

Local Coverage Determination (LCD): Chiropractic Services (L34009)

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Contractor Information

Contractor Name Noridian Healthcare Solutions, LLC Back to Top	Contract Number 02402	Contract Type A and B MAC	Jurisdiction J - F
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LCD Information

Document Information

LCD ID
L34009

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LCD Title
Chiropractic Services

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Jurisdiction
Washington

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N/A

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N/A

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N/A

Title XVIII of the Social Security Act, Section 1833(e). This section prohibits Medicare payment for any claim, which lacks the necessary information to process the claim.

CMS Medicare Benefit Policy Manual, Pub. 100-2, Chapter 15, Sections 30.5 and 240. These sections address Chiropractor's Services and Chiropractic Services - General, respectively.

CMS Medicare Claims Processing Manual, Pub. 100-4 Chapter 12, Section 220. This section addresses Chiropractic Services.

National policy limits the coverage of chiropractic services to the "hands on" manual manipulation of the spine for symptomatology associated with spinal subluxation. Accordingly, CPT code 98943, CMT, extraspinal, one or more regions, is not a Medicare benefit.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

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.

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.

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.

Effective for claims with dates of service on or after January 1, 2000, an x-ray is not required to demonstrate the subluxation. However, an x-ray may be used for this purpose if the chiropractor so chooses.

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 as defined above:

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

In any case in which the term(s) used to describe the service performed suggests that it may not have been treatment by means of manual manipulation, the carrier analyst refers the claim for professional review and interpretation.

Subluxation is defined as a motion segment, in which alignment, movement integrity, and/or physiological function of the spine are altered although contact between joint surfaces remains intact.

A subluxation may be demonstrated by an x-ray or by physical examination, as described below.

1. Demonstrated by X-Ray

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.

2. Demonstrated by Physical Examination

Evaluation of musculoskeletal/nervous system to identify:

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

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under "physical examination" are required, one of which must be asymmetry/misalignment or range of motion abnormality.

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.

A - 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.

B - Documentation Requirements: Subsequent Visits

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

1. History
 - Review of chief complaint;
 - Changes since last visit;
 - System review if relevant.
2. Physical exam
 - 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.

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 demonstrated by x-ray or physical exam as described above.

Most spinal joint problems may be categorized as follows:

1. 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.

2. Chronic subluxation: A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as in 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. (Medicare Benefit Policy Manual 100-2, 15, 240.1.3)

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.

3. Maintenance therapy: 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. The AT modifier must not be placed on the claim when maintenance therapy has been provided. Claims without the AT modifier will be considered as maintenance therapy and denied. Chiropractors who give or receive from beneficiaries an ABN shall follow the instructions in Pub. 100-04, Medicare Claims Processing Manual, Chapter 23, section 20.9.1.1 and include a GA (or in rare instances a GZ) modifier on the claim.*

Maintenance therapy is not a covered benefit.

4. Exacerbations: An exacerbation is a temporary marked deterioration of the patient's condition due to flare-up of the condition being treated. This must be documented on the claim form and must be documented in the patient's clinical record, including the date of occurrence, nature of the onset or other pertinent factors that will support the reasonableness and necessity of treatments for this condition.

5. Recurrence: A recurrence is a return of symptoms of a previously treated condition that has been quiescent for 30 or more days. This may require the reinstatement of therapy.

6. 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. 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; and
- Radiculopathy with progressive neurological signs.

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 odontoid process;
- 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, vertebral artery insufficiency syndrome; and
- A significant major artery aneurysm near the proposed manipulation.

Location of Subluxation:

The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified:

Area of Spine - Names of Vertebrae - Number of Vertebrae - Short Form or Other Name

Neck - Occiput (Occ, CO), Cervical (C1 thru C7), Atlas (C1), Axis (C2) - 7

Back - Dorsal (D1 thru D12) or Thoracic (T1 thru T12) or Costovertebral (R1 thru R12) or Costotransverse (R1 thru R12) - 12

Low Back - Lumbar (L1 thru L5) - 5

Pelvis - Ilii, r and l (I, Si)

Sacral - Sacrum, Coccyx, S, SC

In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.

