BlueCross BlueShield of Vermont
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Corporate Medical Policy
Chiropractic Services

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Document Precedence

BCBSVT Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract language, the member's contract language takes precedence.

Description

"The practice of chiropractic" means the diagnosis of human ailments and diseases related to subluxations, joint dysfunctions, neuromuscular and skeletal disorders for the purpose of their detection, correction or referral in order to restore and maintain health, including pain relief, without providing drugs or performing surgery; the use of physical and clinical examinations, conventional radiologic procedures and interpretation, as well as the use of diagnostic imaging read and interpreted by a person so licensed, and clinical laboratory procedures to determine the propriety of a regimen of chiropractic care; adjunctive therapies approved by the board, by rule, to be used in conjunction with chiropractic treatment; and treatment by adjustment or manipulation of the spine or other joints and connected neuromusculoskeletal tissues and bodily articulations. 26 V.S.A. § 521(3).

Policy

Subject to applicable certificates of coverage, BCBSVT provides benefits for medically necessary chiropractic services, including supportive care, for neuromusculoskeletal conditions as more fully described in this policy. BCBSVT or its designee will determine whether a health care service is medically necessary for the member. BCBSVT determinations of medical necessity shall be based on clinical information that is supported by contemporaneous clinical

records and that is available before or during the time of service. The fact that any group or provider has furnished, prescribed, ordered or recommended a treatment does not of itself make the treatment a medically necessary covered benefit. Inclusion of a service on the fee schedule shall not be considered a determination that the service is medically necessary in all circumstances. Inclusion of a service within the scope of practice of a licensee does not in itself make the service a medically necessary covered benefit.

When service or procedure is covered

We cover medically necessary Chiropractic Care, including:

- Office visits, spinal and extraspinal manipulations and associated modalities;
- Home, hospital, or nursing home visits; or
- Diagnostic services (e.g., X-rays and laboratory)

The Plan covers care by Chiropractors who are:

- Network providers and/or participate with the Plan;
- working within the scope of their licenses; and
- treating members for a neuromusculoskeletal condition.

Medical Necessity

"Medically necessary care" means health care services, including diagnostic testing, preventive services and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the member's diagnosis or condition. Medically necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professionals in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and

1. help restore or maintain the member's health; or
2. prevent deterioration of or palliate the member's condition; or
3. prevent the reasonably likely onset of a health problem or detect an incipient problem.

In order to be considered medically necessary, treatment must meet all of the following criteria:

- Informed by generally accepted medical or scientific evidence
- Consistent with standards of the practitioner's own professional community

- Appropriate in terms of type, amount, frequency, level, intensity, setting and duration for the symptoms, findings and condition of the member
- Scheduled, modified and discontinued appropriately based on the patient's response to treatment
- Expected and/or demonstrated to produce a therapeutic benefit of measureable improvement in the member's net health outcome as evidenced by a clinically significant decrease in symptoms and/or a clinically significant increase in function
    - Note: During a course of treatment, when the patient's symptoms and functional status become stable without additional objectively measured clinical improvement and without reasonable clinical expectation of additional objectively measurable clinical improvement in net health outcome, the patient is considered to have reached a clinical plateau known as maximal medical improvement. Services beyond the point of maximal medical improvement are not considered medically necessary.
    - Note: For relapsing and recurring conditions that have achieved a stable level of symptoms and function, demonstration of clinically significant measurable deterioration of symptoms and/or functional status when ongoing treatment is withdrawn may be considered evidence of medical necessity for resumption of treatment. See definition of supportive care.

Chiropractic manipulation for persons without an identifiable clinical condition, functional limitation or symptom, is not considered medically necessary.

<u>Physical Exam as a Basis for Medical Necessity</u>

1. To be considered medically necessary, treatment based on findings during physical examination must be based on a finding of asymmetry or misalignment identified on a sectional or segmental level and at least two more of the following and must be clearly documented:
    - Pain/tenderness evaluated in terms of location, quality, and intensity.
    - Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease in sectional or segmental mobility).

- Tissue and/or tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.

