Chiropractic Care

Humana

Medical Coverage Policy

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Change Summary: Updated Coverage Determination, Coverage Limitations, References

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Disclaimer

Description

Chiropractic is a health care discipline that focuses on the relationship between the body's (primarily the spine) structure and function. Chiropractic care is provided by a Doctor of Chiropractic (DC), also known as a chiropractor or a chiropractic physician whose focus is diagnosis and treatment of mechanical disorders of the spine and musculoskeletal system. The goal of chiropractic treatment is to affect the nervous system and improve health. Chiropractic care is based on the theory that a spinal joint dysfunction can interfere with the nervous system and impact the overall health of an individual.

Chiropractors use a type of hands on therapy known as manipulation (or adjustment) as their primary treatment. The manipulations are most commonly of the spine, though they may also give adjustments to extremities and other joints.

Based upon state specific license and scope of practice, they may also utilize other treatment modalities such as cold/heat therapy, electrical stimulation, ultrasound and therapeutic exercise instruction.

Coverage Determination

Please refer to specific certificate language to determine benefit availability and the terms and conditions of coverage for chiropractic care (eg, spinal manipulations/adjustments).

Any state mandates for chiropractic care take precedence over this medical coverage policy.

Humana members may be eligible under the Plan for **chiropractic care** when the following general criteria are met:

- Chiropractic care must be performed by a licensed healthcare professional acting within their state specific licensure and scope of practice in their licensed jurisdiction where the services are provided; **AND**

- Services provided must be of the complexity and nature to require that they are performed by a licensed chiropractor or provided under their direct supervision by a licensed ancillary person according to state licensure laws; **AND**

- Services must be provided in accordance with an ongoing, written plan of care that is in accordance with applicable federal and state laws and regulations and nationally accepted professional standards of care; **AND**

    - The plan of care should be of such sufficient detail and include appropriate objective and subjective data to demonstrate the medical necessity of the proposed treatment. This information should include at least the following:

        - Reasonable estimate as to the time when these goals will be achieved; **AND**

        - Frequency and duration of the treatments provided must be reasonable and customary under the generally accepted standards of

practice for chiropractic care; **AND**

- Initial evaluation/assessment/history and physical; **AND**
- Long and short term goals that are specific, quantifiable (measurable) and objective; **AND**
- Specific chiropractic techniques, treatments or exercises to be used along with identification of spinal and/or body region treated; **AND**

- Individual must have a musculoskeletal or neuromusculoskeletal condition, creating a functional impairment, necessitating an appropriate, medically necessary evaluation and treatment services; **AND**
- Services provided must be clinically indicated, medically necessary, in accordance with each subscriber certificate and appropriately documented in the medical record; **AND**
- There must be a reasonable expectation of recovery or improvement in function to support the onset and continuation of a therapeutic level care plan; **AND**
- Services should be reflective of an acute care model and episodic in nature; ongoing care after the condition has stabilized or the individual's condition has reached a clinical plateau, called maximum medical improvement (MMI), may not qualify as medically necessary covered services

Humana members may be eligible under the Plan for **fluidized therapy** (fluidotherapy) if the above general criteria are met, in addition to the following:

- Maximum duration of fluidized therapy treatment is 4 weeks; **AND**
- Utilized as an alternative to other heat therapy modalities in the treatment of acute or subacute traumatic or nontraumatic musculoskeletal disorders of the extremities; **AND**
- If the following contraindications to fluidized therapy are not present:

- Severe circulatory disorders (eg, arterial, lymphatic or venous disorders); **OR**
- Systemic infectious diseases

Note: The criteria for **chiropractic care** (manipulation) are not consistent with the Medicare National Coverage Policy, and therefore may not be applicable to Medicare members. Refer to the CMS website for additional information.

