Coverage Summary

Chiropractic Services

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<td>Approved by: UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 03/19/2019</td>
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Related Medicare Advantage Policy Guidelines:

- Chiropractic Services
- Osteopathic Manipulations (OMT)
- Vertebral Axial Decompression (VAX-D) (NCD 160.16)

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The benefit information in this Coverage Summary is based on existing national coverage policy, however Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (Medicare IOM Pub. No. 100-16, Ch. 4, §90.5).

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I. COVERAGE

Coverage Statement: Chiropractic services are covered when Medicare coverage criteria are met.

Note: Depending on the member’s plan, members may have additional chiropractic benefit. Refer to the member’s Evidence of Coverage (EOC)/Summary of Benefits (SB) to determine coverage eligibility for additional chiropractic benefit.

If member has the additional benefit (routine benefit, not Medicare-covered), contact Optum Health Physical Health (OHPH) at (866) 785-1654. For California members, contact (800) 428-6337. (Depending on the member’s plan and state, some Medicare covered chiropractic benefits are also handled by OHPH.)

Guidelines/Notes:

1. Manual manipulation of the spine is covered for subluxation of the spine and supporting structures as defined by Medicare.
   a. Subluxation maybe supported by X-ray or physical examination:
**X-Ray:**

1) X-ray may be used to document subluxation but is not required after January 1, 2000.

2) 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 three 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.

3) A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.

**Physical Examination:**

1) A physical (palpitory) exam is used to evaluate the musculo-skeletal/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.

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

b. Manual devices may be used but there is no additional payment for use of the device or for the device itself. Manual devices are hand-held with the thrust of the force of the device being controlled manually.

c. Most spinal joint problems fall into the following categories:

   **Acute:** A patient's condition is considered to be 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 treatment is expected to be an improvement in, or arrest of progression of the patient's condition. This result should be obtained within a reasonable and generally predictable period of time. Some patients with acute conditions may require several weeks of treatment, (e.g., up to three months), while others require a much shorter duration of treatment. Initially, services may be more frequent, but Medicare would expect to see a decrease in frequency as a result of the improvement in the patient's condition.

   **Chronic:** 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 continued therapy can be expected to result in some functional improvement.

   **Note:** Some Local Coverage Determinations (LCDs) have the following additional categories of spinal joint problems. See the [LCDs for Chiropractic Services](#). (Accessed March 7, 2019)
• **Exacerbation:** An exacerbation is a temporary marked deterioration of the patient’s condition due to an acute flare-up of the condition being treated. This must be documented in the patient’s clinical record, including the date of occurrence, nature of the onset, or other patient factors that will support the medical necessity of treatments for this condition.

• **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 re-institution of therapy.

d. Once the functional status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulation treatment is considered **maintenance therapy** and is **not covered**.

e. X-rays, office physical and examination or other diagnostic tests furnished by or ordered by a chiropractor are **not covered**.

f. Dynamic thrust is the therapeutic force or maneuver delivered by the practitioner during manipulation in the anatomic region of involvement.

1) 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
- Radiculopathy with progressive neurological signs

**Note:** A relative contraindication is that condition that adds significant risk of injury to the patient from dynamic thrust, but does not rule out the use of dynamic thrust. The chiropractor should discuss this risk with the patient and record this in the chart.

2) Dynamic thrust is **absolutely contraindicated** and **not covered** 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 dislocation with signs of instability;
- An unstable os odontoideum;
- Malignancies that involve the vertebral column;
- Infection of the bones or joints of the vertebral column;
- Signs and symptoms of myelopathy or cauda equina syndrome;
- For cervical spinal manipulations, vertebrobasilar insufficiency syndrome; or
- A significant major artery aneurysm near the proposed manipulation.


Also see the *Medicare Benefit Policy Manual, Chapter 15, §30.5 - Chiropractor’s Services.* (Accessed March 7, 2019)

*Local Coverage Determinations (LCDs) exist and compliance with these policies is required where applicable. See the *LCDs for Chiropractic Services.* (Accessed March 7, 2019)
2. **Power traction equipment/devices** (e.g., VAX-D®, DRX9000, SpineMED™, Spina System™, Lordex® Decompression Unit, DRS System™) **are not covered.** See the *NCD for Vertebral Axial Decompression (VAX)* (160.16). (Accessed March 7, 2019)

3. **Fluidized therapy dry heat** for certain musculoskeletal disorders **is covered** as an acceptable alternative to other heat therapy modalities in the treatment of acute or subacute traumatic or non-traumatic musculoskeletal disorders of the extremities. Fluidized therapy is a high intensity heat modality consisting of a dry whirlpool of finely divided solid particles suspended in a heated air stream, the mixture having the properties of a liquid. See the *NCD for Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders* (150.8). (Accessed March 7, 2019)

### II. Definitions

**Maintenance Therapy:** A treatment plan that seeks 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. *Medicare Benefit Policy Manual, Chapter 15, §240 - Chiropractic Services – General.* (Accessed March 7, 2019)


**Range of Motion Abnormality:** Changes in active, passive and accessory joint movements resulting in an increase or a decrease of sectional or segmental mobility. *Medicare Benefit Policy Manual, Chapter 15, §240 - Chiropractic Services – General.* (Accessed March 7, 2019)

**Subluxation:** A motion segment in which alignment, movement integrity and/or physiological function of the spine are altered, although contact between joint surfaces remains intact. *Medicare Benefit Policy Manual, Chapter 15, §240 - Chiropractic Services – General.* (Accessed March 7, 2019)

### III. References

### IV. Revision History

04/01/2019 Updated policy introduction; added language to clarify:

- There are instances where [the Coverage Summary] may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG)
- In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence (*Medicare IOM Pub. No. 100-16, Ch. 4, §90.5*)

03/19/2019 Annual review with the following update:

Guideline 1.a (X-ray) – deleted the following (no longer included in the Medicare
reference manual; no other Medicare sourcing found):

*Only diagnostic X-ray(s) is to be used to support the diagnosis of spinal subluxation.*

03/20/2018 Annual review; no updates.

03/21/2017 Annual review; no updates.

03/15/2016 Annual review; no updates.

03/24/2015 Annual review; no updates.

03/18/2014 Annual review with following updates:
- Guidelines #1.a: Deleted information pertaining to chiropractor technical component billing for X-ray.
- Guidelines #1.d: Deleted the reference to “unchanged for four weeks” and “medically necessary”.
- Revised definition of *Subluxation*.

04/29/2013 Annual review with following updates:
- Guidelines #1 (Manual manipulation of the spine): Replaced the link from Pinnacle Online Provider Medguide Publication (no longer available) to Novitas Local Coverage Article for Chiropractic Services (A47798).
- Guidelines #2 (Ideofluoroscopy): Section deleted; only available LCD which address Ideofluoroscopy, i.e., Pinnacle LCD for Chiropractic Service (Manual Manipulation) retired.

04/23/2012 Annual review, no updates.

04/26/2011 Annual review; the note pertaining to the Plus Plan rider and LifeCare was deleted as this rider is no longer offered and LifeCare is no longer used as a vendor. Also updated Guidelines #2 (Ideofluoroscopy) using the standard CS format and using the Pinnacle L11919 guidelines for states with no LCDs.

10/21/2010 Updated the link to the Pinnacle Online Provider MedGuide Publication (Guidelines #2 Ideofluoroscopy).