There are two ways in which the level of the subluxation may be specified.

- The exact bones may be listed, for example: C5, C6, etc.
- The area may suffice if it implies only certain bones such as: Occipito-atlantal (occiput and C1 (atlas)), lumbosacral (L5 and Sacrum), sacro-iliac (sacrum and ilium).

Following are some common examples of acceptable descriptive terms for the nature of the abnormalities:

- Off-centered
- Misalignment
- Malpositioning
- Spacing - abnormal, altered, decreased, increased
- Incomplete dislocation
- Rotation
- Listhesis - antero, postero, retro, lateral, spondylo
- Motion - limited, lost, restricted, flexion, extension, hyper mobility, hypomotility, aberrant

Other terms may be used. If they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements, they are acceptable.

Treatment Parameters

The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration in such condition within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as three months of treatment but some require very little treatment. In the first several days, treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.

Chronic spinal joint condition implies, of course, the condition has existed for a longer period of time and that, in all probability, the involved joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.

Some chiropractors have been identified as using an "intensive care" concept of treatment. Under this approach multiple daily visits (as many as four or five in a single day) are given in the office or clinic and so-called room or

ward fees are charged since the patient is confined to bed usually for the day. The room or ward fees are not covered and reimbursement under Medicare will be limited to not more than one treatment per day.

Compliance with the provisions in this policy is subject to monitoring by post payment data analysis and subsequent medical review.

[Back to Top](#)

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999 Not Applicable

CPT/HCPCS Codes

Group 1 Paragraph: Note: CPT code 98943, CMT, extraspinal, one or more regions, is not a Medicare benefit.

Group 1 Codes:

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

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph: Note: Diagnosis codes are based on the current ICD-10-CM codes that are effective at the time of LCD publication. Any updates to ICD-10 codes will be reviewed by Noridian, and coverage should not be presumed until the results of such review have been published/posted.

These are the **only** covered ICD-10 codes that support medical necessity:

Primary: ICD-10-CM Codes (Names of Vertebrae)

The precise level of subluxation must be listed as the primary diagnosis.

Group 1 Codes:

ICD-10 Codes

Description

M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region

ICD-10 Codes	Description
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region

Group 2 Paragraph: Secondary ICD-10-CM Codes

Category I - ICD-10-CM Diagnosis (diagnoses that generally require short term treatment):

Group 2 Codes:

ICD-10 Codes	Description
G44.1	Vascular headache, not elsewhere classified
G44.209	Tension-type headache, unspecified, not intractable
G44.219	Episodic tension-type headache, not intractable
G44.229	Chronic tension-type headache, not intractable
M24.50	Contracture, unspecified joint
M47.10	Other spondylosis with myelopathy, site unspecified
M47.21	Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.24	Other spondylosis with radiculopathy, thoracic region
M47.25	Other spondylosis with radiculopathy, thoracolumbar region
M47.26	Other spondylosis with radiculopathy, lumbar region
M47.27	Other spondylosis with radiculopathy, lumbosacral region
M47.28	Other spondylosis with radiculopathy, sacral and sacrococcygeal region
M47.811	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M47.819	Spondylosis without myelopathy or radiculopathy, site unspecified
M47.891	Other spondylosis, occipito-atlanto-axial region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.10	Ankylosing hyperostosis [Forestier], site unspecified
M48.11	Ankylosing hyperostosis [Forestier], occipito-atlanto-axial region
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M48.18	Ankylosing hyperostosis [Forestier], sacral and sacrococcygeal region
M48.19	Ankylosing hyperostosis [Forestier], multiple sites in spine
M54.2	Cervicalgia
M54.5	Low back pain
M54.6	Pain in thoracic spine
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
R51	Headache

