Medicare Medical Policy

Chiropractic Care

MEDICARE MEDICAL POLICY NUMBER: 243

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INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

NOTE: Chiropractic care may be specifically excluded under some health benefit plans. When covered, chiropractic care may be subject to the terms, conditions and limitations of the applicable plan's benefit language. Some plans may also include a maximum allowable benefit for duration of treatment or number of visits. When the maximum allowable benefit is exhausted, coverage will no longer be provided even if the medical necessity criteria described are met. Members should familiarize themselves with the benefit limits of their health plan for chiropractic services to avoid unexpected denials.

Service	Medicare Guidelines
Spinal Chiropractic Services (CPT 98940 - 98942) – ***Neuromusculoskeletal*** *Conditions (Medicare-Covered Chiropractic Services)*	**General coverage guidance:** • Local Coverage Article: Billing and Coding: Chiropractor Services (A57914) • Medicare Benefit Policy Manual: Chapter 15 – Covered Medical and Other Health Services, §240.1 – Coverage of Chiropractic Services *(See all subsections for additional information)* **Contraindications to spinal manipulation with dynamic thrust:** • Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §240.1.3 – Necessity for Treatment, B. Contraindications
*Routine Chiropractic Services (CPT 98940-98943) (Includes Non-Spinal and maintenance therapy) –****Any Condition***	**For members without a supplemental "routine chiropractic services" benefit:** • Extraspinal chiropractic services (CPT 98943): ○ LCA: Billing and Coding: Chiropractor Services (A57914) "National policy limits the coverage of chiropractic services to the 'hands on' manual manipulation of the spine for symptomatology associated with spinal subluxation. Accordingly, CPT code 98943, CMT, extraspinal, one or more regions, is not a Medicare benefit."

	• Maintenance therapy: ○ Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §240.1.3 – Necessity for Treatment, A. Maintenance Therapy • **Non**-neuromusculoskeletal conditions: Medicare states, "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 expectation of recovery or improvement of function."[2] Therefore, coverage is limited to the treatment of ***neuromusculoskeletal*** conditions and related disorders only. **For members with a supplemental "routine chiropractic services" benefit:** • Coverage may be provided for Medicare Advantage plan members **IF** the member EOC states coverage is available for "routine chiropractic services" or "routine chiropractic care." According to Medicare, these this coverage "may include conservative management of **neuromusculoskeletal disorders and related functional clinical conditions including, but not limited to, back pain, neck pain and headaches**, and the provision of spinal and other therapeutic manipulation/adjustments."[1] • Routine chiropractic services must be considered medically necessary by the Company. See the bullet "For all members" below for more information regarding what indications are considered medically necessary by the Company. • **Maintenance therapy** may also be eligible for coverage under MA plans that have this supplemental benefit; however, most plans have a calendar year limit on the number of visits that are allowed. **For all members:** • Chiropractic services will be considered **not medically necessary** for Medicare Advantage members for **non**-neuromusculoskeletal disorders or related clinical conditions. Examples include, but may not be limited to, anxiety, hernias, gastro-esophageal reflux (GERD), etc. Additional information regarding coverage of chiropractic services can be found in the **Company medical policy for Chiropractic Care**.

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DOCUMENTATION

While chiropractic services are not subject to routine utilization review for medical necessity, the following information must be recorded and kept on file within the medical record[3,4]:

- Specification of the precise spinal location and level of subluxation giving rise to the diagnosis and symptoms.
- Documentation of subluxation:
  - When the subluxation is demonstrated by an x-ray, the x-ray must have been taken "at a time reasonably proximate to the initiation of a course of treatment. (According to Medicare, this means no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment, unless more specific x-ray evidence is warranted.)
    - Exceptions: In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the member'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. In addition, a previous CT scan and/or MRI is also acceptable evidence if a subluxation of the spine is demonstrated.
  - When subluxation is demonstrated by physical exam, documentation must include **at least two** of the following evaluation details, **and** one of those must be **either** 2 **or** 3:
    1. Pain/tenderness evaluated in terms of location, quality, and intensity;
    2. Asymmetry/misalignment identified on a sectional or segmental level;
    3. Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); and
    4. Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.
- Documentation of medical history which includes the following elements:
  - Symptoms causing patient to seek treatment;
  - Family history if relevant;
  - Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);
  - Description of present illness:
  - 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.
- For initial visits, in addition to the above medical history, documentation must include a detailed record of the following elements:

- 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 and that have a direct relationship to the level of subluxation.
  - According to Medicare, "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."
  - Also according to Medicare, "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."
- Evaluation of musculoskeletal/nervous system through physical examination.
- 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.
- 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.

