Clinical Policy Title: Chiropractic care

Clinical Policy Number: 15.02.01

Effective Date: December 1, 2013
Initial Review Date: July 17, 2013
Most Recent Review Date: July 20, 2016
Next Review Date: July 2017

Related policies:
None.

ABOUT THIS POLICY: AmeriHealth Caritas Northeast has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Northeast’s clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of “medically necessary,” and the specific facts of the particular situation are considered by AmeriHealth Caritas Northeast when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Northeast’s clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Northeast’s clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Northeast will update its clinical policies as necessary. AmeriHealth Caritas Northeast’s clinical policies are not guarantees of payment.

Coverage policy

AmeriHealth Caritas Northeast considers the use of chiropractic care services to be clinically proven and therefore, medically necessary when the following criteria are met:

- The care services are provided by a licensed chiropractor practicing within the scope of his/her license.
- The services are provided for neuromuscular symptoms amenable to chiropractic care for restoration of optimal function.
- There is a documented plan of care which directs chiropractic care to the presenting symptoms.
- Improvement is documented within three weeks after initiation of care, and there is a documented anticipated duration of chiropractic care with defined frequency of visits and end-point of treatment. Based upon state requirements, no more than 24 visits/year may be required to achieve maximal therapeutic benefit for each noncontiguous condition.
- Chiropractic care is restricted to treatment of neuromuscular symptoms arising from the spine.

Policy contains:
- Chiropractic manipulation.
- Physical therapy in chiropractic practice.
- Chiropractic imaging.
- Vertebral Axial Decompression (VAX-D).
- Surface electromyography.
Limitations:

All other uses of chiropractic care services are not medically necessary. This includes, but is not limited to, the following:

- Non-neuromuscular disorders outside of the axial skeleton such as cranial manipulation, treatment of attention deficit hyperactivity disorder (ADHD) or nutritional disorders.
- Unexpected services such as laboratory testing, post-treatment imaging or more than two therapy modalities in one visit.
- Age ranges without an evidence basis for chiropractic care, such as infants or the very elderly. Prior authorization is required for patients 21 years or younger.
- Contraindications to high-velocity manipulation therapies:
  - Osseous conditions, e.g., region of fractures, severe osteoporosis, multiple myeloma, osteomyelitis, local primary or metastatic bone tumors, Paget’s disease.
  - Neurologic conditions, e.g., progressive or sudden neurologic deficits (such as cauda equine syndrome).
  - Inflammatory conditions, e.g., active rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis or Reiter’s syndrome.
  - Bleeding disorders, congenital or acquired.
  - Abdominal aortic aneurysm.
  - Unstable spondylolisthesis.
  - Burn or open wound in the area of treatment.
  - Manipulation of implanted devices.
- Non-proven diagnostic or treatment modalities such as vertebral axial decompression treatment (VAX-D), contour analysis, concept therapy, and surface electromyograms.
- Manipulation under anesthesia (MUA) for the following conditions:
  - Arthrofibrosis of knee following total knee arthroplasty, knee surgery, or fracture (see table 1); or
  - Chronic, refractory frozen shoulder (adhesive capsulitis) (see Table 1); or
  - Reduction of a displaced fracture (e.g., vertebral, long bones); or
  - Reduction of acute/traumatic dislocation (e.g., vertebral, perched cervical facet).

State requirements if different from AmeriHealth Caritas Northeast:

- **Florida**
  - Limited to 24 visits per calendar year.
  - Children under 21 require prior authorization.

- **Louisiana**
  - Limited to care under the referral of a primary care physician only.
  - Limited to spinal manipulation only.
  - No physical therapy or modalities covered.
  - Children under 13 years of age are not covered.
  - Children between 13 and 21 years of age require prior authorization.
- **Nebraska**
  - Limited “coverage of chiropractic services to treatment of the spine by manual manipulation (i.e., by use of hands only) and certain spinal x-rays.”
  - For clients 21 years of age and older: Manual manipulation of the spine is limited to 12 treatments per calendar year.
  - For clients 20 years of age and younger: Manual manipulation of the spine is limited to 18 treatments during the initial five-month period from the age of initiation of treatment for the reported diagnosis. A maximum of one treatment per month is covered thereafter if needed for stabilization care.
  - No more than one treatment per client per day is covered.
  - Non-covered services when arranged for or provided by a chiropractor:
    - Laboratory tests.
    - Orthopedic devices.
    - Physiotherapy (e.g., ultrasound, diathermy, etc.).
    - Nutritional supplements.
    - EKGs.
    - Acupuncture.

