



Kansas City

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Manipulations and Chiropractic Care

Policy Number: 2.01.500
Origination: 9/2004

Last Review: 9/2014
Next Review: 9/2015

Policy

Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for manipulations and chiropractic care when it is determined to be medically necessary because the criteria shown below are met.

When Policy Topic is covered

Note: Verify "Chiropractic Services" benefits and "Exclusions and Limitations" prior to review of Medical Necessity.

Chiropractic manipulation may be **medically necessary** for:

LOW BACK PAIN when indicated for ANY ONE of the following:

- Episode of acute or subacute, (ie, <12 weeks), low back pain and **ALL** of the following:
 - Persists despite home exercises from the inception of the current episode
 - Significantly affects ability to perform job or activities of daily living
- Chronic back pain and ALL of the following:
 - Involves a flare-up of a previously stable condition
 - Persists despite home exercises from the inception of the current episode
 - Significantly affects ability to perform job or activities of daily living

Begin with 2 to 6 weeks of therapy, generally at 2 visits per week.

NECK PAIN which has failed to respond to ALL of the following:

- Persists despite home exercises from the inception of the current episode, AND
- Significantly affects ability to perform job or activities of daily living

Begin with 2 to 6 weeks of therapy, generally at 2 visits per week.

MIGRAINE HEADACHES when ANY ONE of the following is present:

- Unresponsive to medication management
- Intolerant of medication management
- Rapid return of headache episodes after medication withdrawal

Begin with 6 to 8 weeks of therapy, generally at 2 to 3 visits per week, if patient responsive after 2 weeks

CERVICOGENIC HEADACHE when ALL of the following are present:

- Cervicogenic headache as defined by ALL of the following:
 - Unilateral or unilateral-dominant headache
 - Associated with neck pain
 - Headache aggravated by changing posture or position
- Symptoms have failed to respond despite home exercises from the inception of the current episode.

Begin with 8 to 12 sessions of therapy

Refer to [The Chiropractic Standard Treatment Guideline](#) at the end of this policy as a guide to coverage decisions. It is not intended to influence treatment decisions.

When Policy Topic is not covered

Chiropractic manipulation is considered **investigational** for the following indications, including but not limited to:

- Fibromyalgia
- Tension Headache
- Maintenance or preventive chiropractic therapy (efficacy remains unproven)
- Otitis Media
- Asthma
- Colic

Note: Massage is a contract exclusion on most benefit plans.

Considerations

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. An additional new patient Evaluation and Management service may be reported separately using the modifier '-25' for a new patient when a manipulation/adjustment occurs at the same visit. This may be reported only when the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and post service work associated with the procedure.

An established E/M service may be reported using the modifier '-25' on the same day as a manipulation when the patient presents with a different diagnosis which requires a significant separately identifiable E/M service. Records may be requested to substantiate the E/M '-25' modified code.

The following modalities when billed on the same date will not be paid separately. Both procedures will be combined and the procedure code which provides the greatest amount of reimbursement will be allowed:

- Two thermal producing modalities (i.e., hot packs and ultrasound, diathermy and hot pack, etc.)
- Contrast therapies (i.e., cold packs and ultrasound, cold packs and diathermy)
- Manual therapy techniques (i.e., CPT 97140) when performed in the same region(s) as spinal manipulation

The following applies to manual therapy techniques when performed in regions other than those regions manipulated:

- The 59 modifier may be appropriate to append to code 97140 if the documentation supports its use
- The CPT code 97140 for manual therapy techniques is a timed code and therefore the documentation must include time
- Code 97140-59 will be limited to one unit per date of service

Description of Procedure or Service

The "practice of chiropractic" is defined as the science and art of examination, diagnosis, adjustment, manipulation and treatment of malpositioned articulations and structures of the body, both in inpatient and outpatient settings. The adjustment, manipulation, or treatment shall be directed toward restoring and maintaining the normal neuromuscular and musculoskeletal function and health. It shall not include the use of operative surgery, obstetrics, osteopathy, podiatry, nor the administration or prescribing of any drug or medicine nor the practice of medicine.

