



## Chiropractic Services Medical Necessity Guideline

<b>Medical Necessity Guideline (MNG) Title: Chiropractic Services</b>		
<b>MNG #: 050</b>	<input checked="" type="checkbox"/> <b>CCA Senior Care Options (HMO D-SNP) (MA)</b>  <input checked="" type="checkbox"/> <b>CCA One Care (Medicare-Medicaid) (MA)</b>	<b>Prior Authorization Needed?</b> <input type="checkbox"/> <b>Yes (always required)</b> <input checked="" type="checkbox"/> <b>Yes (only in certain situations. See this MNG for details)</b> <input type="checkbox"/> <b>No</b>
<b>Benefit Type:</b> <input checked="" type="checkbox"/> <b>Medicare</b> <input checked="" type="checkbox"/> <b>Medicaid</b>	<b>Approval Date:</b> 3/4/2021	<b>Effective Date:</b> 05/22/2021; 11/14/24; 1/1/25
<b>Last Revised Date:</b> 9/2/2021; 6/10/2022; 10/12/2023; 11/9/2023; 3/14/2024; 11/14/24; 1/1/25	<b>Next Annual Review Date:</b> 03/04/2022; 9/2/2022; 6/10/2023; 10/12/2024; 11/14/25	<b>Retire Date:</b>

**OVERVIEW:**

Chiropractors are specially trained in the evaluation and treatment of spinal conditions. Spinal joint distortions such as restriction and/or misalignment, also known as subluxations, can result in irritation and/or pressure at the spinal nerve. Chiropractic adjustment or chiropractic manipulation treatment (CMT) is used to correct spinal subluxations and improve spinal alignment and motion, thereby relieving nerve pressure and irritation and pressure.

**DEFINITIONS:**

**Chiropractic Manipulative Treatment (CMT):** The correction of misalignments, subluxations, or segmental joint dysfunction of the bony articulations of the vertebral column, the pelvis, and adjacent areas

**Chiropractor:** One who is licensed to practice chiropractic manipulation to correct interference with spinal nerves by adjusting the spinal column.

**Office Visit:** A visit by member to a chiropractor's office for evaluation and management services performed by a chiropractor. These services do not include chiropractic manipulative treatment (CMT).

**Subluxation:** A segmental joint dysfunction, misalignment, fixation, or abnormal spacing of the vertebrae.

**Maintenance Therapy-** A treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to 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.



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### DECISION GUIDELINES

The **initial 36 visits** of chiropractic treatment do not require prior authorization for **One Care and SCO members**. **Visits exceeding 36 per calendar year require prior authorization and may be requested in increments of up to 8 visits.**

**NOTE:** Evaluation and management visits (CPT 99202 and 99212) do not require authorization.

#### **Clinical Coverage Criteria:**

Commonwealth Care Alliance (CCA) may cover chiropractic manipulative treatment to treat subluxation of the spine when all of the following criteria are met:

1. Member has a documented neuromusculoskeletal condition. Neuromuscular conditions considered to provide therapeutic grounds for chiropractic treatment include:
  - a. Functional disabilities of the spine
  - b. Nerve pains
  - c. Documented incidents that produce sprains and strains of the spinal axis; and
2. Documentation includes objective and measurable goals and progress toward treatment goals as a direct result of chiropractic treatment and includes an assessment tool such as Patient-Reported Outcomes Measurement Information System (PROMIS®)-29, PEG-3 (Pain intensity, interference with enjoyment of life, interference with general activity), Oswestry Disability Index (ODI), Brief Pain Inventory (BPI), PHQ-9 (Patient Health Questionnaire-9) or similar objective measure of member's level of function.

