

Adult chiropractic clinical guideline for Tennessee

Effective January 1, 2022, the Division of TennCare will require authorization for adult chiropractic services.

This document defines general principles used to determine the medical necessity of chiropractic services for adults, which is based on the definition and Local Coverage Determination (LCD) L37254 from the Centers for Medicare & Medicaid Services (CMS) and CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, Section 240.1.3.

All coding requirements and contracting questions should be directed to your Provider Relationship Management associate or Provider Services at **833-731-2154**.

These guidelines can be found at <https://provider.wellpoint.com/TN/> > Provider Resources and Documents > *Medical Policies* and *Clinical UM Guidelines*.

provider.wellpoint.com/tn/

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POLICY:

This document defines general principles used to determine the medical necessity of Chiropractor for adults, which is based on the definition and Local Coverage Determination (LCD) L37254 from the Centers for Medicare & Medicaid Services (CMS) and CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3.

The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3)

DEFINITIONS:

Most spinal joint problems fall into the following categories:

Acute subluxation - A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

Chronic subluxation - 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. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3)

Acute exacerbation is a temporary but marked deterioration of the patient's condition that is causing significant interference with activities of daily living due to an acute flare-up of the previously treated condition. The patient's clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment. As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time.

Chiropractic manipulative treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

Maintenance Therapy Maintenance - Services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

PROCEDURE:

Medically Necessary:

Most spinal joint problems fall into the following categories:

Acute subluxation - A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of chiropractic manipulation is expected to be an improvement in, or arrest of progression, of the patient's condition.

Chronic subluxation - 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. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3)

An **acute exacerbation** is a temporary but marked deterioration of the patient's condition that is causing significant interference with activities of daily living due to an acute flare-up of the previously treated condition. The patient's clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment. As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period of time.

Maintenance Therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3A)

Contraindications:

Dynamic thrust is the therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust but does not rule out the use of dynamic thrust. The doctor should discuss this risk with the patient and record this in the chart.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3B)

The following are relative contraindications to Dynamic thrust:

- Articular hyper mobility and circumstances where the stability of the joint is uncertain;
- Severe demineralization of bone;

- Benign bone tumors (spine);
- Bleeding disorders and anticoagulant therapy; and
- Radiculopathy with progressive neurological signs.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3B)

Dynamic thrust is absolutely contraindicated near the site of demonstrated subluxation and proposed manipulation 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 dislocations or healed fractures and dislocations with signs of instability;
- An unstable os odontoideum;
- Malignancies that involve the vertebral column;
- Infection of bones or joints of the vertebral column;
- Signs and symptoms of myelopathy or cauda equina syndrome;
- For cervical spinal manipulations, vertebrobasilar insufficiency syndrome; and
- A significant major artery aneurysm near the proposed manipulation.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3B)

Limitations

The term “physician” under Part B includes a chiropractor who meets the specified qualifying requirements set forth in §30.5 but only for treatment by means of manual manipulation of the spine to correct a subluxation.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240)

Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation provided.

Such treatment is legal in the State where performed. All other services furnished or ordered by chiropractors are not covered.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 30.5)

Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of the hands. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15: Section 240.1.3)

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor’s order is covered. This means that if a chiropractor orders, takes, or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test, can be used for claims processing purposes, but

Medicare coverage and payment are not available for those services. This prohibition does not affect the coverage of x-rays or other diagnostic tests furnished by other practitioners under the program. For example, an x-ray or any diagnostic test taken for the purpose of determining or demonstrating the existence of a subluxation of the spine is a diagnostic x-ray test covered under §1861(s)(3) of the Act if ordered, taken, and interpreted by a physician who is a doctor of medicine or osteopathy. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.1)

The mere statement or diagnosis of "pain" is not sufficient to support medical necessity for the treatments. The precise level(s) of the subluxation(s) must be specified by the chiropractor to substantiate a claim for manipulation of each spinal region(s). There are five spinal regions addressed by this LCD: cervical region (atlanto-occipital joint), thoracic region (costovertebral/costotransverse joints), lumbar region, pelvic region (sacro-iliac joint) and sacral region (ref. CPT®Professional Edition 2017 p. 672).

Medicare does not cover chiropractic treatments to extraspinal regions (CPT 98943). The five extraspinal regions are: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities; rib care (excluding costotransverse and costovertebral joints) and abdomen (CPT Assistant Nov 98:38). The five extraspinal regions referred to are: head (including, temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints) and abdomen (CPTAssistant Nov 98:38). Medicare does not cover chiropractic treatments to extraspinal regions (CPT 98943), which includes the head, upper and lower extremities, rib cage and abdomen.