Rationale

There is good evidence for the short-term efficacy of manipulation for acute and subacute low back pain.(1, 2, 3, 4, 5)

Although not proven in a clinical study, some patients may either return to work sooner or not lose any work time with a quicker referral for care. Consideration should therefore be taken for patients who are missing work due to an episode of low back pain.

Chronic low back pain is generally defined as pain present >12 weeks. RCTs have been performed comparing care to placebo as well as to other conservative therapies. Most of the trials evaluated short-term therapy taking place over a matter of weeks. Outcomes were also generally measured after 4 to 8 weeks, although a few trials measured clinical outcomes for up to 1 year. Virtually all reviews believe there is good evidence to support the short-term efficacy of manipulation for chronic low back pain when compared to placebo, but the evidence for long-term benefit is inconclusive. Some trials have also found benefit for care when compared to other types of conservative or usual care.(1, 2, 5, 6, 7)

Maintenance or preventive therapy has not been studied in any valid way and there is currently no evidence demonstrating efficacy or utility for maintenance therapy. (1)

Occasionally, excessive resource utilization by a patient with chronic back pain can be reduced by monthly or osteopathic visits, particularly when used as an alternative to spine surgery or ongoing frequent office visits and polypharmacy. Only one small randomized controlled trial involving 21 patients exists in the literature. An active treatment group was compared with a waiting list group over 4 weeks. No statistically significant difference between the 2 groups was achieved. Flexion, extension, pain scale, tender points, group strength, and several other parameters were evaluated. There was some statistically significant improvement in the treatment group when status before and after 4-week treatment was evaluated. (8, 9)

When compared with physical therapy or acupuncture, manipulation may provide some short-term benefit. In a systematic review in 1996, 1 out of 2 trials evaluating manual therapy, ie, manipulation, mobilization, or massage, alone, found benefit. In 7 trials involving manual therapy combined with other therapies, a pooling of the trials found approximately 16% improvement for manual therapy. Another trial compared manual therapy with physiotherapy and found them to be equally efficacious. One other trial compared acupuncture, nonsteroidal anti-inflammatories, and spinal manipulation for patients with neck pain present for >13 weeks. Patients were treated for 4 weeks. Only spinal manipulation was able to obtain a statistically significant improvement when compared to baseline. Long-term outcomes are generally unavailable. (10, 11, 12, 13, 14)

Occasionally, excessive resource utilization by a patient with chronic neck pain can be reduced by monthly or osteopathic visits, particularly when used as an alternative to ongoing frequent office visits and polypharmacy. Over 200 patients were evaluated in an RCT which compared spinal manipulation alone, amitriptyline alone, and the combination of the two. Patients were treated for 8 weeks and final follow-up was 4 weeks after completion of treatment. Headache symptoms index for patients was modestly improved for all 3 groups but there was no statistical difference between the 3 groups at any point. No placebo controlled trials or comparison with triptans were found. No other studies with longer term outcomes are reported. (15) A randomized controlled trial of 200 patients divided patients into four groups: manipulative therapy, exercise therapy, combined therapy, and a control group, who received no intervention. Both exercise therapy and manipulation significantly improved patients symptoms after 8 to 12 sessions. Symptoms were still significantly better than the control group at twelve month follow-up. (16, 17)

