Local Coverage Determination (LCD): Chiropractic Services (L31862)

Contractor Information

Contractor Name	Contract Number	Contract Type
CGS Administrators, LLC opens in new window	15102	MAC - Part B

Back to Top

LCD Information

Document Information

LCD ID
L31862

Jurisdiction
Kentucky

LCD Title
Chiropractic Services

Original Effective Date
For services performed on or after 04/30/2011

Revision Effective Date
For services performed on or after 10/17/2011

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N/A

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N/A

Notice Period Start Date
N/A

Notice Period End Date
N/A

CMS National Coverage Policy Language quoted from Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Code of Federal Regulations:

42 CFR 410.21 describes limitations on services of a chiropractor.

42 CFR Section 410.32, indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements).

CMS Publications:

CMS Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 5:

70.6 Chiropractors

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:

30.5 Physician Services – Chiropractor's Services

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:

240 Chiropractic Services - General

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

Abstract:

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. Medicare covers limited chiropractic services when performed by a chiropractor who is *licensed or legally authorized to furnish chiropractic services by the State or jurisdiction in which the services are furnished* (CMS Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 5, Section 70.6). A chiropractor must also meet uniform minimum standards as set forth in the CMS Internet-Only Manual (IOM) Publication 100-1, Chapter 5, Section 70.6. This policy restates language directly from the CMS Internet-Only manuals and if necessary provides clarification to educate providers on specified Medicare requirements for the diagnosis, treatment, documentation and billing of chiropractic services.

Indications

Chiropractic Services – Active Treatment:

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)

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.

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

B. 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, Section240.1.3B)

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). The need for an extensive, prolonged course of treatment should be appropriate to the reported procedure code(s) and must be documented clearly in the medical record.

The five extraspinal regions referred to 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). 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.*

Other Comments:

For claims submitted to the Part A MAC: This coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated CGS Administrators LLC Services to process their claims.

Bill type codes only apply to providers who bill these services to the Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

Use of Modifiers
Services rendered for covered acute conditions shall be billed with the -AT modifier.

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 Advance Beneficiary Notice shall follow the instructions in Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 20.9.1.1 and include a GA modifier on the claim indicating that they have properly executed an ABN or in rare instances a GZ modifier on the claim indicating no ABN was issued.

For services other than manual manipulation that are statutorily excluded add the modifier GY. It is not required that you bill these excluded services to Medicare but beneficiaries often request this in order to provide a secondary insurer with a denial notice.

For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.

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.

011x Hospital Inpatient (Including Medicare Part A)
012x Hospital Inpatient (Medicare Part B only)
013x Hospital Outpatient
021x Skilled Nursing - Inpatient (Including Medicare Part A)
022x Skilled Nursing - Inpatient (Medicare Part B only)
023x Skilled Nursing - Outpatient
071x Clinic - Rural Health
073x Clinic - Freestanding
077x Clinic - Federally Qualified Health Center (FQHC)
085x Critical Access Hospital

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.

Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.
0510 Clinic - General Classification
0520 Free-Standing Clinic - General Classification
0940 Other Therapeutic Services - General Classification
0960 Professional Fees - General Classification

CPT/HCPCS Codes
Group 1 Paragraph: N/A

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

ICD-9 Codes that Support Medical Necessity
Group 1 Paragraph: It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Primary Diagnosis Codes

The primary diagnosis must be subluxation, and must indicate the level of the subluxation

Group 1 Codes:
739.1 NONALLOPATHIC LESIONS OF CERVICAL REGION NOT ELSEWHERE CLASSIFIED
739.2 NONALLOPATHIC LESIONS OF THORACIC REGION NOT ELSEWHERE CLASSIFIED
739.3 NONALLOPATHIC LESIONS OF LUMBAR REGION NOT ELSEWHERE CLASSIFIED
739.4 NONALLOPATHIC LESIONS OF SACRAL REGION NOT ELSEWHERE CLASSIFIED
739.5 NONALLOPATHIC LESIONS OF PELVIC REGION NOT ELSEWHERE CLASSIFIED

Group 2 Paragraph: Secondary ICD-9-CM codes

The secondary diagnosis must reflect the neuromusculoskeletal condition necessitating the treatment.