Group 3 Paragraph: Category II - ICD-10-CM Diagnosis (diagnoses that generally require moderate term treatment:

Group 3 Codes:

ICD-10 Codes	Description
G54.0	Brachial plexus disorders
G54.1	Lumbosacral plexus disorders
G54.2	Cervical root disorders, not elsewhere classified
G54.3	Thoracic root disorders, not elsewhere classified
G54.4	Lumbosacral root disorders, not elsewhere classified
G54.8	Other nerve root and plexus disorders
G55	Nerve root and plexus compressions in diseases classified elsewhere
M25.50	Pain in unspecified joint
M43.11	Spondylolisthesis, occipito-atlanto-axial region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M43.14	Spondylolisthesis, thoracic region
M43.15	Spondylolisthesis, thoracolumbar region
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
M43.19	Spondylolisthesis, multiple sites in spine
M43.27	Fusion of spine, lumbosacral region
M43.28	Fusion of spine, sacral and sacrococcygeal region
M43.6	Torticollis
M46.01	Spinal enthesopathy, occipito-atlanto-axial region
M46.02	Spinal enthesopathy, cervical region
M46.03	Spinal enthesopathy, cervicothoracic region
M46.04	Spinal enthesopathy, thoracic region
M46.05	Spinal enthesopathy, thoracolumbar region
M46.06	Spinal enthesopathy, lumbar region
M46.07	Spinal enthesopathy, lumbosacral region
M46.08	Spinal enthesopathy, sacral and sacrococcygeal region
M46.09	Spinal enthesopathy, multiple sites in spine
M48.01	Spinal stenosis, occipito-atlanto-axial region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.06	Spinal stenosis, lumbar region
M48.07	Spinal stenosis, lumbosacral region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.12	Cervical disc disorder with radiculopathy, mid-cervical region
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.82	Other cervical disc disorders, mid-cervical region
M50.83	Other cervical disc disorders, cervicothoracic region
M50.90	Cervical disc disorder, unspecified, unspecified cervical region
M50.92	Cervical disc disorder, unspecified, mid-cervical region
M50.93	Cervical disc disorder, unspecified, cervicothoracic region
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy, lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.84	Other intervertebral disc disorders, thoracic region
M51.85	Other intervertebral disc disorders, thoracolumbar region
M51.86	Other intervertebral disc disorders, lumbar region
M51.87	Other intervertebral disc disorders, lumbosacral region
M53.0	Cervicocranial syndrome
M53.1	Cervicobrachial syndrome

ICD-10 Codes	Description
M53.2X7	Spinal instabilities, lumbosacral region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.86	Other specified dorsopathies, lumbar region
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.11	Radiculopathy, occipito-atlanto-axial region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.821	Other myositis, right upper arm
M60.822	Other myositis, left upper arm
M60.831	Other myositis, right forearm
M60.832	Other myositis, left forearm
M60.841	Other myositis, right hand
M60.842	Other myositis, left hand
M60.851	Other myositis, right thigh
M60.852	Other myositis, left thigh
M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.9	Myositis, unspecified
M62.830	Muscle spasm of back
M79.1	Myalgia
M79.7	Fibromyalgia
M99.20	Subluxation stenosis of neural canal of head region
M99.21	Subluxation stenosis of neural canal of cervical region
M99.22	Subluxation stenosis of neural canal of thoracic region
M99.23	Subluxation stenosis of neural canal of lumbar region
M99.30	Osseous stenosis of neural canal of head region
M99.31	Osseous stenosis of neural canal of cervical region
M99.32	Osseous stenosis of neural canal of thoracic region
M99.33	Osseous stenosis of neural canal of lumbar region
M99.40	Connective tissue stenosis of neural canal of head region
M99.41	Connective tissue stenosis of neural canal of cervical region
M99.42	Connective tissue stenosis of neural canal of thoracic region
M99.43	Connective tissue stenosis of neural canal of lumbar region
M99.50	Intervertebral disc stenosis of neural canal of head region
M99.51	Intervertebral disc stenosis of neural canal of cervical region
M99.52	Intervertebral disc stenosis of neural canal of thoracic region
M99.53	Intervertebral disc stenosis of neural canal of lumbar region
M99.60	Osseous and subluxation stenosis of intervertebral foramina of head region
M99.61	Osseous and subluxation stenosis of intervertebral foramina of cervical region
M99.62	Osseous and subluxation stenosis of intervertebral foramina of thoracic region
M99.63	Osseous and subluxation stenosis of intervertebral foramina of lumbar region
M99.70	Connective tissue and disc stenosis of intervertebral foramina of head region
M99.71	Connective tissue and disc stenosis of intervertebral foramina of cervical region
M99.72	Connective tissue and disc stenosis of intervertebral foramina of thoracic region
M99.73	Connective tissue and disc stenosis of intervertebral foramina of lumbar region
Q76.2	Congenital spondylolisthesis
S13.4XXA	Sprain of ligaments of cervical spine, initial encounter
S13.8XXA	Sprain of joints and ligaments of other parts of neck, initial encounter

