LCD L32718 - Chiropractic Services

Print

Contractor Information

Contractor Name:

Novitas Solutions, Inc.

Contractor Number(s):

04911, 07101, 07102, 07201, 07202, 07301, 07302, 04111, 04112, 04211, 04212, 04311, 04312, 04411, 04412

Contractor Type:

MAC Part A & B

LCD Information

Document Information

LCD ID Number

L32718

LCD Title

Chiropractic Services

Contractor's Determination Number

L32718

AMA CPT/ADA CDT Copyright Statement

Primary Geographic Jurisdiction

Arkansas, Louisiana, Mississippi, Colorado, Texas, Oklahoma, New Mexico

Oversight Region

Central Office

Original Determination Effective Date

For services performed on or after 08/13/2012

Original Determination Ending Date

N/A

Revision Effective Date

For services performed on or after 01/01/2013

Revision Ending Date

N/A

CMS National Coverage Policy

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for chiropractic services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for chiropractic services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies regarding chiropractic services are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

- *Medicare Benefit Policy Manual* – Pub. 100-2, Chapter 15, Section 30.5, Section 240.1.3.
- *Medicare National Coverage Determinations Manual* – Pub. 100-03.
- Correct Coding Initiative – *Medicare Contractor Beneficiary and Provider Communications Manual* – Pub. 100-09, Chapter 5.
- Social Security Act (Title XVIII) Standard References, Sections:
  - 1862 (a)(1)(A) Medically Reasonable & Necessary.
  - 1862 (a)(1)(D) Investigational or Experimental.
  - 1833 (e) Incomplete Claim.

Jurisdiction “H” Notice:

Jurisdiction “H” comprises the states of Arkansas, Louisiana, Mississippi, Colorado, New Mexico, Oklahoma, and Texas. Novitas is responsible for claims payment and Local Coverage Determination (LCD) development for this jurisdiction. This LCD was created as a part of the legacy transition (8/13/2012 – 11/19/2012); and, is a consolidation of the previous legacy contractors’ policies. Coverage of each LCD begins when the state/contract number combination **officially** is integrated into the Jurisdiction. On the CMS MCD, this date is known as either the **Original Effective Date** or the **Revision Effective Date**. The following table details the official effective dates for each state/contract number combination.

ST	**Legacy A Contractor & Contract Number**	**Legacy B Contractor & Contract Number**	**J "H" MAC A Contractor & Contract Number**	**J "H" MAC B Contractor & Contract Number**	**J "H" Effective Date**
AR		PBSI: 00520 (J7)		Novitas: 07102	08/13/12
LA		PBSI: 00528 (J7)		Novitas: 07202	08/13/12
AR	PBSI: 00020 (J7)		Novitas: 07101		08/20/12
LA	PBSI: 00233 (J7)		Novitas: 07201		08/20/12
MS	PBSI: 00233 (J7)		Novitas: 07301		08/20/12
MS		Cahaba: 00512 (J7)		Novitas: 07302	10/22/12
J 4 States	Trailblazer: 04901		Novitas: 04911		10/29/12

CO	Trailblazer: 04101		Novitas: 04111		10/29/12
NM	Trailblazer: 04201		Novitas: 04211		10/29/12
OK	Trailblazer: 04301		Novitas: 04311		10/29/12
TX	Trailblazer: 04401		Novitas: 04411		10/29/12
CO		Trailblazer: 04102		Novitas: 04112	11/19/12
NM		Trailblazer: 04202		Novitas: 04212	11/19/12
OK		Trailblazer: 04302		Novitas: 04312	11/19/12
TX		Trailblazer: 04402		Novitas: 04412	11/19/12

Indications and Limitations of Coverage and/or Medical Necessity

Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

Chiropractic services are subject to national regulation, which provides definitions, indications and limitations for Medicare payment of chiropractic service. Please see *Medicare Benefit Manual* sections referenced above for national definitions, indications and limitations.

Medicare expects that acute symptoms/signs due to subluxation or acute exacerbation/recurrence of symptoms/signs due to subluxation might be treated vigorously. Improvement in the patient's symptoms is expected and in order for payment for chiropractic services to continue, should be demonstrated within a time frame consistent with the patient's clinical presentation. Failure of the patient's symptoms to improve accordingly or sustained worsening of symptoms should prompt referral of the patient for evaluation and/or treatment by an appropriate practitioner.

This LCD imposes diagnosis limitations that support diagnosis to procedure code automated denials. Medicare will allow up to 12 chiropractic manipulations per month and 30 chiropractic manipulation services per beneficiary per year. Despite allowing up to these maximums, each patient's condition and response to treatment must medically warrant the number of services reported for payment, and Medicare does not expect that patients will routinely require the maximum allowable number of services. Additionally, Medicare requires the medical necessity for each service to be clearly demonstrated in the patient's medical record.