For Medicare purposes, a chiropractor must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, contractors may deny if appropriate after medical review. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3) Modifier AT must only be used when the chiropractic manipulation is "reasonable and necessary" as defined by national policy and the LCD. Modifier AT must not be used when maintenance therapy has been performed. The need for a prolonged course of treatment should be appropriate to the reported procedure code(s) and medical necessity must be documented clearly in the medical record.

General Information

Associated Information

Documentation Requirements:

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Chiropractic care is focused on the treatment goals outlined in the Plan of Care.

A plan of care should be individualized for each patient and should include the following:

- Recommended level of care (duration and frequency of visits)
- Specific treatment goals (with documentation of progress or lack thereof within the clinical records)
- Objective measures to evaluate treatment effectiveness (with qualitative and/or quantitative measures)

The use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Therefore, treatment effectiveness must be assessed at appropriate intervals during subsequent visits (objective measurable goals).

Specific recommendations (i.e. 'home program'; life style modifications; etc.) for ongoing amelioration of musculoskeletal complaints should be provided as early in the course of treatment as possible; should be reinforced at each visit; and documented in the medical record.

For patients who have not achieved the goals documented in the Plan of Care, the practitioner should conclude the episode of chiropractic care in the last visit by documenting the clinical factors that contributed to the inability to meet the stated goals in the treatment plan.

The precise level of subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine.

The level of spinal subluxation must bear a direct causal relationship to the patient's symptoms, and the symptoms must be directly related to the level of the subluxation that has been diagnosed.

Dynamic thrust is the therapeutic force or maneuver delivered by the physician during manipulation in the anatomic region of involvement. A relative contraindication is a condition that adds significant risk of injury to the patient from dynamic thrust but does not rule out the use of dynamic thrust. The doctor must discuss this risk with the patient and record this in the chart.

The need for a prolonged course of treatment must be clearly documented in the medical record. Treatment should result in improvement or arrest of deterioration of subluxation within a reasonable and generally predictable period of time.

The word "correction" may be used in lieu of "treatment." Also, a number of different terms composed of the following words may be used to describe manual manipulation:

- Spine or spinal adjustment by manual means;
- Spine or spinal manipulation;
- Manual adjustment; and

- Vertebral manipulation or adjustment.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.1)

Documentation Requirements: History

The history recorded in the patient record should include the following:

- Symptoms causing patient to seek treatment;
- Family history if relevant;
- Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);
- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity, frequency, location and radiation of symptoms;
- Aggravating or relieving factors; and
- Prior interventions, treatments, medications, secondary complaints

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2.2).

Documentation Requirements: Initial Visit

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History as stated above.
2. Description of the present illness including:
 - Mechanism of trauma;
 - Quality and character of symptoms/problem;
 - Onset, duration, intensity, frequency, location, and radiation of symptoms;
 - Aggravating or relieving factors;
 - Prior interventions, treatments, medications, secondary complaints; and
 - Symptoms causing patient to seek treatment.

These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be

causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is “pain” is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

3. Evaluation of musculoskeletal/nervous system through physical examination.
4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.
5. Treatment Plan: The treatment plan should include the following:
 - Recommended level of care (duration and frequency of visits);
 - Specific treatment goals; and
 - Objective measures to evaluate treatment effectiveness.
6. Date of the initial treatment.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2.2A)

Documentation Requirements: Subsequent Visits

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

1. History (an interval history sufficient to support continuing need; document substantive changes)
 - Review of chief complaint;
 - Changes since last visit;
 - System review if relevant.
2. Physical exam (interval; document subsequent changes; a full repeat P.A.R.T. is not expected)
 - Exam of area of spine involved in diagnosis;
 - Assessment of change in patient condition since last visit;
 - Evaluation of treatment effectiveness;
3. Documentation of treatment given on day of visit.

(CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2.2B)

4. Documentation of how the day’s treatment fits within the plan of care (e.g. “visit 4 of planned 7 treatments”) and anyway the treatment plan is being changed.

Documentation: X-Ray/CT/MRI

An x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is

warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment.