- **Pennsylvania Northeast**
  - Children 13 to 21 years of age do not require authorization. The State limits pediatric patients to 18 visits in a five-month period for the same diagnosis and then one per month. Adults are limited to 12 visits per year. There is an SOP for children three to 12 may have first 10 visits approved without a doctor’s review: A clinical H&P should be included for review with each pediatric patient and a musculoskeletal complaint should be primary. Non-musculoskeletal complaints will require review by medical director.
  - Related primary diagnosis codes: 646.93, 648.73, 648.93, 739.0 – 739.8

- **Pennsylvania Keystone First**
  - Keystone First SOP: Chiropractic treatment that does not meet InterQual but is the first- or second-set 12-visit request (up to 24 total) does not need medical review and can be approved per SOP.

- **South Carolina**
  - Chiropractic visits are limited to six visits per year.
  - Limited to spinal manipulation only.
  - No physical therapy services or modalities covered.
  - Symptoms only for axial spine.
  - Prior authorization required for children under 13 years of age.

- **Washington, D.C.**
  - Provides no benefits for chiropractic services.

**Alternative covered services:**
Physician office visits to primary care or orthopedic surgeon and physical and/or occupational therapy services. Prescribed medications.

**Background**

Chiropractic is the single most frequently used complementary or alternative health service in the United States. The field of chiropractic arose from the work of Daniel David Palmer in the 1890s in Iowa. The original theories of disease originating from spinal subluxations have evolved to the modern definition from the American Chiropractic Association: “Chiropractic is a branch of the healing arts which is concerned with human health and disease processes. Doctors of Chiropractic are physicians who consider man as an integrated being and give special attention to the physiological and biochemical aspects including structural, spinal, musculoskeletal, neurological, vascular, psychological, nutritional, visceral, emotional and environmental relationships, and are trained in diagnosis so they may treat patients effectively and make timely referral to appropriate health care providers.”

In the twenty-first century, chiropractors are the third-largest group of health care professionals after medical physicians and dentists. The field of chiropractic is now more focused on treatment of neuromuscular disorders and maintenance of spinal health. The American Chiropractic Association indicates that chiropractors primarily focus on back pain, neck pain, joint pains and headaches through manipulation of the spine. Chiropractors typically use a short-lever, high-velocity thrust manipulation, whereas osteopathic spinal manipulation is more likely to use long lever adjustments. Multiple studies have failed to demonstrate that spinal manipulation is superior to standard medical care giving equivalent outcomes for muscular back pain. Studies such as those listed in the Summary of clinical evidence do demonstrate that chiropractic manipulation produces results which are equivalent to physical therapy, osteopathic mobilization or home exercise programs. Medications with anti-inflammatory drugs and/or muscle relaxants are equivalent to or inferior to these other physical treatments. No studies have demonstrated superior results by adding physical therapy modalities to chiropractic manipulation.

A majority of muscular neck and back pains are self-limited and will resolve without treatment. This makes evaluation of the effectiveness of chiropractic therapy much more difficult, as, for many people seen, the resolution of pain comes with time and appears to be independent of any treatment provided. Further, as Haneline, from the Palmer College of Chiropractic West, and others have pointed out, the literature on the effectiveness of spinal manipulation is generally of low quality, suffering from lack of standard rigor in methodological design and from small numbers. Based upon the treatment, studies cannot be blinded, further reducing the scientific rigor. Most studies are observational and subject to reporting bias.

Chiropractic enjoys significant popularity. The profession seeks to improve health through spinal adjustments for relief of acute pain syndromes, chronic pain conditions and maintenance of health through episodic adjustments. In the early 1990s, the Mercy Center Consensus Conference established
the first set of practice parameters for the profession. The International Chiropractic Association published a new set of parameters in a 2008 listing of range of visits (see below).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Average # visits</th>
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<tbody>
<tr>
<td>Uncomplicated axial pain</td>
<td>18 visits over four to seven weeks</td>
</tr>
<tr>
<td>Complicated axial pain</td>
<td>24 to 60 visits over 20 weeks</td>
</tr>
<tr>
<td>Headache</td>
<td>23 visits over five to seven weeks</td>
</tr>
<tr>
<td>Motor vehicle accident</td>
<td>21 to 76 visits over 56 weeks</td>
</tr>
</tbody>
</table>

From International Chiropractors Association, Best Practices and Practice Guidelines.