2. Most spinal joint problems fall into the following categories:

ACUTE CARE:

- Acute care is considered treatment of an illness, injury, or condition, marked by a sudden onset or abrupt change of the member's health status that requires prompt medical attention. Acute care may range from outpatient evaluation and treatment to intensive inpatient care. Acute care is intended to produce measurable improvement or maximum rehabilitative potential within a reasonable and medically predictable period of time, or that is moving the member toward a less restrictive setting. Acute services means services which, according to generally accepted professional standards, are expected to provide or sustain significant, measurable clinical improvement within a reasonable and medically predictable period of time.
- A patient's condition is considered to be acute when the patient is being treated for a new injury, or new exacerbation. The result of chiropractic treatment is expected to be an improvement in, or arrest of progression of the patient's condition. This result should be obtained within a reasonable and generally predictable period of time.

CHRONIC CARE:

- A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment.

SUPPORTIVE CARE:

- Supportive care is defined as services provided for a known relapsing or recurring condition to prevent an exacerbation of symptoms that would require additional services to restore an individual to his or her usual state of health or to prevent progressive deterioration. Documentation in the medical record must demonstrate that previously when the member reached therapeutic goals he/she could not sustain this improvement and progressively deteriorated when treatment was withdrawn. This pattern must be clearly documented in the medical record with specific notation made as to the required treatment interval.

Medical Necessity of Dynamic Thrust

Dynamic thrust provided for a patient who has a relative contraindication for the service is not considered medically necessary when a risk discussion appropriate for informed consent is not documented. The following are relative contraindications to Dynamic thrust:

- 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.

Dynamic thrust is absolutely contraindicated, and is not considered medically necessary in the following:

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

To be considered medically necessary, treatment based on functional assessment must be based on objectively documented findings of limitations of bodily function and/or functional capabilities. The treatment plan must document the degree to which function is expected to be restored by treatment. Ongoing treatment must be informed by repeated functional assessment to document the extent to which planned recovery in function and capability has been achieved.

Documentation

Chiropractic Records at Initial Assessment and Scheduled Reassessments

Records shall include, at a minimum, documentation of the following, when applicable, consistent with guidance from the American Chiropractic Association (ACA) in the Clinical Documentation Manual:

a) The patient's case history and physical documents contain appropriate subjective and objective information for presenting complaints.
b) Findings of all examinations performed.
c) Findings of special studies, including but not limited to x-ray studies taken or reviewed, and laboratory studies.
d) Explicit notation in the record on follow-up plans regarding consultation advice and abnormal lab and imaging study results.
e) Clinical impression (including rationale for changes in diagnosis).
f) Treatment plan (including rationale for changes in duration or frequency and measurable long and short term goals).
g) Specific description of anatomical site(s) or region(s) of all treatment services.
h) Details and rationale for supportive procedures or therapies.
i) A clear description of the type of adjustment provided, including the body region to which the adjustment was performed, and,
j) A post-manipulation evaluation of the patient's response to the treatment.

The request for additional visits must be accompanied by supporting documentation of medical necessity to include:

- a prescribed treatment program that is expected to result in significant therapeutic improvement over a clearly defined period of time;
- the symptoms being treated;
- diagnostic procedures and results;
- frequency, duration and results of planned treatment modalities; anticipated length of treatment plan with identification of quantifiable, attainable short-term and long-term goals; and
- demonstrated progress toward significant functional gains and/or improved activity tolerances.

All decisions made by a chiropractor regarding the use of supportive physical medicine modalities and procedures should be predicated upon a properly documented clinical rationale, which is consistent with current educational and practice standards. The details of all modalities or procedures provided shall be recorded when performed, including time for all constant attendance modalities and therapeutic procedures. Physical medicine services must be

delivered by a qualified provider of physical medicine services practicing within the scope of practice of the applicable license.

Chiropractic Records at Interval Visits and Therapies Must Document:

a) Unresolved problems from previous office visits are addressed in subsequent visits.
b) Progress notes for each patient encounter in a separate note meeting these standards.
c) The results of treatment, including changes in symptoms and function.
d) Plan for follow-up care if any.

Laboratory Testing

Conservative management of neuromusculoskeletal conditions does not routinely include the use of laboratory testing. Tests that may be considered medically necessary in the treatment of neuromusculoskeletal conditions are listed in the code appendix.

