

Clinical Policy: Chiropractic Care

Reference Number: MI.CP.MP.535

Last Review Date: 04/25

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Spinal Manipulation	Spinal manipulation is a form of manual therapy that involves the movement of a joint near the end of the clinical range of motion.
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.
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. 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.
Maintenance Therapy	A treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.

Policy/Criteria

- I. It is the policy of MeridianHealth affiliated with Centene Corporation® that chiropractic care is **medically necessary** for the following indications:
 - A. Requests for up to 18 visits may be approved by a referral specialist. **Requests over the initial 18 visits required prior authorization and must be reviewed by a Medical Director.**
 - B. Spinal manipulation is the only covered chiropractic procedure.
 - C. **For Beneficiaries Under the Age of 18:**
 - i. Providers must submit a prior authorization (PA) request before performing manipulations on patients under the age of 18 years old.
 - D. **Required Documentation:** Meridian considers chiropractic services by means of manual manipulation medically necessary when appropriate. **The following clinical documentation should be submitted at time of request:**
 - i. Documentation of subluxation by x-ray
 - ii. Date of onset of current complaint and the frequency of visits to date, including a brief history of complaint, initial symptoms and significant symptom characteristics
 - iii. Level of subluxation and associated diagnosis, including complications or predisposing conditions, if present
 - iv. Physical and objective findings

- v. Radiographic findings, including significant findings in support of diagnosis (If documentation other than x-rays supports the medical necessity of spinal manipulation for children, MeridianHealth reserves the right to request x-ray documentation if deemed necessary.)
 - vi. Member's response to current treatment (improvement to date, if any)
 - vii. Estimate of continued treatment necessary for current complaint
 - viii. Expected and anticipated benefit of continued treatment
 - ix. Any additional details, comments, etc. that may be of assistance in the evaluation.
- E. **Relative 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.
- F. The following are **relative contraindications** to dynamic thrust:
- i. Articular hyper mobility and circumstances where the stability of the joint is uncertain;
 - ii. Severe demineralization of bone;
 - iii. Benign bone tumors (spine);
 - iv. Bleeding disorders and anticoagulant therapy; *and*
 - v. Radiculopathy with progressive neurological signs.
- G. Dynamic thrust is **absolutely contraindicated** near the site of demonstrated subluxation and proposed manipulation in the following:
- i. Acute arthropathies characterized by acute inflammation and ligamentous laxity and anatomic subluxation or dislocation; including acute rheumatoid arthritis and ankylosing spondylitis;
 - ii. Acute fractures and dislocations or healed fractures and dislocations with signs of instability;
 - iii. An unstable os odontoideum;
 - iv. Malignancies that involve the vertebral column;
 - v. Infection of bones or joints of the vertebral column;
 - vi. Signs and symptoms of myelopathy or cauda equina syndrome;
 - vii. For cervical spinal manipulations, vertebrobasilar insufficiency syndrome; and
 - viii. A significant major artery aneurysm near the proposed manipulation.
 - ix. Risk factors for dissection (eg, a prior history of cervical artery dissection, recent neck trauma, stroke or transient ischemic attack [TIA] symptoms, Ehlers-Danlos syndrome type IV)
 - x. Down Syndrome (because of risk of Acute atlantoaxial instability)
 - xi. Upper cervical instability
- H. **Absolute Contraindications:**
- i. If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary.
 - ii. Chiropractic maintenance therapy (treatment being supportive in nature and not corrective) is not considered to be medically reasonable or necessary

- iii. Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.
 - iv. Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.
 - v. Chiropractic care in persons, whose condition is neither regressing nor improving, is considered not medically necessary.
 - vi. Manipulation is considered experimental and investigational when it is rendered for non-neuromusculoskeletal conditions (examples include, but are not limited to: attention-deficit hyperactivity disorder, dysmenorrhea, epilepsy; and gastro-intestinal disorders) because its effectiveness for these indications is unproven.
 - vii. Manipulation for children ages 12 and under is considered experimental and investigational for non-neuromuscular skeletal indications. Examples include, but are not limited to: constipation, ear infections, etc.
 - viii. Chiropractic manipulation has no proven value for treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence, unless the member is presenting pain or spasm, or some other medically necessary indications for chiropractic manipulation are present.
- I. **Non-Covered Chiropractic Services:** The following chiropractic services are excluded from Medicaid coverage are all services other than manual manipulation of the spine and spinal x-rays. Medicaid does not cover the following services when rendered by a chiropractor:
- i. Consultations
 - ii. Fracture care
 - iii. Home visits
 - iv. Injections
 - v. Laboratory tests
 - vi. Maintenance therapy
 - vii. Medical supplies
 - viii. Evaluation and management services
 - ix. Plaster casts
 - x. Inpatient hospital visits
- J. **Non-Covered Chiropractic Procedures:** MeridianHealth considers the following chiropractic procedures experimental and investigational and therefore are **not covered benefits**:
- i. Active Release Technique
 - ii. Active Therapeutic Movement (ATM2)
 - iii. Advanced Biostructural Correction (ABC) Chiropractic Technique
 - iv. Applied Spinal Biomechanical Engineering
 - v. Atlas Orthogonal Technique
 - vi. Bioenergetic Synchronization Technique
 - vii. Biogeometric Integration
 - viii. Blair Technique
 - ix. Bowen Technique
 - x. Chiropractic Biophysics Technique
 - xi. Coccygeal Meningeal Stress Fixation Technique
 - xii. Cranial Manipulation
 - xiii. Directional Non-Force Technique