Covered diagnoses are displayed in four groups in this policy, with the groups being displayed in ascending specificity. Medicare does not expect that substantially more than the following numbers of treatments will usually be required:

- Twelve (12) chiropractic manipulation treatments for Group A diagnoses.
- Eighteen (18) chiropractic manipulation treatments for Group B diagnoses.
- Twenty-four (24) chiropractic manipulation treatments for Group C diagnoses.
- Thirty (30) chiropractic manipulation treatments for Group D diagnoses.

Notice: This LCD imposes diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS NCDs, and all Medicare payment rules.

As published in CMS IOM, Pub. 100-08, Section **13.5.1**, to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary

under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the clinical trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member.
  - Furnished in a setting appropriate to the patient's medical needs and condition.
  - Ordered and furnished by qualified personnel.
  - One that meets, but does not exceed, the patient's medical needs.
  - At least as beneficial as an existing and available medically appropriate alternative.

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.

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.

CPT/HCPCS Codes

Note: Providers are reminded to refer to the long descriptors of the CPT codes in their CPT books. The American Medical Association (AMA) and the Centers for Medicare & Medicaid Services (CMS) require the use of short CPT descriptors in policies published on the Web.

Code	Description
98940	Chiropract manj 1-2 regions
98941	Chiropract manj 3-4 regions
98942	Chiropractic manj 5 regions

ICD-9 Codes that Support Medical Necessity

Note: Providers should continue to submit ICD-9-CM diagnosis codes without decimals on their claim forms and electronic claims.

The CPT/HCPCS codes included in this LCD will be subjected to "procedure to diagnosis" editing. The following lists include only those

diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

Medicare is establishing the following limited coverage for **CPT/HCPCS codes *98940, 98941* and *98942***:

Primary Diagnosis Codes

Covered for:

Code	Description
739.0 - 739.5	NONALLOPATHIC LESIONS OF HEAD REGION NOT ELSEWHERE CLASSIFIED - NONALLOPATHIC LESIONS OF PELVIC REGION NOT ELSEWHERE CLASSIFIED

Secondary Diagnosis Codes

Group A Diagnoses
Covered for:

Code	Description
307.81	TENSION HEADACHE
719.48*	PAIN IN JOINT INVOLVING OTHER SPECIFIED SITES
723.1	CERVICALGIA
724.1 - 724.2	PAIN IN THORACIC SPINE - LUMBAGO
724.5	BACKACHE UNSPECIFIED
724.8	OTHER SYMPTOMS REFERABLE TO BACK
728.85	SPASM OF MUSCLE
784.0	HEADACHE

Note: When using 719.48*, you must specify spine as the site.
Group B Diagnoses
Covered for:

Code	Description
720.1	SPINAL ENTHESOPATHY
721.0 - 721.2	CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY - THORACIC SPONDYLOSIS WITHOUT MYELOPATHY

721.6	ANKYLOSING VERTEBRAL HYPEROSTOSIS
721.90 - 721.91	SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MYELOPATHY - SPONDYLOSIS OF UNSPECIFIED SITE WITH MYELOPATHY
724.79	OTHER DISORDERS OF COCCYX
729.1	MYALGIA AND MYOSITIS UNSPECIFIED
729.4	FASCIITIS UNSPECIFIED
846.0 - 846.3	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN - SACROTUBEROUS (LIGAMENT) SPRAIN
846.8	OTHER SPECIFIED SITES OF SACROILIAC REGION SPRAIN
847.0 - 847.4	NECK SPRAIN - SPRAIN OF COCCYX

Group C Diagnoses
Covered for:

Code	Description
353.0 - 353.4	BRACHIAL PLEXUS LESIONS - LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.8	OTHER NERVE ROOT AND PLEXUS DISORDERS
722.91 - 722.93	OTHER AND UNSPECIFIED DISC DISORDER OF CERVICAL REGION - OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION
723.0	SPINAL STENOSIS IN CERVICAL REGION
723.2 - 723.5	CERVICOCRANIAL SYNDROME - TORTICOLLIS UNSPECIFIED

Group D Diagnoses
Covered for:

Code	Description
721.3	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY
721.41 - 721.42	SPONDYLOSIS WITH MYELOPATHY THORACIC REGION - SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
721.7	TRAUMATIC SPONDYLOPATHY

722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.10 - 722.11	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY - DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51 - 722.52	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC - DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.6	DEGENERATION OF INTERVERTEBRAL DISC SITE UNSPECIFIED
722.81 - 722.83	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION - POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
724.01 - 724.03	SPINAL STENOSIS OF THORACIC REGION - SPINAL STENOSIS, LUMBAR REGION, WITH NEUROGENIC CLAUDICATION
724.3 - 724.4	SCIATICA - THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
724.6	DISORDERS OF SACRUM
738.4	ACQUIRED SPONDYLOLISTHESIS
756.11 - 756.12	CONGENITAL SPONDYLOLYSIS LUMBOSACRAL REGION - SPONDYLOLISTHESIS CONGENITAL
839.01 - 839.08	CLOSED DISLOCATION FIRST CERVICAL VERTEBRA - CLOSED DISLOCATION MULTIPLE CERVICAL VERTEBRAE
839.20 - 839.21	CLOSED DISLOCATION LUMBAR VERTEBRA - CLOSED DISLOCATION THORACIC VERTEBRA
839.41 - 839.42	CLOSED DISLOCATION COCCYX - CLOSED DISLOCATION SACRUM
953.0 - 953.4	INJURY TO CERVICAL NERVE ROOT - INJURY TO BRACHIAL PLEXUS