Diagnostic Imaging

To be considered medically necessary, imaging studies must meet the following four standards:

1. The study must be obtained based on clinical need.
2. The study must be of sufficient diagnostic quality.
3. There must be an adequate written report of the study.
4. The information from the study must be correlated with patient management.

The need for frequent diagnostic images for purely biomechanical analysis is not well-supported, nor is the need for routine imaging of patients prior to release from care. 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.

The selection of patients for radiographic examination is based on the following guidelines:

1. The need for radiographic examination is based on history and physical examination findings.
2. The potential diagnostic benefit of the radiographic examination is judged to outweigh the risks of ionizing radiation.

3. Radiography is used to help the practitioner diagnosis pathology, identify contraindications to chiropractic care, identify bone and joint morphology, and acquire postural and biomechanical information.
4. Routine radiography of patient as a screening procedure is not appropriate practice in chiropractic care and is not considered medically necessary.

Patient Selection for Imaging

The selection of patients for radiographic examination is based on the following guidelines:

1. The need for radiographic examination is based on history and physical examination findings.
2. The potential diagnostic benefit of the radiographic examination is judged to outweigh the risks of ionizing radiation.
3. Radiography is used to help the practitioner diagnosis pathology, identify contraindications to chiropractic care, identify bone and joint morphology, and acquire postural and biomechanical information.
4. Routine radiography of patient as a screening procedure is not appropriate practice in chiropractic care and is not considered medically necessary.

When service or procedure may not be covered

Benefit Exclusions: We Provide No Chiropractic Benefits for:

- Services that are not provided in accordance with accepted professional medical standards in the United States.
- Acupuncture, acupressure or massage therapy; hypnotherapy, rolfing, Reiki, homeopathic or naturopathic remedies. Benefits will be provided for Medically Necessary Covered Services when performed within the scope of a naturopathic Physician's license.
- Any other procedure not specifically listed in this policy as a covered chiropractic service.
- Biofeedback or other forms of self-care or self help training.
- Services in excess of the limitations or maximums set forth in our member's Contract.
- Services or medications that we determine are Investigational, mainly for research purposes or Experimental in nature.
- Care for which there is no therapeutic Benefit or likelihood of improvement.

- Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress.
- Care provided but not documented with clear, legible notes indicating patient's symptoms, physical findings, Physician's assessment, and treatment modalities used (billed).
- Cognitive training or retraining and educational programs, including any program designed principally to improve academic performance, reading or writing skills, except for diabetes education.
- Custodial Care.
- Group exercise and physical medicine treatment performed in a group.
- Hypnotherapy.
- Massage therapy.
- Nutritional Supplements.
- Webster Technique for breech babies.
- Chiropractic obstetrical procedures including prenatal and postnatal care.
- Personal service, comfort or convenience items.
- Physical fitness equipment, braces and devices intended primarily for use with sports or physical activities other than Activities of Daily Living (e.g. knee braces for skiing, running or hiking); weight loss or exercise programs; health club or fitness center memberships.
- Pneumatic cervical traction devices
- Prescription or administration of drugs by a chiropractor.
- Support therapies, including pastoral counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy, smoking cessation therapy, stress management, wilderness programs, adventure therapy and bright light therapy.
- Supportive services that include nutritional counseling, educational services and printed materials.
- Supplying/dispensing of medical supplies or durable medical equipment (DME). NOTE: Chiropractors may *prescribe* DME.
- Work hardening programs and work-related illnesses or injuries (or those which you claim to be work-related, until otherwise finally adjudicated), provided such illnesses or injuries are Covered by workers' compensation or should be so Covered. (This provision shall not be deemed to require an individual, such as a sole proprietor or an owner partner, as a condition to obtaining coverage, to obtain workers' compensation if he or she is not under a legal obligation to be so Covered.)
- Services and supplies not specifically described as Covered.
- Surgery.
- Treatment after the 12th visit, unless a Prior Approval Request is approved.

- Treatment solely to establish or re-establish the capability to perform occupational, hobby, sport or leisure activities.
- Treatment of mental health conditions.
- Services by a provider who is not in our network.
- Services, including modalities that do not require the constant attendance of a Chiropractor.
- Treatment of any "visceral condition," that is a dysfunction of the abdominal or thoracic organs, or other condition that is not neuromusculoskeletal in nature.
- Provider exclusion – benefits are not available for treatment of a member of your immediate family or yourself.