Coverage Limitations

Humana members may **NOT** be eligible under the Plan for **chiropractic care** for any indications, treatment techniques or modalities other than those listed above including, but may not be limited to:

- Adjustments/manipulations in a asymptomatic individual or for those without an identifiable clinical condition; **OR**
- Adjustments/manipulations in an individual whose condition is neither regressing nor improving; **OR**
- Augmented soft tissue mobilization (ASTYM or ASTM technique); **OR**
- Back school and other return-to-work/reintegration or vocational programs including work hardening (may be excluded by certificate); **OR**
- Cold therapy devices/heating devices/combination heat and cold therapy devices (convenience items) (for information regarding coverage determination/ limitations, please refer to Cold Therapy Devices/Heating Devices/Combined Heat and Cold Therapy Devices Medical Coverage Policy); **OR**
- Cost of supplies (eg, theraband, electrodes) used in furnishing chiropractic care is included in the general services with which they are associated. Separate coverage may exist for custom fabricated splints and other designated items (for information regarding coverage determination/limitations, please refer to Orthotics Medical Coverage Policy); **OR**

- Duplicative services for the same clinical condition or problem, such as chiropractic care and habilitative or rehabilitative physical or occupational therapy. If both therapies are provided, the treatment programs must be separately determined and part of specific, separate written treatment plans; the therapies must provide significantly different treatments and not be seen as generally duplicating each other; **OR**

- Graston technique; **OR**

- Internal manipulation (transvaginal, transrectal) for conditions including, but may not be limited to: chronic pelvic pain, vulvodynia, pudendal neuralgia or interstitial cystitis; **OR**

- Kinesio taping; **OR**

- Lifestyle enhancement care, such as exercises to promote overall fitness, flexibility, provide diversion or motivation; **OR**

- Maintenance care (may be excluded by certificate) consists of activities that generally are intended to preserve the individual's present level of function and/or prevent regression of that level of function including, but may not be limited to, the following:

    - Maintenance begins when the therapeutic goals of the treatment program are achieved or when no further significant progress is made or reasonably seen as occurring (eg, transition to a home exercise program [HEP]); **AND**

    - Individual has achieved generally accepted normal levels of function and/or muscle strength and has reached a plateau (generally a period of 4 weeks or less, depending on the specific condition and/or individual situation); **OR**

- Nonmusculoskeletal or nonneuromusculoskeletal conditions; **OR**

- Portable (home) ultrasound devices (for information regarding coverage determination/limitations, please refer to Durable Medical Equipment Medical Coverage Policy); **OR**

- Treatments for sports related rehabilitation***** or other similar avocational activities such as, but may not be limited to:
  - Baseball pitching/throwing
  - Cheerleading
  - Golfing
  - Martial arts of all types
  - Organized football, baseball, basketball, soccer, lacrosse, swimming, track and field, etc. at a college, high school, other school or community setting
  - Personal return to running rehabilitation
  - Professional and amateur tennis
  - Professional and amateur/hobby/academic dance
  - Weightlifting and similar activities

*****Refers to continued treatment for sports related injuries in an effort to improve above and beyond normal ability to perform ADLs; it is not intended to return the individual to their previous (or improved) level of sports competition or capability.

These are considered not medically necessary as defined in the member's individual certificate. Please refer to the member's individual certificate for the specific definition.

Humana members may **NOT** be eligible under the Plan for **chiropractic care** for **temporomandibular joint disorders**. This is considered experimental/investigational as it is not identified as widely used and generally accepted for the proposed use as reported in nationally recognized peer-reviewed medical literature published in the English language.

Humana members may **NOT** be eligible under the Plan for **chiropractic care** utilizing any of the following diagnostic or treatment techniques including, but may not be limited to:

- Chiropractic Biophysics (CBP); **OR**
- Computerized inclinometer ROM device (eg, Dual Inclinometer Range of Motion device); **OR**
- Computerized muscle testing; **OR**
- Digital postural analysis; **OR**
- Digitalizing of X-rays (also known as a roentgenometric procedure including, but not limited to, the Spinalyzer); **OR**
- Dry hydrotherapy, also known as hydromassage, aqua massage or water massage (eg, Aqua Massage, Aqua MED, H2O Massage System and Hydrotherapy Tables); **OR**
- Dynamic spinal visualization (videofluoroscopy of the spine) (for information regarding coverage determination/limitations, please refer to Videofluoroscopy, Dynamic MRI for Musculoskeletal Indications Medical Coverage Policy); **OR**
- Low level laser therapy or high power laser therapy (for information regarding coverage determination/limitations, please refer to Low Level Laser and High Power Laser Therapy Medical Coverage Policy); **OR**
- Manipulation under anesthesia (for information regarding coverage determination/limitations, please refer to Manipulation Under Anesthesia Medical Coverage Policy); **OR**
- Matrix therapies (also known as Matrix Regeneration Therapy); **OR**
- Microcurrent (also known as Acuscope or Electro-acuscope); **OR**