3 RCTs for tension type headaches are reported in the literature. The first trial compared short-term spinal manipulation with low level laser therapy and friction massage for 3 weeks. The manipulation groups experience a statistically significant improvement comparing pretreatment to posttreatment, but the differences between the 2 groups did not reach statistical significance. (18) Another trial compared spinal manipulation with amitriptyline therapy. Although amitriptyline was felt to be slightly more effective in reducing pain it was associated with more side effects. 4 weeks after discontinuation, patients receiving spinal manipulative therapy experienced more sustained benefit than the group receiving amitriptyline. (19) Another trial compared soft tissue treatment alone, considered the control

treatment, with soft tissue treatment combined with chiropractic manipulation for patients with tension headaches. No statistically significant differences between the groups were found for the 3 outcome measures. Although there was a trend towards improvement within the groups, the differences were not statistically significant. (20) 2 recent systematic reviews draw a conclusion that the lack of moderate or high-quality, placebo-controlled trials with long-term follow-up prevents a determination of efficacy for manipulative therapy for tension headaches. (21, 22) Occasionally, excessive resource utilization by a patient with headaches can be reduced by monthly chiropractic or osteopathic visits, particularly when used as an alternative to ongoing frequent office visits and polypharmacy or whether prevents significant work loss. Likewise, patient with headache initiated by neck pain may benefit from care.

Manipulation in lieu of antibiotics for treatment of suppurative otitis media has not been proven by adequate scientific studies, published in peer-reviewed scientific journals. Manipulative procedures are not proven to be an effective substitute for childhood immunizations or for the treatment of infectious diseases, and are not covered for these indications. (23, 24)

From 473 unique citations, 68 full text articles were retrieved and evaluated, which resulted in nine citations to three RCTs (156 patients) suitable for inclusion. Trials could not be pooled statistically because studies that addressed similar interventions used disparate patient groups or outcomes. The methodological quality of one of two trials examining chiropractic manipulation was good and neither trial found significant differences between chiropractic spinal manipulation and a sham maneuver on any of the outcomes measured. One small trial compared massage therapy with a relaxation control group and found significant differences in many of the lung function measures obtained. However, this trial had poor reporting characteristics and the data have yet to be confirmed. There is insufficient evidence to support the use of manual therapies for patients with asthma. There is a need to conduct adequately-sized RCTs that examine the effects of manual therapies on clinically relevant outcomes. Future trials should maintain observer blinding for outcome assessments, and report on the costs of care and adverse events. Currently, there is insufficient evidence to support or refute the use of manual therapy for patients with asthma. (25)

Twenty-one rheumatology patients (25-70 yr) were provided treatment consisting of 4 weeks of spinal manipulation, soft tissue therapy and passive stretching at the chiropractors' discretion. Chiropractic management withheld for 4 weeks with continuation of prescribed medication. Changes in scores on the Oswestry Pain Disability Index, Neck Disability Index, Visual Analogue Scale, straight leg raise and lumbar and cervical ranges of motion were observed. Results indicated that chiropractic management improved patients' cervical and lumbar ranges of motion, straight leg raise and reported pain levels. These changes were judged to be clinically important within the confines of the sample only. Further study with a sample size of 81 (for 80% power at $\alpha < \text{or} = .05$) is recommended to determine if these findings are generalizable to the target population of fibromyalgia sufferers. (26)

The study design was a systematic review of randomized clinical trials (RCTs). The objectives of the present study were to assess the effectiveness of physiotherapy and (spinal) manipulation in patients with tension-type headache (TTH). No systematic review exists concerning the effectiveness of physiotherapy and (spinal) manipulation primarily focusing on TTH. Literature was searched using a computerized search of MEDLINE, EMBASE and the Cochrane library. Only RCTs including physiotherapy and/or (spinal) manipulation used in the treatment of TTH in adults were selected. Two reviewers independently assessed the methodological quality of the RCTs using the Delphi-list. A study was considered of high quality if it satisfied at least six points on the methodological quality list. Twelve publications met the inclusion criteria, including three dual or overlapping publications resulting in eight studies included. These studies showed a large variety of interventions, such as chiropractic spinal manipulation, connective tissue manipulation or physiotherapy. Only two studies were considered to be of high quality, but showed inconsistent results. Because of clinical heterogeneity and poor methodological quality in many studies, it appeared to be not possible to draw valid conclusions. Therefore, the conclusion is that there is insufficient evidence to either support or refute the effectiveness of physiotherapy and (spinal) manipulation in patients with TTH. (27)

