MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	**Chiropractic Care**
Policy Number	**10.01.02**
Category	**Contract Clarification**
Original Effective Date	**10/18/01**
Committee Approval Date	**11/15/01, 11/21/02, 12/11/03, 03/04/05, 02/23/06, 02/22/07, 02/28/08, 02/26/09, 02/25/10, 02/24/11, 02/27/12, 02/28/13, 02/27/14, 02/26/15, 02/25/16, 04/27/17, 02/22/18, 02/28/19, 04/23/20, 06/24/21, 10/20/21, 07/21/22, 07/20/23**
Current Effective Date	**07/20/23**
Archived Date	**N/A**
Archive Review Date	**N/A**
Product Disclaimer	• *If a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

I. Based upon our criteria and assessment of the peer-reviewed literature, chiropractic care has been medically proven to be effective and, therefore, is considered **medically appropriate** for**:** diagnosis and management of neuromusculoskeletal conditions, within the boundaries set by state licensure, by a licensed Doctor of Chiropractic (DC).

II. Based upon our criteria and assessment of the peer-reviewed literature, chiropractic care has been medically proven to be effective and, therefore, is considered **medically appropriate** when **ALL** of the following criteria are met:
   A. There is documented history, examination, and diagnosis of a neuromusculoskeletal condition; and
   B. There is a reasonable expectation of recovery or improvement in function; and
   C. Treatment is provided in accordance with standards of generally accepted chiropractic practice; and
   D. The diagnostic procedures and therapeutic interventions are clearly related to the patient's symptoms/condition being treated; and
   E. Individualized treatment plans incorporate objective measures of patient-based outcomes.

III. Maintenance care begins when the therapeutic goals of a treatment plan have been achieved or when no additional functional progress is apparent or expected to occur. Maintenance care is considered **not medically necessary**.

IV. Based on our criteria and assessment of the peer-reviewed literature, chiropractic care has not been medically proven to be effective and, therefore, is considered **not medically necessary** as a treatment intervention to restore spinal curves or in treatment of idiopathic scoliosis in an asymptomatic patient.

V. Based on our criteria and assessment of the peer-reviewed literature, routine or repeat x-ray use to assess the function or structure of the spine has not been medically proven to be effective and, therefore, is considered **not medically necessary** in the absence of red flags or clinical reasons to suspect serious underlying pathology.

VI. Based upon our criteria and assessment of the peer-reviewed literature, chiropractic care has not been medically proven to be effective and, therefore, is considered **investigational** when it is rendered for non-neuromusculoskeletal conditions (e.g., infantile colic, childhood asthma, hypertension, primary dysmenorrhea).

Refer to Corporate Medical Policy #7.01.76 Spinal Manipulation under Anesthesia

Refer to Corporate Medical Policy #8.01.12 Physical Therapy (PT)

POLICY GUIDELINES

I. Coverage of chiropractic care is limited to medically necessary services provided by a licensed DC, within the scope of their license, in connection with the detection or correction of spinal misalignment or mechanical/myofascial extremity pain.

II. Contraindications include, but are not limited to, recent compression fracture, severe osteoporosis, inflammatory arthropathy in the active systemic stage, or locally if acute inflammation is present, infections, cauda equina syndrome, progressive or sudden neurological deficit and visceral disease.

III. All chiropractic care is subject to retrospective utilization review for determining medical necessity. Coverage for services determined to be not medically necessary will be denied.

IV. Examples of red flags, which may indicate the possibility of a more serious underlying condition, include back pain and/or back pain with radiculopathy in one or more of the following settings:
   A. history of cancer,
   B. unexplained weight loss,
   C. immunosuppression,
   D. urinary infection,
   E. intravenous drug use,
   F. prolonged use of corticosteroids,
   G. back pain not improved with conservative management,
   H. history of significant trauma,
   I. minor fall or heavy lift in a potentially osteoporotic or elderly individual,
   J. prolonged use of steroids,
   K. acute onset of urinary retention or overflow incontinence,
   L. loss of anal sphincter tone or fecal incontinence,
   M. saddle anesthesia, or
   N. global or progressive motor weakness in the lower limbs.