In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided 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 is acceptable evidence if a subluxation of the spine is demonstrated. (CMS Publication100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.2.1)

If the diagnostic studies have been taken in a hospital or outpatient facility, a written report, including interpretation and diagnosis by a physician must be present in the patient's medical record. Documentation of the chiropractor's review of the x-ray (MRI/CT) noting the level of subluxation must be maintained in the medical record.

Documentation: Demonstrated by Physical Examination (aka "P.A.R.T. Evaluation Process")

The P.A.R.T. evaluation process is recommended as the examination alternative to the previously mandated demonstration of subluxation by x-ray/MRI/CT for services beginning January 1, 2000. The acronym P.A.R.T. identifies diagnostic criteria for spinal dysfunction (subluxation).

P - Pain/tenderness evaluated in terms of location, quality and intensity: The perception of pain and tenderness is assessed. Most primary neuromusculoskeletal disorders manifest primarily by a painful response. Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore, pain intensity may be assessed using one or more of the following; visual analog scales, algometers, pain questionnaires, etc.

A - Asymmetry/misalignment identified on a sectional or segmental level: observation (posture and heat analysis), static palpation for misalignment of vertebral segments, diagnostic imaging, etc.

R - Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility. Range of motion abnormalities may be identified through one or more of the following: motion palpation, observation, stress diagnostic imaging, range of motion, measurement(s), etc.

T - Tissue, tone changes in the characteristics of contiguous or associated soft tissues including skin, fascia, muscle and ligament:
Abnormalities in tone, texture and/or temperature may be identified through one or more of the following procedures: observation, palpation, use of instrumentation, test of length and strength, etc.

To demonstrate a subluxation based on physical examination, two of the four (P.A.R.T.) criteria are required, one of which must be asymmetry/misalignment or range of motion abnormality.

Documentation of changes in the patient's examination, status, progression must be recorded at each visit.

The evaluation process must be ongoing. Signs and certain symptoms must be rechecked during the course of treatment to determine the extent of the patient progress. Standardized measurement scales (e.g., Visual Analogue Scale (VAS), Oswestry Disability Questionnaire, and the Quebec Back Pain Disability Scale) may be used to measure improvement or lack thereof. This ongoing evaluation and assessment forming the basis for treatment modification is a key factor in total patient management. The initial examination, no matter how thorough, cannot be expected to provide all the answers. A treatment trial should be instituted with its effects assessed to determine whether it should be continued or a different plan devised. Moreover, it is the examination that forms the foundation for treatment, guiding the doctor in selecting appropriate treatment techniques, frequency, and course of treatment.

On receipt of a request for documentation, at a minimum, the practitioner must submit the Initial Visit's (ref. CMS 1500 box 14) Treatment Plan, the Concluding/Discharge Visit and Subsequent Visits that demonstrate any change in the History, Physical Exam or Treatment Plan.

REFERENCES:

Government Agency, Medical Society, and Other Authoritative Publications:

- Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual.
Available at: [Local Coverage Determination for Chiropractic Services \(L37254\) \(cms.gov\)](#)
- [Medicare Benefit Policy Manual \(cms.gov\)](#) in CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15, see Section 240.

E&M	Description
99202	Office or other outpatient visit for the evaluation and management of a new patient , which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient , which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99212	Office or other outpatient visit for the evaluation and management of an established patient , which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient , which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
Radiology	
72020	72020 - Radiologic examination, spine, single view, specify level

72040	72040 - Radiologic examination, spine, cervical; two or three views
72050	72050 - Radiologic examination, spine, cervical; four or five views
72070	72052 - Radiologic examination, spine, cervical; six or more views
72072	72070 - Radiologic examination, spine; thoracic, two views
72080	72072 - Radiologic examination, spine; thoracic, three views
72081	72074 - Radiologic examination, spine; thoracic, minimum of four views
72082	72080 - Radiologic examination, spine; thoracolumbar junction, minimum two views
72100	72081 - Radiologic examination, spine; entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view
72110	72082 - Radiologic examination, spine; entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); two or three views
72114	72083 - Radiologic examination, spine; entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); four or five views
72120	72084 - Radiologic examination, spine; entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); minimum of 6 views
72170	72100 - Radiologic examination, spine, lumbosacral; two or three views
72190	72110 - Radiologic examination, spine, lumbosacral; minimum of four views
72200	72114 - Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views
72220	72120 - Radiologic examination, spine, lumbosacral, bending views only, two or three views
Manipulation codes	DESCRIPTION
98940	98940 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 1-2 REGIONS
98941	98941 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 3-4 REGIONS
98942	98942 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, 5 REGION