Services Considered Not Medically Necessary: We Provide No Chiropractic Services For:

- Care when there is neither regression nor improvement.
- Care provided as an adjunct to training for athletic, recreational, and occupational activities.
- General conditioning program or self-monitored repetitive exercises or exercise equipment to increase strength and endurance.
- Infrared heat, paraffin baths and contrast baths under any circumstances.
- Hot or cold packs.
- Repetitive exercises to improve walking and/or running distance, strength, and endurance assisted services in supporting unstable members.
- Therapy for a condition when the therapeutic goals of a treatment plan have been achieved and no progress is apparent or expected to occur.
- Services or medications we determine are not Medically Necessary.
- Unattended services/modalities:
    - CPT codes 97010 – 97028 (application of a modality that does not require direct one on one patient contact by provider).
- Whirlpool.

Experimental/Investigational Services: We Provide No Chiropractic Benefits For:

- Aqua Massage tables.
- Applied Spinal Biomechanical Engineering.
- Atlas Orthogonal Technique.
- BioEnergetic Synchronization Technique.
- Biogeometric Integration.
- Blair Technique.

- Chiropractic Biophysics Technique, known as Chiropractic Biomechanics of Posture (CPB).
- Coccygeal Meningeal Stress Fixation Technique.
- Computerized radiographic mensuration analysis for assessing spinal mal-alignment.
- Cranial Manipulation.
- Craniosacral Therapy.
- Cryotherapy, cryo spa, whole body cryotherapy.
- Diathermy.
- Digital Postural Analysis.
- Digital Radiographic Measurement.
- Directional Non-force Technique.
- Dry hydrotherapy (i.e., Aquamed, Sidmar).
- Gait analysis.
- Kinesiology Taping.
- Paraspinal Surface Electromyography (SEMG), and Macro Electromyography; Gait analysis is considered investigational.
- Hubbard Tank.
- Infrared.
- Iontophoresis/Phonophoresis.
- Koren Specific Technique.
- Low Level Laser Therapy/Cold Laser.
- Lumbar/Cervical Extension Machines (Med X).
- Manipulation for infant colic.
- Manipulation under Anesthesia.
- Moire Contourographic Analysis.
- Network Technique (Network chiropractic care/ Network Spinal Analysis (NSA))
- Network Spinal Analysis software
- Neural Organizational Technique
- Neuro Emotional Technique
- Neurocalometer/Nervoscope
- Oscillating Platform Therapy (Spineforce)
- Para-Spinal Electomyography (EMG)/Surface Scanning EMG
- Power traction equipment/devices (e.g., VAX-D, DRX 9000, SpineMED, Spina System, Lordex Decompression Unit, DRS System)
- Prolotherapy
- Sacro-Occipital Technique
- SCENAR Therapy
- Sensory Integration Therapy
- Spinal manipulation under anesthesia
- Spinalator Tables

- Spinoscopy
- Thermography
- Therapeutic Magnetic Resonance (TMR)
- Treatment with crystals
- Thermal Massage Bed, Hydro Therapy Massage
- Ultraviolet
- Upledger Technique
- Vasopneumatic devices
- Vertebral axial decompression - (i.e. DRS System, DRX Systems, DTS, VAX-D Table, Alpha Spina System, Accuspina, Lordex Lumbar Spine System, Internal Disc Decompression (IDD)), distraction tables. (S9090)
- Whitcomb Technique
- Whole Body Vibration Therapy, Wobble Chair
- Whole Body Advance Exercise
- Wobble chair

Policy Guidelines

Benefits are subject to all terms, limitations and conditions of the subscriber contract.

Benefits for medically necessary chiropractic services are only available when treatment is provided by a licensed chiropractor who participates contractually in our network. Benefits may be subject to member out of pocket cost, including copayment, coinsurance or deductible amounts. In most states, the scope of chiropractic practice may include services that are not included in covered benefits.

Prior approval is required for the 13th visit forward per plan year.

After 12 visits in a plan year, prior approval is required for additional chiropractic treatment with the same, or a different, chiropractic physician. A request for prior approval must contain clinical information required for determination of medical necessity criteria as specified in this policy. If continued chiropractic care is considered medically necessary, up to 6 additional visits will be allowed, after which prior approval will again be required for additional visits. No more than 6 additional visits will be allowed without a clinical update of a member's status.