- Monochromatic infrared energy (MIRE) therapy (for information regarding coverage determination/limitations, please refer to Code Compendium (Wound Care) Medical Coverage Policy); **OR**

- National Upper Cervical Chiropractic Association (NUCCA) technique; **OR**

- Surface EMG (for information regarding coverage determination/limitations, please refer to Nerve Conduction Testing, Somatosensory and Visual Evoked Potentials, Surface Electromyography Medical Coverage Policy); **OR**

- Thermography (also known as a paraspinal thermal scan); **OR**

- Vertebral decompression therapy, also known as mechanized spinal distraction therapy, intervertebral differential dynamics therapy, intervertebral disc decompression (IDD) or powered traction device (eg, Accu-Spina System, Decompression Reduction Stabilization [DRS] System, DRX 9000, DX2 Decompression System, Integrity Spinal Care System, Intervertebral Differential Dynamics Therapy [IDD Therapy], Lordex Lumbar Spine System, MTD 4000 Mettler Traction Decompression System, SpineRx-LDM and VAX-D Spinal Decompression System)

These are considered experimental/investigational as they are not identified as widely used and generally accepted for the proposed uses as reported in nationally recognized peer-review medical literature published in the English language.

Background

Additional information about **musculoskeletal conditions and chiropractic care** may be found from the following websites:

- American Academy of Orthopaedic Surgeons
- American Chiropractic Association
- American College of Rheumatology
- National Institute of Arthritis and Musculoskeletal and Skin Diseases
- National Institute of Neurological Disorders and Stroke
- National Library of Medicine

Medical Alternatives

Alternatives to **chiropractic care** include, but may not be limited to, the following:

- Occupational or physical therapy (please refer to Physical Therapy and Occupational Therapy Medical Coverage Policy)
- Pain management

Physician consultation is advised to make an informed decision based on an individual's health needs.

Humana may offer a disease management program for this condition. **The member may call the number on his/her identification card to ask about our programs to help manage his/her care.**

Provider Claims Codes

Any CPT, HCPCS or ICD codes listed on this medical coverage policy are for informational purposes only. Do not rely on the accuracy and inclusion of specific codes. Inclusion of a code does not guarantee coverage and or reimbursement for a service or procedure.

CPT® Code(s)	Description	Comments
29200	Strapping; thorax	**Not Covered if used to report Kinesio taping**
29240	Strapping; shoulder (eg, Velpeau)	**Not Covered if used to report Kinesio taping**
29260	Strapping; elbow or wrist	**Not Covered if used to report Kinesio taping**
29280	Strapping; hand or finger	**Not Covered if used to report Kinesio taping**
29520	Strapping; hip	**Not Covered if used to report Kinesio taping**
29530	Strapping; knee	**Not Covered if used to report Kinesio taping**
29540	Strapping; ankle and/or foot	**Not Covered if used to report Kinesio taping**

29550	Strapping; toes	**Not Covered if used to report Kinesio taping**
29799	Unlisted procedure, casting or strapping	**Not Covered if used to report Kinesio taping**
97012	Application of a modality to 1 or more areas; traction, mechanical	
97039	Unlisted modality (specify type and time if constant attendance)	**Not Covered if used to report chiropractic care outlined in Coverage Limitations**
97139	Unlisted therapeutic procedure (specify)	**Not Covered if used to report chiropractic care outlined in Coverage Limitations**
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	**Not Covered if used to report any treatment outlined in Coverage Limitations section augmented soft tissue mobilization or Graston® Technique**
97545	Work hardening/conditioning; initial 2 hours	**Not Covered**
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)	**Not Covered**
97799	Unlisted physical medicine/rehabilitation service or procedure	
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	
98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions	
CPT® Category III Code(s)	**Description**	**Comments**
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	**Not Covered**

0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic and lumbosacral, when performed)	**Not Covered**
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)	**Not Covered**
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)	**Not Covered**
HCPCS Code(s)	**Description**	**Comments**
S8990	Physical or manipulative therapy performed for maintenance rather than restoration	**Not Covered**
S9090	Vertebral axial decompression, per session	**Not Covered**
S9117	Back school, per visit	**Not Covered**

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