To investigate the efficacy of chiropractic spinal manipulation in the management of infantile colic, one hundred infants with typical colicky pain were recruited to a randomized, blinded, placebo controlled clinical trial. Nine infants were excluded because inclusion criteria were not met, and five dropped out, leaving 86 who completed the study. There was no significant effect of chiropractic spinal manipulation. Thirty two of 46 infants in the treatment group (69.9%), and 24 of 40 in the control group (60.0%), showed some degree of improvement. CONCLUSION: Chiropractic spinal manipulation is no more effective than placebo in the treatment of infantile colic. This study emphasizes the need for placebo controlled and blinded studies when investigating alternative methods to treat unpredictable conditions such as infantile colic. (28)

To document the potential role of maintenance chiropractic spinal manipulation to reduce overall pain and disability levels associated with chronic low-back conditions after an initial phase of intensive chiropractic treatments, thirty patients with chronic nonspecific low-back pain were separated into 2 groups. The first group received 12 treatments in an intensive 1-month period but received no treatment in a subsequent 9-month period. For this group, a 4-week period preceding the initial phase of treatment was used as a control period to examine the sole effect of time on pain and disability levels. The second group received 12 treatments in an intensive 1-month period and also received maintenance spinal manipulation every 3 weeks for a 9-month follow-up period. Pain and disability levels were evaluated with a visual analog scale and a modified Oswestry questionnaire, respectively. The 1-month control period did not modify the pain and disability levels. For both groups, the pain and disability levels decreased after the intensive phase of treatments. Both groups maintained their pain scores at levels similar to the postintensive treatments throughout the follow-up period. For the disability scores, however, only the group that was given spinal manipulations during the follow-up period maintained their postintensive treatment scores. The disability scores of the other group went back to their pretreatment levels. This experiment suggests that maintenance spinal manipulations after intensive manipulative care may be beneficial to patients to maintain subjective postintensive treatment disability levels. Future studies, however, are needed to confirm the finding in a larger group of patients with chronic low-back pain. (29)

In a separate report, a 26-year-old female patient presenting with uncomplicated chronic low back pain who received chiropractic maintenance care was studied using 2 quality of life outcome assessment instruments. Outcome measures included Short-form (SF-36) subscales, Quality of Well-Being Scale, Visual Analog Scale, and number of tender vertebral spinous processes. After 9 months of care the SF-36 subscale scores showed improvement. The SF-36, although low before care, approached normal on 3 subscales and exceeded normal population values on 5 subscales after 9 months. The SF-36 physical and mental composite scores improved from mean baseline scores of 23.4 and 25.3 to 43.7 and 62.8, respectively, after 9 months of care. The Quality of Well-Being Scale scores improved from a mean pre-intervention score of 1.1 to a post-intervention score of 8.2. The Visual Analog Scale scores improved from a mean pre-intervention score of 8 to a post-intervention score of 1.5. The mean number of chiropractic vertebral subluxations, detected via palpation of spinous process tenderness, went from a pre-care mean of 6.5 to a post-care mean of 4. To conclude, the patient appeared to experience improvement in quality of life while showing signs suggestive of improved spinal function. The relationship between indicators of vertebral subluxation and quality of life deserves further investigation using a research design that allows for exploration of possible causal relationships. (30)

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Billing Coding/Physician Documentation Information

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	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions
98925	Osteopathic manipulative treatment (OMT); one to two body regions involved
98926	Osteopathic manipulative treatment (OMT); three to four body regions involved
98927	Osteopathic manipulative treatment (OMT); five to six body regions involved
98928	Osteopathic manipulative treatment (OMT); seven to eight body regions involved
98929	Osteopathic manipulative treatment (OMT); nine to ten body regions involved

Additional Policy Key Words

N/A

Policy Implementation/Update Information

9/1/04	New policy added to the Therapy section.
2/1/05	Changes made to the description section of the policy. No policy statement changes.
9/1/05	No policy statement changes.
9/1/06	No policy statement changes.
9/1/07	No policy statement changes.
10/1/08	The policy statement was revised to clarify benefit language regarding massage. The Billing Coding section was revised to clarify reimbursement policy.
9/1/09	No policy statement changes.
9/1/10	No policy statement changes.
9/1/11	No policy statement changes.
9/1/12	No policy statement changes.
9/1/13	No policy statement changes.
9/1/14	No policy statement changes.