- Documentation for subsequent visits must include:
  - History (review of chief complaint, changes since last visit, system review [if relevant]).
  - Physical exam (exam area of spine involved in diagnosis, assessment of change in patient condition since last visit, evaluate of treatment effectiveness).
  - Treatment given on the date of the visit.

BACKGROUND

Traditional Medicare vs. Medicare Advantage

Traditional Medicare benefits for chiropractic services are limited to spinal manipulation only. Extraspinal chiropractic services and maintenance therapy are not covered benefits under Original Medicare. However, as a Medicare Advantage plan, additional chiropractic services may be eligible for coverage for members with a "routine chiropractic services" supplemental benefit. *(Medicare Managed Care Manual, Chapter 4 - Benefits and Beneficiary Protections, §30.3 – Examples of Eligible Supplemental Benefits)*

> "MA plans may choose to offer routine chiropractic services as a supplemental benefit as long as the services are provided by a state-licensed chiropractor practicing in the state in which he/she is licensed and is furnishing services within the scope of practice defined by that state's licensure and practice guidelines. The routine services may include conservative management of

neuromusculoskeletal disorders and related functional clinical conditions including, but not limited to, back pain, neck pain and headaches, and the provision of spinal and other therapeutic manipulation/adjustments.

“X-rays or other diagnostic or therapeutic services furnished or ordered by a chiropractor may be covered by the MA plan as a supplemental benefit as long as the chiropractor is state-licensed and is practicing within the states’ licensure and practice guidelines.”

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

GENERAL

CMS has developed policies which specifically limit coverage to manual manipulation of the spine to correct a subluxation; however, individual member benefits may have coverage of chiropractic care beyond what Medicare allows. The codes that accurately reflect chiropractic services are CPT Codes 98940, 98941, 98942, and 98943. Documentation must clearly reflect the medical necessity for the service billed.

Benefits

Manipulation of the Spine (Traditional Medicare-Covered Chiropractic Services)

CPT codes 98940-98942 will be considered a covered benefit and **medically necessary** when the claim is reported with one of these diagnosis codes: M99.00-M99.05, M99.10-M99.15.

Routine Chiropractic Services (Supplemental Chiropractic Benefit)

CPT codes 98940-98943 will be considered **medically necessary** when the claim is reported with any of the ICD-10 diagnosis codes listed in the Billing Guidelines Appendix below.

Separate Reimbursement

Some services provided by a chiropractor may be medically appropriate, but separate reimbursement is not generally provided (exceptions may exist if the individual has a supplemental “routine chiropractic services” benefit). These include, but may not be limited to:

- If a chiropractor orders, takes, or interprets an x-ray or other diagnostic procedure to demonstrate a subluxation of the spine, the x-ray can be used for documentation. However, there is no coverage or payment for these services or for any other diagnostic or therapeutic service ordered or furnished by the chiropractor.[5,6]
- In performing manual manipulation of the spine, some chiropractors use manual devices that are hand-held with the thrust of the force of the device being controlled manually. While such manual manipulation may be covered, there is no separate payment permitted for use of this device.[5,6]

CODES*		
CPT	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
HCPCS	None	

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. Centers for Medicare and Medicaid Services (CMS). Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections, §30.3 – Examples of Eligible Supplemental Benefits. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c04.pdf. Accessed 4/19/2024.
2. CMS. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §240.1.3 - Necessity for Treatment; Available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf. Accessed 4/3/2024.
3. CMS. Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, §220 – Chiropractic Services; Available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf. Accessed 4/19/2024.
4. CMS. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §240.1.2 – Subluxation May Be Demonstrated by X-Ray or Physician's Exam; Available at:

https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf. Accessed 4/22/2024.
5. CMS. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §240 – Chiropractic Services – General; Available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf. Accessed 4/19/2024.
6. CMS. Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services, §30.5 – Chiropractor's Services; Available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf. Accessed 4/19/2024.
7. 42 CFR §410.21. Limitations on services of a chiropractor.

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
10/2022	Annual review (converted to new format 2/2023)
10/2023	Annual review; no change to criteria, add CMS references/resources
6/2024	Interim update to establish medically necessary parameters for chiropractic services

APPENDICES

Medicare states, "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 expectation of recovery or improvement of function."[5] Diagnosis codes for medically necessary indications for the "routine chiropractic services" supplemental benefit include the ICD-10 codes listed below.