CLINICAL POLICY

Chiropractic Care

- xiv. FAKTR (Functional and Kinetic Treatment with Rehab) Approach
 - xv. Gonzalez Rehabilitation Technique
 - xvi. Koren Specific Technique
 - xvii. Manipulation for infant colic
 - xxviii. Manipulation for internal (non-neuromusculoskeletal) disorders
 - xix. Manipulation Under Anesthesia
 - xx. Moire Contourographic Analysis
 - xxi. Network Technique
 - xxii. Neural Organizational Technique
 - xxiii. Neuro Emotional Technique
 - xxiv. Sacro-Occipital Technique
 - xxv. Spinal Adjusting Devices (ProAdjuster, PulStarFRAS, Activator)
 - xxvi. Therapeutic (Wobble) Chair
 - xxvii. Upledger Technique and Cranio-Sacral Therapy
 - xxviii. Webster Technique (for breech babies)
 - xxix. Whitcomb Technique
- K. **Experimental Investigational Diagnostic Procedures:** MeridianHealth considers the following diagnostic procedures experimental and investigational and therefore are **not covered benefits**:
- i. Computerized radiographic mensuration analysis for assessing spinal mal-alignment
 - ii. Dynamic spinal visualization (including digital motion x-ray and videofluoroscopy, also known as cineradiography)
 - iii. Neurocalometer/Nervoscope - see CPB 0029 - Thermography
 - iv. Para-spinal electromyography (EMG)/Surface scanning EMG - see CPB 0112 - Surface Scanning and Macro Electromyography
 - v. Spinoscropy - see CPB 0112 - Surface Scanning and Macro Electromyography
 - vi. Thermography - see CPB 0029 - Thermography.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Note: Diagnosis

CLINICAL POLICY

Chiropractic Care

Chiropractors must use at least one diagnosis code in conjunction with the procedure codes when billing chiropractic services. Michigan Department of Health and Human Services (MDHHS) follows the Medicare diagnosis coding requirements for chiropractic services.

Note: Procedure Codes

Chiropractors must use at least one appropriate procedure code from the Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS) coding manuals. A list of procedure codes covered by MDHHS is maintained on the MDHHS website.

CPT®*	Description

HCPCS®*	Description

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date		08/19/16
Annual Review with no changes		09/20
Annual review with no changes		12/16/21
Annual review: MDHHS and UpToDate references updated, no content changes		01/09/23
Retired as no PA required for intital 18 visits		02/17/23
Reinstatement of policy for over quantity request (>18 visits) as a PA is required	03/23	03/23
Annual review with some changes	03/25	03/25

References

1. “Spinal manipulation in the treatment of muscoloskeletal pain”. updated: Dec 02, 2024
<https://www.uptodate.com/contents/spinal-manipulation-in-the-treatment-of->

CLINICAL POLICY

Chiropractic Care

[musculoskeletalpain?search=.%20https%3A%2F%2Fwww.uptodate.com%2Fcontents%2Fspinal-manipulation-in-the-treatment-of-musculoskeletal-pain%3Fsource%3Dsearch_result%26search%3Dchiropractic%26selectedTitle%3D1%257E37&source=search_result&selectedTitle=3%7E150&usage_type=default&display_rank=2](https://www.uptodate.com/contents/Spinal-manipulation-in-the-treatment-of-musculoskeletal-pain?search=.%20https%3A%2F%2Fwww.uptodate.com%2Fcontents%2Fspinal-manipulation-in-the-treatment-of-musculoskeletal-pain%3Fsource%3Dsearch_result%26search%3Dchiropractic%26selectedTitle%3D1%257E37&source=search_result&selectedTitle=3%7E150&usage_type=default&display_rank=2)

2. Michigan Department of Health and Human Services Medicaid Provider Manual. Version Date, January 1, 2025 “Chiropractor”. Pages 1-5.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

CLINICAL POLICY

Chiropractic Care

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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