These conditions represent acute and chronic pain syndromes. The use of chiropractic services for maintenance has been reviewed in CMS Local Coverage Determinations, which concluded:

“Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, and Section 240.1.3A).”

**Contraindications to chiropractic care:**

There are only rare circumstances in which serious injury occurs as a direct result of care provided by a chiropractic physician. Many patients may have muscle stiffness and soreness following an adjustment, but these are typically transient. However, with the unusual complications, a set of contraindications to chiropractic dynamic thrust therapies has evolved and includes:

- **Absolute contraindications:**
  - Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation, including acute rheumatoid arthritis and ankylosing spondylitis.
  - Acute fractures and dislocations or healed fractures and dislocations with signs of instability.
  - An unstable os odontoideum.
  - Malignancies that involve the vertebral column.
  - Infection of bones or joints of the vertebral column.
  - Signs and symptoms of myelopathy or cauda equina syndrome.
  - For cervical spinal manipulations, vertebrobasilar insufficiency syndrome.
  - A significant major artery aneurysm near the proposed manipulation.

- **Relative contraindications:**
  - Articular hypermobility and circumstances where the stability of the joint is uncertain.
  - Severe demineralization of bone.
- Benign bone tumors (spine).
- Bleeding disorders and anticoagulant therapy.
- Radiculopathy with progressive neurological signs.

(From CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3B.

**Searches**

We searched PubMed and the databases of:

- UK NHS Centre for Reviews and Dissemination.
- AHRQ guideline clearinghouse and evidence-based practice centers.
- Centers for Medicare & Medicaid Services (CMS).

We conducted searches on June 8, 2016, using the terms “chiropractic care,” “spine manipulation” and “chiropractic services.”

We included:

- **Systematic reviews**, which pool results from multiple studies to achieve larger sample sizes and greater precision of effect estimation than in smaller primary studies. Systematic reviews use predetermined transparent methods to minimize bias, effectively treating the review as a scientific endeavor, and are thus rated highest in evidence-grading hierarchies.
- **Guidelines based on systematic reviews.**
- **Economic analyses**, such as cost-effectiveness, and benefit or utility studies (but not simple cost studies), reporting both costs and outcomes — sometimes referred to as efficiency studies — which also rank near the top of evidence hierarchies.

**Findings**

Spinal manipulation/mobilization is effective in adults for acute, subacute and chronic low back pain; migraine and cervicogenic headache; cervicogenic dizziness. Manipulation/mobilization is effective for several extremity joint conditions, and thoracic manipulation/mobilization is effective for acute/subacute neck pain. The evidence is inconclusive for cervical manipulation/mobilization alone for neck pain of any duration and for manipulation/mobilization for mid-back pain, sciatica, tension-type headache, coccydynia, temporomandibular joint disorders, fibromyalgia, premenstrual syndrome and pneumonia in older adults. Spinal manipulation is not effective for asthma and dysmenorrhea when compared to sham manipulation or for Stage 1 hypertension when added to an antihypertensive diet. In children, the evidence is inconclusive regarding the effectiveness for otitis media and enuresis, and it is not effective for infantile colic and asthma when compared to sham manipulation. Massage is effective in adults for chronic low back pain and chronic neck pain. The evidence is inconclusive for knee osteoarthritis, fibromyalgia, myofascial pain syndrome, migraine headache and premenstrual syndrome. In children, the evidence is inconclusive for asthma and infantile colic.
Most research on chiropractic has focused on spinal manipulation. Practitioners perform manipulation by using their hands or a device to apply a controlled force to a joint. The amount of force applied depends on the form of manipulation used. Spinal manipulation appears to benefit some people with low-back pain and may also be helpful for headaches, neck pain, upper- and lower-extremity joint conditions, and whiplash-associated disorders. Side effects from spinal manipulation can include temporary headaches, tiredness or discomfort in the parts of the body that were treated. There have been rare reports of serious complications such as stroke, but whether spinal manipulation actually causes these complications is unclear. Safety remains an important focus of ongoing research. In the United States, chiropractic is often considered a complementary health practice. According to the 2007 National Health Interview Survey (NHIS), which included a comprehensive survey of the use of complementary health practices by Americans, about 8 percent of adults (more than 18 million) and nearly 3 percent of children (more than 2 million) had received chiropractic or osteopathic manipulation, a type of manipulation practiced by osteopathic physicians combined with physical therapy and instruction in proper posture. There is no robust data concerning the incidence or prevalence of adverse reactions after chiropractic. Further investigations are urgently needed to assess definite conclusions regarding this issue.