Although prior approval is required for chiropractic care that is over the initial 12 visits in a plan year and after completion of additional visits authorized under a chiropractic plan of treatment, an acute episode may occur at a time

when no visits are currently authorized and there is insufficient time to obtain approval prior to treatment. In this setting, one additional visit for medically necessary care may be approved retroactively if the request is made within 3 business days of the visit. This request must specify the date of the additional visit. If further care beyond this visit is medically necessary, approval will be granted up to six visits, including the visit authorized retroactively.

Members may pay, at their own expense, for chiropractic care designed to prepare them for specific occupational, hobbies, sports, and leisure & recreational activities in addition to any other non-covered services such as acupuncture or massage therapy. A self-pay agreement, including details of services and member liability must be entered into prior to rendering these services and must be maintained as part of the medical record. Maintenance/Wellness Care/Therapy should be reported under procedure HCPCS code S8990 (physical or manipulative therapy performed for maintenance rather than restorative).

Physical Medicine Treatments

Physical medicine modalities and therapeutic procedures performed by a chiropractor will be evaluated and subject to the BCBSVT Physical Therapy Medical Policy.

Modality codes 97032 & 97035 are generally considered to be an adjunct to a variety of therapies and when billed by an allopathic, osteopathic, or chiropractic physician, these services do not count against the defined benefit limit for PT, ST, OT combined.

Modality CPT Codes 97032 & 97035 will only count as an individual Chiropractic visit if no other chiropractic services are rendered at the same visit.

Chiropractic Manipulation Therapy (CMT)

Reimbursement is allowed for one clinically indicated and medically necessary spinal manipulation code (CPT 98940-98942) per date of service. Reimbursement of specific CMT codes is subject to the subscriber certificate.

For purposes of CMT, there are five spinal regions: cervical (includes atlanto-occipital joint); thoracic (includes costovertebral and costotransverse joints); lumbar; sacral; pelvic (includes sacroiliac joint).

- CPT 98940 – CMT; spinal, one to two regions.
- CPT 98941 – CMT; spinal, three to four regions.
- CPT 98942 – CMT; spinal, five regions.

- CPT 98943 – CMT; extraspinal, one or more regions: head, including TMJ; lower extremities; upper extremities; rib cage (not including costovertebral and costotransverse joints); abdomen.

NOTE: CPT code 97140 (manual therapy techniques, 1 or more regions, each 15 minutes) cannot be billed when a manipulation is performed in the same spinal or extraspinal area.

The pre-, intra-, and post-service components of a manipulation service include:

- An update of the patient's history regarding any changes positive or negative since the prior visit.
- A review of the chart, prior treatment plan, or diagnostic imaging.
- Performance of an assessment to determine the location and intensity of the patient's symptoms and medical necessity of the manipulation (with or without use of an instrument as the assessment tool)
- Manual palpation that documents pain or tenderness including location, intensity, quality, tissue response of muscles (spasms, hypertonicity, etc.).
- Motion palpation, joint evaluation, or whatever technique is used to locate and evaluate joint dysfunction/fixations.
- The manipulation of the joint(s) identified in the evaluation to restore normal joint motion/mechanics. Proper documentation of each area manipulated also must be noted in each daily note including technique or instrumentation used if not done by hand.
- A post-manipulation evaluation of the patient's response to the treatment should be noted.
- A determination to continue, cease, or minimally alter the treatment plan
- Patient education or instructions.
- Imaging review
- Chart documentation, consultation and reporting

<u>Evaluation and Management (E/M)</u>

Manipulation (98940-98943) includes a pre-manipulation assessment

A separate E/M service should not be routinely reported with manipulation. This means that a separate evaluation and management (E/M) service for a separate condition will only be paid in the following circumstances:

- Initial examination of a new patient or condition;

- Acute exacerbation of symptoms or a significant change in the patient's condition; or
- Distinctly different indications, which are separately identifiable and unrelated to the manipulation

Devices

BCBSVT will not pay separately for the use of instrument-assisted adjustment techniques using external devices. The use of these devices has not been shown to produce incremental benefit for patient outcomes

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy. Benefits are subject to all terms, limitations and conditions of the subscriber contract.

