manipulation for internal (non-neuromusculoskeletal) disorders
xix. Manipulation Under Anesthesia
xx. Moire Contourographic Analysis
xxi. Network Technique
xxii. Neural Organizational Technique
xxiii. Neuro Emotional Technique
xxiv. Sacro-Occipital Technique
xxv. Spinal Adjusting Devices (ProAdjuster, PulStarFRAS, Activator)
xxvi. Therapeutic (Wobble) Chair
xxvii. Upledger Technique and Cranio-Sacral Therapy
xxviii. Webster Technique (for breech babies)
xxix. Whitcomb Technique

K. **Experimental Investigational Diagnostic Procedures:** MeridianHealth considers the following diagnostic procedures experimental and investigational and therefore are **not covered benefits:**
   i. Computerized radiographic mensuration analysis for assessing spinal mal-alignment
   ii. Dynamic spinal visualization (including digital motion x-ray and videofluoroscopy, also known as cineradiography)
   iii. Neurocalometer/Nervoscope - see CPB 0029 - Thermography
   iv. Para-spinal electromyography (EMG)/Surface scanning EMG - see CPB 0112 - Surface Scanning and Macro Electromyography
   v. Spinoscopy - see CPB 0112 - Surface Scanning and Macro Electromyography
   vi. Thermography - see CPB 0029 - Thermography.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Note: Services are limited to chiropractic manipulative treatment as identified in the Chiropractor Fee Schedule (https://www2.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx) to correct spinal subluxation. Only the following procedures may be submitted for reimbursement by the chiropractor:

Procedure Codes:
- 98940 - Chiropractic manipulative treatment, spinal, 1-2 region
- 98941 - Chiropractic manipulative treatment, spinal, 3-4 region
- 98942 - Chiropractic manipulative treatment, spinal, 5 regions

Note: IDHFS is awaiting approval from the federal Centers for Medicare & Medicaid Services (CMS) before initiating payment of fee-for-service (FFS) adult claims. Adult FFS claims with dates of service beginning December 1, 2021 will be held by HFS until CMS approval is given and then released into processing.

CPT®* Codes	Description
98940	Chiropractic manipulative treatment, spinal, 1-2 region
98941	Chiropractic manipulative treatment, spinal, 3-4 region
98942	Chiropractic manipulative treatment, spinal, 5 regions

HCPCS ®* Codes	Description

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Revisions Date	Approval Date
Original approval date		08/19/16
Annual Review with no changes		09/20
Reinstatement of Adult Chiropractic Services per Public Act 102-0043	12/1/2021	
Annual Review	12/21	12/21

Reviews, Revisions, and Approvals	Revisions Date	Approval Date
Annual Review		12/2022

References

1. "Spinal manupulation in the treatment of muscoloskeletal pain". Topic 7776 Version 33.0. UpToDate. Accessed 11/14/2022. https://www.uptodate.com/contents/spinal-manipulation-in-the-treatment-of-musculoskeletal-pain?source=search_result&search=chiropractic&selectedTitle=1%7E37
2. Illinois Department of Healthcare and Family Services. "Handbook for Providers of Chiropractic Services". Chapter B-200. Accessed 10/15/2021.
3. Reinstatement of Adult Chiropractic Services per Public Act 102-0043. Provider Notice Issued 11/05/2021: https://www2.illinois.gov/hfs/MedicalProviders/notices/Pages/prn211105a.aspx

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.

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