Diagnoses that Support Medical Necessity

N/A

ICD-9 Codes that DO NOT Support Medical Necessity

N/A

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

All diagnoses not listed in the “ICD-9-CM Codes That Support Medical Necessity” section of this LCD.

Other Information

Documentation Requirements

Documentation supporting medical necessity should be legible, maintained in the patient’s medical record and made available to Medicare upon request.

Please see *Medicare Benefit Manual* sections referenced above for national documentation requirements for Medicare payment of chiropractic services.

Appendices

N/A

Utilization Guidelines

Medicare covers the following numbers of chiropractic manipulation services per beneficiary:

- **Twelve (12) chiropractic manipulation treatments per month.**
  And,
- **Thirty (30) chiropractic manipulation treatments per year.**

Notice: This LCD imposes utilization guideline limitations. Despite Medicare allowing up to these maximums, each patient’s condition and response to treatment must medically warrant the number of services reported for payment. Medicare requires the medical necessity for each service reported to be clearly demonstrated in the patient’s medical record. Medicare expects that patients will not routinely require the maximum allowable number of services.

Sources of Information and Basis for Decision

OIG Reports and Instructions:

OIG Report OEI-07-07-00390, Inappropriate Medicare Payments For Chiropractic Services; Published May 2009.

Other Local Coverage Determinations

“Chiropractic Services,” TrailBlazer LCD, 4N-6B (L26631)

Novitas Solutions, Inc. – JH Local Coverage Determination (LCD) Consolidation
Narrative Justification – Most Clinically Appropriate LCD
LCDs Compared:
L30295, Chiropractic Services, TrailBlazer – IV – CO, NM, OK, TX – B
L11919, Chiropractic Service (Manual Spinal Manipulation), Pinnacle – VI – LA
L8177, Chiropractic Service (Manual Spinal Manipulation), Pinnacle – VI – AK
DL32351, Medicine: Chiropractic Services (not considered d/t draft status), Cahaba - MS
CMD Rationale:
The TrailBlazer LCD imposes limits per month and per year and the Pinnacle LCD does not. The LCD from Pinnacle has additional information in the section titled Chiropractic Treatment Guidelines. All LCDs have similar codes. The TrailBlazer LCD Sources of Information and Basis for Decision includes the OIG Report and another TrailBlazer LCD. TrailBlazer LCD is chosen as there are limits on the number of treatments per beneficiary.
L30295 is the most clinically appropriate LCD.

Start Date of Comment Period

N/A

End Date of Comment Period:

N/A

Start Date of Notice Period

06/28/2012

Revision History

Revision History Number

6

Revision History Explanation

Date	Policy #	Description
01/01/2013	(Revision History #6)	LCD revised for dates of service on and after 01/01/2013 to reflect the annual CPT/HCPCS code updates. The following code descriptor(s) have been revised: 98940, 98941, and 98942.
11/19/2012	(Revision History #5)	Per CMS Change Request (CR) 7812, this LCD has been updated with the original effective date of 11/19/2012 to add the Novitas Jurisdiction H Part B MAC Contract Numbers 04112, 04212, 04312, and 04412 for Colorado Part B, New Mexico Part B, Oklahoma Part B, Texas Part B, Indian Health Service (IHS)/Tribal/Urban Indian Providers Part B, and Veterans Affairs (VA) Part B. No other changes were made to this LCD.
10/29/2012	(Revision History #4)	Per CMS Change Request (CR) 7812, this LCD has been updated with the original effective date of 10/29/2012 to add the Novitas Jurisdiction H Part A MAC Contract Numbers 04911, 04111, 04211, 04311, and 04411 for Colorado Part A, New Mexico Part A, Oklahoma Part A, Texas Part A, Indian Health Service (IHS)/Tribal/Urban Indian Providers Part A, and Veterans Affairs (VA) Part A. No other changes were made to this LCD.
10/22/2012	(Revision History #3)	LCD original effective date of 10/22/2012 for Mississippi Part B.
08/20/2012	(Revision History #2)	LCD original effective date of 08/20/2012 for Arkansas Part A, Louisiana Part A and Mississippi Part A.
08/13/2012	(Revision History #1)	LCD original effective date of 08/13/2012 for Arkansas Part B and Louisiana Part B. LCD posted for notice on 06/28/2012.

Reason for Change

HCPCS/ICD9 Descriptor Change

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.