Policy updates:

2016-Added a sixth bullet for added limitation related to MUA:
- Reduction of acute/traumatic dislocation (e.g., vertebral, perched cervical facet).
- Manipulation under anesthesia (MUA) for the following conditions:
  - Arthrofibrosis of knee following total knee arthroplasty, knee surgery, or fracture; or
  - Chronic, refractory frozen shoulder (adhesive capsulitis) (see Table 1); or
  - Reduction of a displaced fracture (e.g., vertebral, long bones)

Summary of clinical evidence:

<table>
<thead>
<tr>
<th>Citation</th>
<th>Content, Methods, Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hurwitz (2002)</td>
<td>Key points:</td>
</tr>
<tr>
<td></td>
<td>Cervical spine manipulation and mobilization for neck pain</td>
</tr>
<tr>
<td></td>
<td>• Randomized trial of 336 patients with neck pain. 171 in manipulation, 165 mobilization.</td>
</tr>
<tr>
<td></td>
<td>• Similar demographics and entry criteria.</td>
</tr>
<tr>
<td></td>
<td>• Cervical spine manipulation and mobilization yield comparable clinical outcomes.</td>
</tr>
<tr>
<td>Gross (2004)</td>
<td>Key points:</td>
</tr>
<tr>
<td></td>
<td>Similar results: manipulation and mobilization for neck pain with or without headache</td>
</tr>
<tr>
<td></td>
<td>• Mobilization and/or manipulation when used with exercise are beneficial for persistent mechanical neck disorders with or without headache.</td>
</tr>
<tr>
<td></td>
<td>• Neither manipulation nor mobilization was superior to the other.</td>
</tr>
<tr>
<td></td>
<td>• Insufficient evidence available to draw conclusions for neck disorder with radicular</td>
</tr>
<tr>
<td>Citation</td>
<td>Content, Methods, Recommendations</td>
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<tr>
<td>-------------------</td>
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</tbody>
</table>
| Haneline (2005)   | **Key points:** Lack of high quality studies for chiropractic manipulation for acute neck pain  
|                   | - Review of 267 citations by Palmer College of Chiropractic West.  
|                   | - Only found one high-quality citation of impact of chiropractic manipulation on acute neck pain.  
|                   | - Scant investigative research into the treatment of acute neck pain with chiropractic manipulation. |
| Bronfort (2012)   | **Key points:** Spinal manipulation, medication or home exercises for acute and subacute neck pain  
|                   | - Non-blinded study of 272 persons ages 18 to 65 with nonspecific neck pain for two to 12 weeks.  
|                   | - Spinal manipulation was more effective than medication in both the short and long term.  
|                   | - Instructional sessions of home exercise with advice resulted in similar outcomes at most time points. |
| Assenfelt (2003)  | **Key points:** Meta-analysis of modalities for treatment of low back pain  
|                   | - Meta-analysis of 39 randomized controlled trials (RCTs).  
|                   | - Spinal manipulative therapy had no statistically or clinically significant advantage over general practitioner care, analgesics, physical therapy, exercises or back school but was superior to sham treatment.  
|                   | - This applied to acute and chronic low back pain. |
| Cherkin (1998)    | **Key points:** Comparison of McKenzie PT, chiropractic and education only  
|                   | - Randomized 321 patients with seven days of back pain randomized to physical therapy (PT), chiropractic or education alone.  
|                   | - PT and chiropractic were marginally better than education alone. |
| Meade (1995)      | **Key points:** Comparison of chiropractic and hospital outpatient management for low back pain  
|                   | - Seven hundred forty-one individuals followed over time with the Oswestry pain and satisfaction of care survey.  
|                   | - At the end of three years Oswestry score greatest in chiropractic group, suggesting greater efficacy for chiropractic.  
|                   | - Only 26% of study patients were available for a two-year survey. |

**Glossary**
**Chiropractic adjustment** — According to the International Chiropractic Association, chiropractic adjustment “is characterized by a specific thrust applied to the vertebra utilizing parts of the vertebra and contiguous structures as levers to directionally correct articular malposition. Adjustment shall be differentiated from spinal manipulation in that the adjustment can only be applied to a vertebral malposition with the express intent to improve or correct the subluxation.”