Refer to the member's plan documents or outline of coverage for availability of benefits.

If the member receives benefits through a self-funded group, benefits may vary or not apply. To verify benefit information, please refer to the member's plan documents or contact the customer service department.

For New England Health Plan (NEHP) members an approved referral authorization is required.

Federal Employee Program (FEP) members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Plan Brochure.

Billing and Coding/Physician Documentation Information

Follow the links listed below for attachments, coding tables and instructions.

Attachment I- Chiropractic Covered Service Codes
Attachment 2- Chiropractic Non-Covered Service Codes
Attachment 3- Chiropractic Covered X-Rays
Attachment 4-Eligible Diagnosis Codes

Eligible Providers

Benefits will be provided for care by a chiropractor that is a duly licensed Doctor of Chiropractic, when acting within the scope of his/her license. BCBSVT reimburses only contracted chiropractors, allopathic and osteopathic

providers for chiropractic and manipulative service for the treatment of orthopedic and neuromusculoskeletal conditions in compliance with appropriate statutes and regulations within the scope of the provider's state practice laws and when it is a covered benefit.

Audit Information

BCBSVT may conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT may recoup all non-compliant payments.

Policy Implementation/Update information

02/2003	Reformatted, 01/2002 updated to include new prior approval requirement - visit limit from six to 12 visits, 13th visit forward requires prior approval; codes reviewed 01/2001 & updated.
09/2003	Language added to reflect current certificate language and regulatory requirements.
01/2005	Major revision defining acute, supportive, and maintenance care; eliminating chronic care as a specific exclusion; and adding criteria for medical necessity for acute and supportive care and therapeutic trials for problems of long standing duration. Included provisions for members to pay for chiropractic care for non-covered conditions.
10/2005	Minor word additions, additional diagnosis codes added based on input from VCA.
10/2006	Reviewed by VCA panel. LLLT and VAD and Work Hardening added as not covered/investigational. CPT codes updated.
10/2007	Updated to include current certificate language. Reviewed by the CAC
01/2008	Reviewed by the Vermont Chiropractic Insurance Panel.
10/2008	Updated. Reviewed by the Vermont Chiropractic Insurance Panel12/04/2008. Reviewed by the CAC 05/2009
04/2010	Updated to clarify training and conditioning as distinct from medical care. Reviewed by CAC 05/18/2010.

02/2011	Updates to: definition of “chiropractic care’; medical necessity criteria; covered laboratory testing and diagnostic imaging; non-covered services; addition of components of a manipulation service, modifier information related to documentation requirements. Maintenance therapy/wellness care should be reported under procedure HCPCS code S8990 (physical or manipulative therapy performed for maintenance rather than restorative). S8990 is a non covered service.
10/2013	Updated with clarifying medical necessity criteria, removal of VAS requirement,; Diagnostic Imaging and patient selection criteria added.
02/2014	ICD-10 Remediated. RLJ

Scientific Background and Reference Resources

Milliman Guidelines for Chiropractic Care
The Vermont Chiropractic Insurance Panel
Agency for Healthcare Research and Quality (AHRQ) (previously Agency for Healthcare Policy and Research [AHCPR]). Chiropractic in the United States: training, practice and research. Publication No. 98-N002. 1997 Dec. Accessed December 8, 2010. Available at URL address: http://www.chiroweb.com/archives/ahcpr/uschiros.htm

American Chiropractic College of Radiology (ACCR). ACCR guideline on computer assisted mensuration for postural analysis of radiographs. 2004. Accessed December 8, 2010. Available at URL address: http://www.accr.org/accrguidlinepage.htm

Centre for Health Services and Policy Research. (1999, May). *A systematic review and critical appraisal of the scientific evidence on craniosacral therapy*.

Retrieved September 17, 2002 from ht BlueCross BlueShield Association. Medical Policy Reference Manual. (10:2008). *Iontophoresis as a technique for drug delivery* (8.03.14). Retrieved February 17, 2009 from BlueWeb. (12 articles and/or guidelines reviewed)

American Chiropractic Association Clinical Documentation Manual, 2nd Edition

American Chiropractic Association Chiropractic Coding Solutions Manual, 2009 14th Annual Edition.