#### **LIMITATIONS/EXCLUSIONS :**

##### **Commonwealth Care Alliance does not cover Chiropractic treatment of:**

1. Diseases and pathological disorders other than those related to a neuromusculoskeletal condition (including, but not limited to, rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia, and emphysema)
2. Non-musculoskeletal disorders including, but not limited to, colic, bronchitis, enuresis, asthma, hypertension, gastrointestinal disorders, infections, fatigue, idiopathic scoliosis, or mental or nervous conditions which are considered investigational
3. Chronic conditions without documented objective measurable improvement
4. Asymptomatic members or members without an identifiable clinical condition

##### **Commonwealth Care Alliance does not cover:**

1. Chiropractic maintenance therapy, as defined above, when further clinical improvement cannot reasonably be expected from continuous ongoing treatment
2. Orthotic devices, corrective devices, and orthopedic appliances
3. Research, or experimental, unproven, or medically unnecessary procedures or treatment
4. CMT treatment to maintain health or prevent regression when the member is no longer suffering or presenting symptoms



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- 5. Supportive services such as, but not limited to, nutritional counseling, and educational services
- 6. Physical therapy, muscular stimulation, heat packs, or massage
- 7. Vitamins, minerals, food supplements, or other such supplies

CCA considers manipulation of spine requiring anesthesia, any region (CPT 22505) experimental and investigational. Refer to CCA Experimental and Investigational Medical Necessity Guidelines.

### CODING:

When applicable, a list(s) of codes requiring prior authorization is provided. This list is for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment.

CPT Code	Description
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions
98942	Chiropractic manipulative treatment (CMT); spinal, five regions

### Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual® criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that



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may require coverage for a specific service. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider’s agreement with the Plan (including complying with Plan’s Provider Manual specifications).

This Medical Necessity Guideline is not a rigid rule. As with all of CCA’s criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member’s unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member’s unique clinical circumstances will generally be required.

### RELATED REFERENCES

1. National Library of Medicine, Chiropractic Care: Attempting a Risk–Benefit Analysis. E. Ernst, MD, PhD, FRCP, Am J Public Health. 2002 October; 92(10): 1603–1604. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447290/>
2. Centers for Medicare & Medicaid Services. Local Coverage Article A57889: Chiropractic Services-Medical Policy Article. Accessed October 20, 2024. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=57889&ver=3&keywordtype=starts&keyword=chirop&bc=0>.
3. Centers for Medicare & Medicaid Services; Medicare Benefit Policy Manual, Chapter 15, Section 240. Accessed October 20, 2024. <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf>
4. Local Coverage Article, Billing and Coding Services Chiropractic Service, A 56273, July 27, 2023. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=56273#:~:text=Coverage%20of%20Chiropractic%20services%20is,comparison%20to%20the%20other%20vertebrae>.
5. 130 CMR: DIVISION OF MEDICAL ASSISTANCE 130 CMR 441.000: CHIROPRACTOR SERVICES. Accessed October 21, 2024. <https://www.mass.gov/doc/chiropractor-services-regulations/download>  
<https://www.mass.gov/doc/130-cmr-441-chiropractor-services/download#:~:text=The%20MassHealth%20agency%20requires%20that,per%20member%20per%20calendar%20year>

### REVISION LOG:

REVISION DATE	DESCRIPTION



## Chiropractic Services Medical Necessity Guideline

6/10/2022	Template changed to include PA requirements and benefit type. Formatting updated to include numbers. Clinical eligibility and Regulatory notes updated.
10/12/2023	Revised the description of covered service, definitions of terms, and simplified the interdisciplinary chronic pain management standard of care while removing reference to the HOPE program. Added list of contraindications for member safety. Updated and confirmed current resources and references.
11/9/23	Limitations section updated to clarify prior authorization requirement for all visits, MAPD.
12/14/23	Remove prior authorization requirement for initial chiropractic visit for MAPD
12/31/23	Utilization Management Committee approval.
3/14/24	Added language to clarify initial evaluations (CPT 99202, 99203) are covered.
11/14/24	Clarified coverage for SCO/One Care and Medicare Advantage. Added definitions and limitations. Removed CPT 98943-no longer a covered service.
1/1/25	CCA products updated. Medicare Advantage Clinical Coverage Criteria and Limitations/Exclusions sections removed.

**APPROVALS:**

David Mello	Senior Medical Director Utilization Review and Medical Policy
<b>CCA Clinical Lead</b>	<b>Title</b>
	11/14/24
<b>Signature</b>	<b>Date</b>
<b>CCA Senior Operational Lead</b>	<b>Title</b>
<b>Signature</b>	<b>Date</b>
Nazlim Hagmann	Chief Medical Officer
<b>CCA CMO or Designee</b>	<b>Title</b>
	11/14/24
<b>Signature</b>	<b>Date</b>