ICD-10 Codes	Description
S16.1XXA	Strain of muscle, fascia and tendon at neck level, initial encounter
S23.3XXA	Sprain of ligaments of thoracic spine, initial encounter
S23.8XXA	Sprain of other specified parts of thorax, initial encounter
S33.5XXA	Sprain of ligaments of lumbar spine, initial encounter
S33.6XXA	Sprain of sacroiliac joint, initial encounter
S33.8XXA	Sprain of other parts of lumbar spine and pelvis, initial encounter

Group 4 Paragraph: Category III - ICD-10-CM Diagnosis (diagnoses that may require long term treatment):

Group 4 Codes:

ICD-10 Codes	Description
M48.31	Traumatic spondylopathy, occipito-atlanto-axial region
M48.32	Traumatic spondylopathy, cervical region
M48.33	Traumatic spondylopathy, cervicothoracic region
M48.34	Traumatic spondylopathy, thoracic region
M48.35	Traumatic spondylopathy, thoracolumbar region
M48.36	Traumatic spondylopathy, lumbar region
M48.37	Traumatic spondylopathy, lumbosacral region
M48.38	Traumatic spondylopathy, sacral and sacrococcygeal region
M50.20	Other cervical disc displacement, unspecified cervical region
M50.21	Other cervical disc displacement, high cervical region
M50.22	Other cervical disc displacement, mid-cervical region
M50.23	Other cervical disc displacement, cervicothoracic region
M50.30	Other cervical disc degeneration, unspecified cervical region
M50.31	Other cervical disc degeneration, high cervical region
M50.32	Other cervical disc degeneration, mid-cervical region
M50.33	Other cervical disc degeneration, cervicothoracic region
M51.24	Other intervertebral disc displacement, thoracic region
M51.25	Other intervertebral disc displacement, thoracolumbar region
M51.26	Other intervertebral disc displacement, lumbar region
M51.27	Other intervertebral disc displacement, lumbosacral region
M51.34	Other intervertebral disc degeneration, thoracic region
M51.35	Other intervertebral disc degeneration, thoracolumbar region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M96.1	Postlaminectomy syndrome, not elsewhere classified

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph: All ICD-10-CM codes not listed in this policy under ICD-10-CM Codes that Support Medical Necessity above.

Group 1 Codes: N/A

ICD-10 Additional Information

[Back to Top](#)

General Information

Associated Information

The following information must be documented in the patient's clinical record on the **initial visit**:

I. History:

- chief complaint including the symptoms present that caused the patient to seek chiropractic treatment

II Present Illness: This can include any of the following as appropriate:

- mechanism of trauma;
- quality and character of problem/symptoms;
- intensity of symptoms;
- frequency of symptoms occurring;
- location and radiation of symptoms;
- onset of symptoms;
- duration of symptoms;
- aggravating or relieving factors of symptoms;
- prior interventions, treatments, including 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 subluxation that has been cited. A statement on a claim that there is "pain" is insufficient. The location of the pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.