American Chiropractic Association web site

Approved by BCBSVT **Date Approved**

Spencer Borden IV, MD
Chair, Medical Policy Committee

Robert Wheeler MD
Chief Medical Officer

Attachment I
Chiropractic Covered Service Codes

Office Visits	Description
99201	Office or other outpatient visit for the evaluation & management (E&M) of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making. Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99202	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision-making. Usually the presenting problem(s) are of low to moderate complexity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99203	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Usually the presenting problem(s) are of moderate severity Physicians typically spend 30 minutes face-to-face with the patient and/or family.
99204	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision

	making of moderate complexity. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99205	Office or other outpatient visit for the E&M of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Usually the presenting problem(s) are of moderate to high severity Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99211	Office or other outpatient visit for the E&M of an established patient that may not require the presence of a physician. Usually the presenting problems are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the E&M of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making. Usually the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.
99213	Office or other outpatient visit for the E&M of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision-making of low complexity. Usually the presenting problem(s) are of low to moderate complexity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
99214	Office or other outpatient visit for the E&M of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.
99215	Office or other outpatient visit for the E&M of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
Inpatient Visits	**Description**
99251	Inpatient (IP) consultation for a new or established patient, which requires these three key components: a problem

	focused history; a problem focused examination; and straightforward medical decision-making. Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 20 minutes at the bedside & on the patient's hospital floor or unit.
99252	IP consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision-making. Usually, the presenting problem(s) are of low severity. Physicians typically spend 40 minutes at the bedside & on the patient's hospital floor or unit.
99253	IP consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision-making of low complexity. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 55 minutes at the bedside & on the patient's hospital floor or unit.
99254	IP consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes at the bedside & on the patient's hospital floor or unit.
99255	IP consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 110 minutes at the bedside & on the patient's hospital floor or unit.
Home Visits	**Description**
99341	Home visit for the evaluation & management (E&M) of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making. Usually the presenting problem(s) are of low severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.
99342	Home visit for the E&M of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision-making of low complexity. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient

	and/or family.
99343	Home visit for the E&M of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision-making of moderate complexity. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
99344	Home visit for the E&M of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision-making of moderate complexity. Usually the presenting problem(s) are of high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
99345	Home visit for the E&M of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision-making of high complexity. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Physicians typically spend 75 minutes face-to-face with the patient and/or family.
99347	Home visit for the E&M of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and straightforward medical decision-making. Usually the presenting problem(s) are of self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.
Home Visits	**Description**
99348	Home visit for the evaluation & management (E&M) of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision-making of low complexity. Usually the presenting problem(s) are of low to moderate severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family
99349	Home visit for the (E&M) of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; and medical decision-making of moderate complexity. Usually the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.
99350	Home visit for the E&M of an established patient, which requires at least two of these three key components: a comprehensive interval history; a comprehensive

	examination; and medical decision-making of moderate to high complexity. Usually the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
Manipulation	**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
Chiropractic Coding Rules	**Description**
1	Chiropractic manipulation treatment includes a pre-manipulation patient assessment.
2	Evaluation & management (E&M) services provided in conjunction with CMT may be reported separately with the addition of CPT modifier -25 (Significant, separately identifiable E&M service by the same physician on the same day of the procedure or other service), along with any diagnostic tests or other therapy provided.
Physical Medicine	**Description**
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97035	Application of a modality to 1 or more areas: ultrasound, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97140	Manual therapy techniques (e.g., mobilization / manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes **<u>NOTE:</u> 97140 should not be billed when a manipulation is performed on the same area.**
Physical Medicine	**Description**

97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care / home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices / adaptive equipment) direct one-on-one contact by provider, each 15 minutes
Physical Coding Rule	**Description**
1	The physician or therapist is required to be in constant attendance when reporting CPT codes for modalities and procedures.
Laboratory	**Description**
80051	Electrolyte panel
81000	Urinalysis
81001	Urinalysis
82550	Creatine kinase (CK) (CPK); total
85027	Complete Blood count (with automated Hgb, Hct, RBC, WBC, platelet)
85651	Sedimentation Rate, manual
Non Covered Laboratory Tests	All Others CPT codes not listed above