Group 2 Codes:

339.89*	OTHER HEADACHE SYNDROMES
353.2	CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3	THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4	LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.8	OTHER NERVE ROOT AND PLEXUS DISORDERS
355.2	OTHER LESION OF FEMORAL NERVE
720.1	SPINAL ENTHESOPATHY
721.0	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY
721.2	THORACIC SPONDYLOSIS WITHOUT MYELOPATHY
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.6	ANKYLOSING VERTEBRAL HYPEROSTOSIS
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82	POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
722.91	OTHER AND UNSPECIFIED DISC DISORDER OF CERVICAL REGION
722.92	OTHER AND UNSPECIFIED DISC DISORDER OF THORACIC REGION
722.93	OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION
723.0	SPINAL STENOSIS IN CERVICAL REGION
723.1	CERVICALGIA
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
723.5	TORTICOLLIS UNSPECIFIED
723.8	OTHER SYNDROMES AFFECTING CERVICAL REGION
724.01	SPINAL STENOSIS OF THORACIC REGION
724.02	SPINAL STENOSIS, LUMBAR REGION, WITHOUT NEUROGENIC CLAUDICATION
724.03	SPINAL STENOSIS, LUMBAR REGION, WITH NEUROGENIC CLAUDICATION
724.1	PAIN IN THORACIC SPINE
724.2	LUMBAGO
724.3	SCIATICA
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
724.5	BACKACHE UNSPECIFIED
724.6	DISORDERS OF SACRUM
724.70	UNSPECIFIED DISORDER OF COCCYX
724.79	OTHER DISORDERS OF COCCYX
724.8	OTHER SYMPTOMS REFERABLE TO BACK
737.0	ADOLESCENT POSTURAL KYPHOSIS
737.12	KYPHOSIS POSTLAMINECTOMY
737.19	OTHER KYPHOSIS ACQUIRED
737.20	LORDOSIS (ACQUIRED) (POSTURAL)
737.21	LORDOSIS POSTLAMINECTOMY
737.29	OTHER LORDOSIS ACQUIRED
737.30	SCOLIOSIS (AND KYPHOSCOLIOSIS) IDIOPATHIC
737.34	THORACOGENIC SCOLIOSIS
737.40	UNSPECIFIED CURVATURE OF SPINE ASSOCIATED WITH OTHER CONDITIONS
737.41	KYPHOSIS ASSOCIATED WITH OTHER CONDITIONS
737.42	LORDOSIS ASSOCIATED WITH OTHER CONDITIONS
737.43	SCOLIOSIS ASSOCIATED WITH OTHER CONDITIONS
738.4	ACQUIRED SPONDYLOLISTHESIS
738.5	OTHER ACQUIRED DEFORMITY OF BACK OR SPINE
754.2	CONGENITAL MUSCULOSKELETAL DEFORMITIES OF SPINE

756.10 CONGENITAL ANOMALY OF SPINE UNSPECIFIED
756.11 CONGENITAL SPONDYLOLYSIS LUMBOSACRAL REGION
756.12 SPONDYLOLISTHESIS CONGENITAL
846.0 LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN
846.1 SACROILIAC (LIGAMENT) SPRAIN
846.2 SACROSPINATUS (LIGAMENT) SPRAIN
846.3 SACROTUBEROUS (LIGAMENT) SPRAIN
846.8 OTHER SPECIFIED SITES OF SACROILIAC REGION SPRAIN
847.0 NECK SPRAIN
847.1 THORACIC SPRAIN
847.2 LUMBAR SPRAIN
847.3 SPRAIN OF SACRUM
847.4 SPRAIN OF COCCYX
Group 2 Medical Necessity ICD-9 Codes Asterisk Explanation: **Use code 339.89 for cervicogenic headache

ICD-9 Codes that DO NOT Support Medical Necessity
Paragraph: Not applicable

N/A
Back to Top

General Information

Associated Information
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.

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 should discuss this risk with the patient and record this in the chart.

The need for an extensive, 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*

   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;
   Documentation of the presence or absence of a subluxation must be present at every visit.