III. Family History: If pertinent

IV. Past health history which may include:

- general health statement
- prior illness(es)
- surgical history
- prior injuries or traumas
- past hospitalizations (as appropriate)
- medications

V. Physical examination: Evaluation of musculoskeletal/ nervous system through physical examination to identify:

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

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under physical examination are required, one of which must be asymmetry/misalignment or range of motion abnormality.

VI. 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.

The **secondary** diagnosis should come from:

Category I, II or III diagnosis (See ICD-9-CM Codes that Support Medical Necessity Section.)

VII. Treatment Plan: The treatment plan should include the following:

- Therapeutic modalities to effect cure or relief (patient education and exercise training).

- The level of care that is recommended (the duration and frequency of visits).
- Specific goals that are to be achieved with treatment.
- Objective measures to evaluate treatment effectiveness.
- Date of initial treatment.

VIII. Subsequent Visits:

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

1. History:
Review of chief complaint;
Changes since last visit;
System review, if relevant.
2. Physical exam:
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.

Medical Necessity of Treatment:

Failure to document that the chiropractic spinal manipulation is reasonable and necessary may result in denial of claim(s).

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.

The Section titled "Does the 'CPT 30% Rule' Apply?" needs clarification. This rule comes from the AMA (American Medical Association), the organization that holds the copyrights for all CPT codes. The rule states that if, in a given section (e.g., surgery) or subsection (e.g., surgery, integumentary) of CPT Manual, more than 30% of the codes are listed in the LCD, then the short descriptors must be used rather than the long descriptors found in the CPT Manual.

This policy is subject to the reasonable and necessary guidelines and the limitation of liability provision.

This medical policy consolidates and replaces all previous policies and publications on this subject by Noridian and its predecessors for Medicare Part B.

Sources of Information and Basis for Decision

- Foundations of Chiropractic Quality Assurance and Practice Parameters; Gatterman. Mosby Year Books, 1995.
- Guidelines for Chiropractic Quality Assurance and Practice Parameters, Second Edition; ed. Haldeman, Chapman-Smith, Peterson. Jones & Bartlett Publishers, 2005
- Chiropractic Physician Consultants
- Other Medicare Part B Carriers' Local Medical Review Policies, e.g., Colorado, Iowa, Kansas, Michigan.
- Noridian Carrier Advisory Committee Members

[Back to Top](#)

Revision History Information

Please note: Most Revision History entries effective on or before 01/24/2013 display with a Revision History Number of "R1" at the bottom of this table. However, there may be LCDs where these entries will display as a separate and distinct row.

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
10/01/2015	R1		

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		This LCD is revised to remove the paragraph, "When requesting an individual consideration through the written redetermination (formerly appeal) process, providers must include all relevant medical records and any pertinent peer-reviewed literature that supports the request. At a minimum two (2) Phase II studies (human studies of efficacy, pivotal) or one (1) Phase III study (evidence of safety and efficacy, pivotal) must be submitted for the Medical Director's review. " from the Associated Information field.	<ul style="list-style-type: none"> Other (Removed the paragraph, "When requesting an individual consideration through the written redetermination (formerly appeal) process, providers must include all relevant medical records and any pertinent peer-reviewed literature that supports the request. At a minimum two (2) Phase II studies (human studies of efficacy, pivotal) or one (1) Phase III study (evidence of safety and efficacy, pivotal) must be submitted for the Medical Director's review. ")

[Back to Top](#)

Associated Documents

Attachments N/A

Related Local Coverage Documents N/A

Related National Coverage Documents N/A

Public Version(s) Updated on 03/20/2015 with effective dates 10/01/2015 - N/A [Updated on 03/31/2014 with effective dates 10/01/2015 - N/A](#) [Back to Top](#)

Keywords

N/A Read the [LCD Disclaimer](#) [Back to Top](#)