Appendix I: Medically necessary indications for the "routine chiropractic services" supplemental benefit.

CODE	DESCRIPTION
G24.3	Spasmodic torticollis
G43.001 - G43.919	Migraine
G44.001 - G44.89	Tension and other headaches
G54.0 - G55	Nerve root and pleus disorders
G56.00 - G56.93	Mononeuritis of upper limb
G57.00 - G59	Mononeuritis of lower limb
G71.00 - G72.9	Muscular dystrophies and other myopathies
G80.0 - G80.9	Cerebral palsy
M05.00 - M08.99	Rheumatoid arthritis and other inflammatory polyarthropathies
M12.00 - M13.89	Other and unspecified arthropathies
M15.0 - M19.93	Osteoarthritis and allied disorders
M20.001 - M25.9	Other joint disorders
M26.601 - M26.69	Temporomandibular joint disorders
M35.3	Rheumatism shoulder lesions and enthesopathies [excludes back]
M40.00 - M40.51	Deforming dorsopathies spondylitis and other dorsopathies [excluding scoliosis]
M42.00 - M54.9	Dorsopathies and spondylopathies
M75.00 - M79.9	
M85.30 - M85.39	Osteitis condensans

M89.00 - M89.09	Algoneurodystrophy
M91.10 - M94.9	Osteochondropathies
M95.3	Acquired deformity of neck
M95.5	Acquired deformity of pelvis
M95.8	Other specified acquired deformities of musculoskeletal system
M95.9	Acquired deformities of musculoskeletal system unspecified
M99.00 - M99.09	Segmental and somatic dysfunction
M99.10 - M99.19	Subluxation complex (vertebral)
M99.83 - M99.84	Other acquired deformity of back or spine
Q65.00 - Q68.8	Congenital musculoskeletal deformities
Q74.1 - Q74.2	Congenital malformations of lower limb including pelvic girdle
Q74.0	Congenital malformations of upper limb including shoulder girdle
Q74.9	Unspecified congenital malformation of limb(s)
Q76.0 - Q76.49	Congenital malformations of spine
Q77.0 -Q77.1	Osteochrondrodysplasia
Q77.4 - Q77.5	Achondroplasia and diastrophic dysplasia
Q77.7 – Q77.9	Spondyloepiphyseal dysplasia and other osteochondrodysplasia
Q78.9	Osteochondrodysplasia, unspecified
Q87.89	Other specified congenital malformation syndromes, not elsewhere classified
R51	Headache
S03.40 - S03.42	Sprain of jaw
S13.0 - S13.9 S23.0 - S23.9 S33.0 - S33.9 S43.001 - S43.92 S53.001 - S53.499 S63.001 - S63.92 S73.001 - S73.199 S83.001 - S83.92 S93.01 - S93.699	Dislocation and sprains of joints and ligaments
S14.2 - S14.9 S24.2 - S24.9 S34.21 - S34.9	Injuries to nerve root(s) spinal pleus(es) and other nerves
S16.1	Strain of muscle fascia and tendon at neck level
S23.41 - S23.429 S33.4 S33.8 - S33.9	Sprain of other ribs sternum and pelvis
S39.002 S39.012 S39.092	Injury or strain of muscle fascia and tendon of lower back
S44.00 - S44.92	Injury of nerves at shoulder and upper arm level
S46.011 - S46.019 S46.111 - S46.119 S46.211 - S46.219 S46.311 - S46.319 S46.811 - S46.819 S46.911 - S46.919	Injury of muscle fascia and tendon at shoulder and upper arm level
S74.00 - S74.92	Injury of nerves at hip and thigh level
S76.011 - S76.019	Injury and strain of muscle fascia and tendon at hip and thigh level

S76.111 - S76.119	
S76.211 - S76.219	
S76.311 - S76.319	
S76.811 - S76.819	
S76.911 - S76.919	
S84.00 - S84.92	Injury of nerves at lower leg level
S86.001 - S86.019	Injury of muscle fascia and tendon at lower leg level
S86.111 - S86.119	
S86.211 - S86.219	
S86.311 - S86.319	
S86.811 - S86.819	
S86.911 - S86.919	
S94.011 - S94.019	Injury of nerves at ankle and foot level
S94.111 - S94.119	
S94.211 - S94.219	
S94.311 - S94.319	
S94.811 - S94.819	
S94.911 - S94.919	
S96.001 - S96.019	Injury of muscle fascia and tendon at ankle and foot level
S96.111 - S96.119	
S96.211 - S96.219	
S96.811 - S96.819	
S96.911 - S96.919	