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. *Progress or lack thereof, related to treatment goals and plan of care.*

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 Publication 100-02, 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: 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: *The perception of pain and tenderness is evaluated in terms of location, quality, and intensity. 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: *Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: 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 may result 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, texture, and temperature abnormality: *Changes in the characteristics of contiguous and associated soft tissue including skin, fascia, muscle and ligament 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 criteria mentioned above, one of which must be asymmetry/misalignment or range of motion abnormality, should be documented.

Documentation of changes in the patient's examination, status, progression and care plan should be maintained in the records at each visit.

The evaluation process must be an ongoing procedure. Even if a complete and thorough examination can be completed during the first visit, 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.

Not applicable

A chiropractic manipulation service for a beneficiary can only be reimbursed once per day.

Chiropractic manipulative therapy to treat the cervical abnormality responsible for acute episodes of cervicogenic headaches meeting HIS or Syaastad's criteria will be allowed. Maintenance therapy for cervicogenic headaches will not be allowed.

The frequency and duration of chiropractic treatment must be medically necessary and based on the individual patient's condition and response to treatment. When services are performed and billed in a manner suggesting

inappropriate or excessive utilization, they may be subject to review for medical necessity.

Sources of Information and Basis for Decision
This bibliography presents those sources that were obtained during the development of this policy. CGS Administrator LLC, is not responsible for the continuing viability of Web site addresses listed below.

Carrier Advisory Committee

CGS Administrators LLC and other Medicare contractors' local coverage determinations.

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Back to Top

Revision History Information

Please note: The Revision History information included in this LCD prior to 1/24/2013 will now display with a Revision History Number of "R1" at the bottom of this table. All new Revision History information entries completed on or after 1/24/2013 will display as a row in the Revision History section of the LCD and numbering will begin with "R2".

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
10/17/2011	R2	Revision #:R5 Revision Effective Date: N/A Revision Explanation: Annual review no changes. Revision #:R4 Revision Effective Date: N/A Revision Explanation: Annual review no changes. Revision #:R3 Revision Effective Date: 4/1/2010 Revision Explanation: Updated the 'Use of Modifiers' statement under the indications and limitations section. Revision #:R2 Revision Effective Date: N/A Revision Explanation: Annual Review; changed any references to CIGNA Government Services to CGS Administrators, LLC. Added revenue codes 0940 based on Uniform Billing Editor, INGENIX	• Other (Annual Review)
10/17/2011	R1	Revision Effective date: 10/17/11 Revision Explanation: Added MAC Part A Contractor #'s 15101 and 15201 to all MAC Part B Contractor # 15102 LCDs. Contractors 15101 and 15201 will be part of the Jurisdiction 15 MAC Contract as of October 17, 2011. Revision#:R1 Revision Effective date: 06/18/11 Revision Explanation: Added MAC Part B Contractor # 15202 to all MAC Part B Contractor # 15102 LCDs. Contractor 15202 will be part of the Jurisdiction 15 MAC Contract as of June 18, 2011. This LCD was converted from L27350 for Jurisdiction 15 A/B MAC on 04/30/2011. All prior notes were retained with the previous carriers version that has been archived in the Medicare Coverage Database. 07/02/2011 - The J15 Contractor adopted a new business name. This LCD revision only includes the change from CIGNA Government Services to CGS Administrators, LLC. No coverage information was included in this revision and no provider action is needed regarding this revision.	• Maintenance (annual review with now changes, formatting, etc)

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		11/25/2012 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document: 98940 descriptor was changed in Group 1 98941 descriptor was changed in Group 1 98942 descriptor was changed in Group 1	

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 01/09/2014 with effective dates 10/17/2011 - N/A Updated on 01/07/2013 with effective dates 10/17/2011 - N/A Updated on 11/25/2012 with effective dates 10/17/2011 - N/A Updated on 02/08/2012 with effective dates 10/17/2011 - N/A Updated on 01/31/2012 with effective dates 10/17/2011 - N/A Updated on 01/31/2012 with effective dates 10/17/2011 - N/A Updated on 09/27/2011 with effective dates 10/17/2011 - N/A Some older versions have been archived. Please visit the MCD Archive Site opens in new window to retrieve them. Back to Top

Keywords

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