DESCRIPTION

Chiropractic is a health care profession that focuses on disorders of the musculoskeletal system (primarily the spine) and the nervous system, and their effects on general health. Chiropractic services are used to treat neuromusculoskeletal complaints, including, but not limited to, back pain, neck pain, pain in the joints of the arms or legs, and headaches. DCs, often referred to as chiropractors, practice a hands-on, drug-free approach to health care that includes patient examination, diagnosis, and treatment. Chiropractors have broad diagnostic skills and are trained to recommend therapeutic and rehabilitative exercises, as well as to provide nutritional, dietary, and lifestyle counseling.

One of the most common and well-known therapeutic procedures performed by DCs is spinal manipulation (sometimes referred to as a "chiropractic adjustment"). The purpose of spinal manipulation is to restore joint mobility by manually applying a controlled force into joints that have become hypomobile – or restricted in their movement – as a result of a tissue injury or restriction. Manipulation, or adjustment, of the affected joint and tissues, restores mobility, potentially alleviating pain and muscle tightness, and restoring function.

New York State law requires that contracts providing physician services, medical, major medical, or similar comprehensive-type coverage, shall include coverage for chiropractic care. Chiropractic care in New York State is defined as detecting and correcting structural imbalance, distortion, or subluxations in the human body through manual or

mechanic means, for the purpose of removing nerve interference effects related to distortion, misalignment, or subluxation of or in the vertebral column.

RATIONALE

Chiropractic care has been utilized for the treatment of idiopathic scoliosis, however scientific evidence is limited, and the efficacy of manual therapy for correcting the scoliotic curve or progression of the curve has not been established in the peer-reviewed published scientific literature. Chiropractic manipulation may be used to improve joint mobility and relieve pain associated with scoliosis.

Plain film radiographs should not be used as a screening procedure without clinical indications. The decision for radiographic re-examination should be based on patient symptoms, physical findings, and the potential impact of the results of the examination on the treatment plan and on the net health outcome for the patient. A literature review performed by Corso et al. (2020) did not identify any relevant studies that investigated the diagnostic or therapeutic utility of cervical, thoracic or lumbar radiographs (in the absence of red flags) for the functional or structural evaluation of the spine. Similarly, Jenkins et al. (2018) found limited evidence to support routine spinal x-rays and strong evidence to support potential harms associated with routine spinal x-rays. Without indicators of serious pathology, the increase in information available from x-ray adds little additional benefit to patient health, and may unnecessarily increase patient concern, increase the risk of developing chronic pain, contribute to fear-avoidance behaviors, and contribute to low-value care.

The long-term safety and effectiveness of the use of chiropractic management and manual therapies in the treatment of non-neuromusculoskeletal conditions, including but not limited to hypertension, asthma, colic and otitis media have not been proven in the medical literature through quality research, such as long-term, randomized, controlled clinical trials. A systematic review was conducted during a Global Summit in September 2019 to evaluate the medical literature on the use of spinal manipulative therapy (SMT) to manage non-musculoskeletal disorders (Côté et al., 2021). Based on six randomized controlled trials, SMT was found to not be superior to sham interventions for the treatment of non-musculoskeletal disorders. The researchers concluded there is no evidence of an effect of SMT for the management of non-musculoskeletal disorders including infantile colic, childhood asthma, hypertension, and primary dysmenorrhea.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).*

Modifiers

Code	Description
AT	Acute or active treatment (this modifier should be used when reporting service 98940, 98941, 98942)

CPT Codes

Code	Description
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 Codes

Code	Description
S8990 **(NMN)**	Physical or manipulative therapy performed for maintenance rather than restoration

ICD10 Codes

Code	Description
Numerous	

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*Key Article

KEY WORDS

Chiropractic Care

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is a Local Coverage Article (LCA) for Chiropractic Services (A57889) effective 1/1/20 that can be found at: https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=57889&ver=3&DocID=A57889&SearchType=Advanced&bc=EAAAAAgAAAAA& accessed 08/09/23.