Clinical Policy: Chiropractic Services

Reference Number: DE.CP.MP.01
Date of Last Revision: 12/23/2023

Coding Implications
Revision Log

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

Description

Chiropractic services are furnished in accordance with 42 CFR 440.60(b) and include only services that are provided by a chiropractor who is licensed by the State and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform. This policy describes the medical necessity guidelines for chiropractic services.

Policy/Criteria

I. It is the policy of Delaware First Health that chiropractic services are **medically necessary** for the following indications:

A. The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative and allowable adjunctive therapy services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery, improvement of function, or preventing deterioration of a chronic condition. The patient must have a spinal or extraspinal condition as demonstrated by x-ray or physical examination.

1. Acute pain and/or dysfunction – A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical examination. The result of chiropractic manipulation and allowable adjunctive therapy is expected to be an improvement in, or arrest of progression, of the patient's condition.
2. Chronic pain and/or dysfunction – 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 or prevent deterioration of a chronic condition.
3. The necessity for care may be demonstrated by x-ray or physician's examination.
   a. X-ray may be used to diagnose spinal or extraspinal conditions. If x-ray is used for this purpose, it must have been taken reasonably close to (within 12 months prior or 3 months following) the beginning of treatment. In certain cases of a chronic condition (e.g., osteoarthritis), an older x-ray may be accepted if the beneficiary'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. A previous CT scan and/or MRI are acceptable evidence if a chronic condition of the spine or an extraspinal region is demonstrated. X-rays that support medical necessity and rule out pathology; the chiropractor may perform the x-rays in his or her office or refer patients for x-rays, MRI, CT scans and/or other allowed diagnostic tests per 24 Del Admin. Code Ch. 700 to a participating facility. X-rays may also be used for routine monitoring.
   b. Physical exam to document spinal or extraspinal dysfunction, pain, or to determine progress; evaluation must be demonstrated by meeting two of the following four criteria, one of which must be asymmetry/misalignment identified

on a sectional or segmental level below: • Pain/tenderness evaluated in terms of location, quality and intensity; • Asymmetry/misalignment identified on a sectional or segmental level; • Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility); • Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

II. It is the policy of Delaware First Health that the following items/services are **not medically necessary**.

A. Vitamins
B. Minerals
C. Supplements
D. Chiropractic maintenance therapy is not considered to be medically necessary and is not covered when provided to Medicaid recipients who do not suffer from chronic pain and/or dysfunction and continued therapy can be expected to result in some functional improvement or prevent deterioration of a chronic condition.
E. Any services outside of scope of state licensure.
F. Room and Ward fees are not covered.
G. Hand-held and other devices used for manipulation/adjustment are eligible for reimbursement, but there is no additional reimbursement amount that can be charged beyond the chiropractic manipulative therapy reimbursed amount published in the current DMMA Fee Schedule.

III. Prior Authorization is required for all chiropractic services as follows.

A. Prior authorization is required for members aged 0-12 and additionally require an order from the primary care provider.
B. No prior authorization is required for members aged thirteen (13) and over for the first twenty-four (24) qualifying visits within a calendar year.
C. Requests should be submitted along with supporting treatment plan. A clear and appropriate treatment plan must document all of the following:
    1. the symptoms or diagnosis treated;
    2. diagnostic procedures and treatment modalities used;
    3. results of diagnostic procedures and treatments; and
    4. anticipated length of treatments.
D. Providers will only be reimbursed for one qualifying visit per day. A qualifying visit is defined as a spinal manipulation, extraspinal manipulation, or adjunctive procedure, or any combination of the three. Evaluation and Management procedures and X-ray are not considered a qualifying visit.

Background

Chiropractic services are furnished in accordance with 42 CFR 440.60(b) and include only services that are provided by a chiropractor who is licensed by the State, and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

Manipulation and allowable adjunctive therapy per 24 Del Admin. Code Ch. 700 associated with the treatment of misaligned, fixated, or displaced vertebrae, including subluxation complex and other extraspinal (head, upper and lower extremities, rib cage, and abdomen) neuromusculoskeletal and soft tissue structures limited to one visit per member per day.

Manipulation and adjunctive therapy for Chronic Pain Management. Chiropractic Chronic Pain Management means continuous, interval-based long-term treatment that is necessary for patients with chronic pain and/or disease. This care includes but is not limited to treatment for patients who must resume care, notwithstanding having been discharged from chiropractic care as cured for any particular ailment, because that person's body is unable to sustain those results due to treatment withdrawal.

One office visit for the evaluation and management of services must be completed for each new patient. Additionally, evaluation and management services to document medical necessity and/or to determine progress or exacerbation may be performed on the same day as treatment and is considered a separate and distinct service.

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 2020, 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.

CPT® Codes	Description
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions.
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions.
98942	Chiropractic manipulative treatment (CMT); spinal, five regions.
98943	Extraspinal - one or more regions.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		

References

1. Centers for Medicare and Medicaid Services. Medicare Coverage Database. Billing and Coding: Chiropractic Services. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56273. Accessed December 3, 2023.

2. Delaware Health and Social Services Division of Medicaid & Medical Assistance. (2020). DMMA Practitioner Provider Specific Policy Manual. Sections 13.0-13.3.
3. 24 Del Admin. Code Ch 700 Board of Chiropractic.

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.

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.