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Chiropractic Standard Treatment Guideline

The Chiropractic Standard Treatment Guideline is a guide to coverage decisions and is not intended to influence treatment decisions. When using this guideline to determine whether a service is covered, please note that member contract language will take precedence over medical policy when there is a conflict.

In order to apply treatment guidelines to specific diagnoses, the severity of the patient's condition (Table A) must be assessed and documented in the Medical Record.

Once the severity of **each component** has been determined, the clinician should use the **overall severity** to determine the number of visits or weeks of treatment recommended in Standard Treatment Durations for Chiropractic Care (Table B).

Table A - Severity Grading for Chiropractic Conditions

Factor	Mild (1)	Moderate (2)	Severe (3)
Pain/discomfort intensity by visual analog scale (VAS) 0 = no pain 10 = most severe pain ever	1 - 3	4 - 7	8 - 10
Activities of daily living (ADL) limitations	Annoying to some limitations	Significant limitations (specify)	Precludes ADLs
Co-morbidities impeding patient recovery	Not a factor	Somewhat a factor	Significant factor
Overall severity (taking into consideration the above three factors)	Mild (1)	Moderate (2)	Severe (3)

Table B - Standard Treatment Durations for Chiropractic Care

Standard Treatment Durations for Chiropractic Care is not all inclusive. For any diagnosis not listed, care plans may be reviewed on an individual consideration basis.

Primary ICD-9	Description	Severity	Weeks	Visits
847.0	Cervical Strain / Sprain	1	4	8
		2	6	14
		3	8	20
739.1	Cervical Segmental Dysfunction	1	4	8
		2	6	12
		3	8	16
722.0	Cervical Intervertebral Disc Syndrome	1	6	12
		2	10	20
		3	12	24
723.2	Cervico-cranial Syndrome	1	4	10
		2	6	14
		3	8	16

723.3	Cervico-brachial Syndrome	1	5	10
		2	7	14
		3	9	18
723.4	Brachial Radiculitis / Neuritis	1	5	10
		2	7	14
		3	9	18
847.1	Thoracic Strain / Sprain	1	4	8
		2	6	12
		3	6	14
739.2	Thoracic Segmental Dysfunction	1	2	5
		2	5	10
		3	8	18
722.11	Thoracic Intervertebral Disc Syndrome	1	4	10
		2	6	16
		3	8	20
729.2 / 353.8	Intercostal Neuralgia/Neuritis	1	4	10
		2	5	12
		3	7	17
739.8	Costo-vertebral Dysfunction	1	2	5
		2	5	10
		3	8	18
353.0	Thoracic Outlet Syndrome	1	2	5
		2	5	12
		3	8	18
847.2	Lumbar Strain/Sprain	1	4	8
		2	6	14
		3	6	16
846.0	Lumbosacral Strain / Sprain	1	4	8
		2	6	14
		3	6	16
846.9	Sacroiliac Strain / Sprain	1	4	8
		2	6	14
		3	6	16
739.3	Lumbar Segmental Dysfunction	1	2	5
		2	5	10
		3	8	20
739.4	Sacroiliac Segmental Dysfunction	1	2	5
		2	5	10
		3	8	20
724.8	Lumbar Facet Syndrome	1	2	5
		2	6	14
		3	8	20

724.3	Sciatic Neuralgia	1	4	10
		2	6	14
		3	8	20
722.10	Lumbar Intervertebral Disc Syndrome	1	4	14
		2	8	20
		3	10	24