**Long-lever adjustments** — Use the femur, shoulder, head or pelvis to manipulate the spine. This technique is used primarily by osteopathic physicians.

**Medically necessary** — A service or benefit is medically necessary if it is compensable under the Medical Assistant program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

**Short-lever, high-velocity thrust** — Employed primarily by chiropractors; uses a specific contact point on a process of a vertebra to manipulate a specific vertebral joint. In performance of this technique, the patient is placed in a lateral decubitus posture close to the leading edge of the treatment table. The free leg, not resting on the table, is flexed at the knee and the pelvis to cause a relative flexion of the lumbar spine. Manipulation of the spine in this case creates a counter-rotational force at the low back.

**Spinal manipulation** — Generic term that refers to the techniques used by osteopathic physicians, physiatrists (rehabilitation specialists), physiotherapists or orthopedic surgeons. Spinal adjustment therapy usually involves more frequent visits than medical treatment for the same condition. Manipulation involves short-lever, high-velocity thrust applied to the affected region of the spine.

**Spinal mobilization** — Refers to passive movements of the spinal articular surfaces through a series of long-lever, low velocity thrusts and/or traction on the vertebral column. This technique is commonly used by physical therapists, osteopathic physicians and chiropractic physicians.

**Subluxation** — In chiropractic, subluxation refers to alteration of the normal dynamics and anatomical or physiologic relationships of contiguous articular structures.

**Thrust or dynamic thrust** — Chiropractic adjustment delivered suddenly and forcefully to move vertebrae, often resulting in a popping sound.
References

Professional society guidelines/other:


Peer-reviewed references:


**Clinical trials:**

Searched clinicaltrials.gov on Accessed June 8, 2016 using terms chiropractic care | Open Studies. 12 studies found, one relevant.

CMS National Coverage Determinations (NCDs):

No NCDs identified as of the writing of this policy.

Local Coverage Determinations (LCDs):

Chiropractic Services. L33982 PA, DC, NJ; Original effective date 10/01/2015; revision effective date 10/01/2015.

Other LCD’s can be found at:


NOTE:
Durable medical equipment ordered by a chiropractic physician is not covered.

Commonly submitted codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comment</th>
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<tbody>
<tr>
<td>98940</td>
<td>Chiropractic manipulative treatment, Spinal 1-2 regions</td>
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</tr>
<tr>
<td>98941</td>
<td>Chiropractic manipulative treatment, Spinal 3-4 regions</td>
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</tr>
<tr>
<td>98942</td>
<td>Chiropractic manipulative treatment, Spinal 5 regions</td>
<td></td>
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<tr>
<td>98943</td>
<td>Chiropractic manipulative treatment, Extraspinal 1 or more regions</td>
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<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>M99.00</td>
<td>Segmental and somatic dysfunction of head region</td>
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<tr>
<td>M99.01</td>
<td>Segmental and somatic dysfunction of cervical region</td>
<td></td>
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<tr>
<td>M99.02</td>
<td>Segmental and somatic dysfunction of thoracic region</td>
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<tr>
<td>ICD-10 Code</td>
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<td>------------</td>
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<tr>
<td>M99.03</td>
<td>Segmental and somatic dysfunction of lumbar region</td>
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<tr>
<td>M99.04</td>
<td>Segmental and somatic dysfunction of sacral region</td>
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<td>M99.05</td>
<td>Segmental and somatic dysfunction of pelvic region</td>
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<td>M99.06</td>
<td>Segmental and somatic dysfunction of lower extremity</td>
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<td>M99.07</td>
<td>Segmental and somatic dysfunction of upper extremity</td>
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<tr>
<td>M99.08</td>
<td>Segmental and somatic dysfunction of rib cage</td>
<td></td>
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<tr>
<td>M00.09</td>
<td>Segmental and somatic dysfunction of abdomen or other regions</td>
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<table>
<thead>
<tr>
<th>HCPCS Level II Code</th>
<th>Description</th>
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