Attachment II
Chiropractic Non-Covered Service Codes

Non Covered Codes	Description	
97010	Application of a modality to 1 or more areas; hot and cold packs	Not Medically Necessary
97012	Traction, mechanical	Not Medically Necessary
97014	Electrical stimulation (unattended)	Not Medically Necessary
97016	Vasopneumatic Devices	Not Medically Necessary
97018	Paraffin bath	Not Medically Necessary
97022	Whirlpool	Not Medically Necessary
97024	Diathermy (e.g., microwave)	Not Medically

		Necessary
97026	Infrared	Not Medically Necessary
97028	Ultraviolet	Not Medically Necessary
97033	Iontophoresis	Investigational
97039	Unlisted modality	Exclusion
97124	Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)	Exclusion - Except for FEP when performed by a chiropractor or physical therapist
97139	Unlisted therapeutic procedure	Exclusion
97532	Development of cognitive skills	Exclusions
97533	Sensory integrative techniques	Exclusions
97537	Community work/reintetration training	Exclusions
97542	Wheelchair managment	Exclusions
97545	Work hardening/conditioning	Exclusions
97546	Work hardening/conditioning each additional hour	Exclusions
99070	Supplies and materials provided by the physician over and above those usually included with the office visit	Exclusions
S8990	Physical or manipulative therapy performed for maintenance rather than restoration	Not medically necessary
S9090	Vertebral axial decompression, per session	Investigational

Attachment III
Chiropractic Covered X-Rays

Covered X-Rays	Description
71100	Radiologic examination, ribs, unilateral; 2 views
72010	Radiologic examination, spine, entire, survey study, anteroposterior & lateral
72020	Radiologic examination, spine, single view, specify level
72040	Radiologic examination, spine, cervical; 2 or 3 views
72050	Radiologic examination, spine, cervical; minimum of 4 views
72052	Radiologic examination, spine, cervical; complete, including oblique & flexion and/or extension studies
72070	Radiologic examination, spine, thoracic; 2 views
72074	Radiologic examination, spine, thoracic; minimum of 4 views
72080	Radiologic examination, spine, thoracolumbar, 2 views

72100	Radiologic examination, spine, lumbosacral; 2 or 3 views
72110	Radiologic examination, spine, lumbosacral; minimum of 4 views
72114	Radiologic examination, spine, lumbosacral; complete, including bending views
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of 4 views
72170	Radiologic examination, pelvis; 1 or 2 views
72200	Radiologic examination, sacroiliac joints; less than 3 views
72220	Radiologic examination, sacrum & coccyx, minimum of 2 views
73000	Radiologic examination, clavicle, complete
73010	Radiologic examination, scapula, complete
73020	Radiologic examination, shoulder; 1 view
73030	Radiologic examination, shoulder, complete, minimum of 2 views
73040	Radiologic examination, shoulder, arthrography, radiological supervision & interpretation
73050	Radiologic examination, acromioclavicular joints, bilateral, with or w/out weighted distraction
73060	Radiologic examination, humerus, minimum of 2 views
73070	Radiologic examination, elbow; 2 views
73090	Radiologic examination, forearm; 2 views
73100	Radiologic examination, wrist; 2 views
73115	Radiologic examination, wrist; arthrography, radiological supervision & interpretation
73120	Radiologic examination, hand; 2 views
73140	Radiologic examination, finger(s), minimum of 2 views
73500	Radiologic examination, hip, unilateral; 1 view
73510	Radiologic examination, hip, complete, minimum of 2 views
73520	Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis
73550	Radiologic examination, femur, 2 views
73560	Radiologic examination, knee; 1 or 2 views
73562	Radiologic examination, knee; 3 views
73564	Radiologic examination, knee; complete, 4 or more views
73590	Radiologic examination, tibia & fibula, 2 views
73600	Radiologic examination, ankle; 2 views
73610	Radiologic examination, ankle; complete, minimum of 3 views
73620	Radiologic examination, foot; 2 views
73630	Radiologic examination, foot; complete, minimum of 3 views
73650	Radiologic examination, calcaneus; minimum of 2 views
73660	Radiologic examination, toe(s), minimum of 2 views

Attachment IV

Click HERE for Applicable ICD (diagnosis) code lists