

Chiropractic Services

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[Instructions for Use](#)

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Related Medicare Advantage Policy Guidelines

- [Chiropractic Services](#)
- [Osteopathic Manipulations \(OMT\)](#)
- [Vertebral Axial Decompression \(VAX-D\) \(NCD 160.16\)](#)

Coverage Guidelines

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.)

Manual Manipulation

Coverage of chiropractic service is specifically limited to treatment of the spine to correct subluxation 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.

All other services furnished or ordered by chiropractors are not covered. Examples include but are not limited to: X-rays, office physical and examination or other diagnostic tests furnished by or ordered by a chiropractor.

Subluxation

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. Subluxation may be demonstrated by an X-ray or physical examination:

X-Ray

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

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

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 above under physical examination are required, one of which must be asymmetry/misalignment or range of motion abnormality.

Maintenance Therapy

Maintenance therapy is 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.

Once the clinical 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.

Dynamic Thrust

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

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.

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 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.

Refer to the:

- [Medicare Benefit Policy Manual, Chapter 15, §240 – Chiropractic Services – General](#). (Accessed March 9, 2021)
- [Medicare Benefit Policy Manual, Chapter 15, §30.5 – Chiropractor's Services](#). (Accessed March 9, 2021)

Local Coverage Determinations (LCDs) exist and compliance with these policies is required where applicable. These LCDs/LCAs are available at <https://www.cms.gov/medicare-coverage-database/>.

Power Traction Equipment

Power traction equipment/devices (e.g., VAX-D[®], DRX9000, SpineMED[™], Spina System[™], Lordex[®] Decompression Unit, and DRS System[™]) are not covered. Refer to the [National Coverage Determination \(NCD for Vertebral Axial Decompression \(VAX\) \(160.16\)](#). (Accessed March 9, 2021)

Fluidized Therapy Dry Heat

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. Refer to the [NCD for Fluidized Therapy Dry Heat for Certain Musculoskeletal Disorders \(150.8\)](#). (Accessed March 9, 2021)

Policy History/Revision Information

| Date | Summary of Changes |
|------------|--|
| 05/01/2021 | Template Update <ul style="list-style-type: none">Reformatted policy; transferred content to new template |
| 03/16/2021 | <ul style="list-style-type: none">Routine review; no change to coverage guidelines |

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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 are 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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