Medical Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Chiropractic Services & Spinal Manipulation

Policy Number: PG0150
Last Review: 12/01/2024

GUIDELINES:

- This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
- This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE:

X Professional
_ Facility

DESCRIPTION:

Chiropractic care is a branch of the healing arts that is based on the relationship between the structure and function of the human body as it relates to the spine. Chiropractic (therapeutic) manipulation may be referred to as spinal and extra-spinal adjustment, manual adjustment, vertebral adjustment, or spinal manipulative therapy (SMT).

Chiropractic Manipulative Treatment (CMT) providers use natural and conservative methods to treat the biomechanics, structure, and function of the spine, in order to promote healing without surgery or medication. CMT is outcome-based care using specific modalities targeted to the functional problem(s) or diagnosis of the patient. Manipulation or adjustment procedures are performed by manual methods only or with device-assisted modalities, to treat symptoms related to the articulations of the spine and musculoskeletal structures, including the extremities. The goal of CMT is relief of discomfort caused by impingement of nerves or other structures of the spinal column (e.g., joints, tissues, muscles).

Regions of the Spine (for procedure codes 98940 through 98942) include:

- Cervical (includes atlanto-occipital joint)
- Thoracic (including costovertebral and costotransverse, excluding anterior rib cage/costosternal)
- Lumbar
- Sacral
- Pelvic (sacro-iliac joint)

Regions of the Extraspinal (98943) include:

- Head (including temporomandibular joint, excluding the atlanto-occipital)
- Lower Extremities
- Upper Extremities
- Anterior rib cage costosternal (excluding costotransverse and costovertebral)
- Abdomen

Chiropractic services that may be eligible for coverage are limited to treatment to correct a structural imbalance or subluxation related to distortion or misalignment of the vertebral column by means of manual spinal manipulation (i.e., by use of the hands) when the condition meets the medical necessity criteria in this policy.

Chiropractors may use manual devices/instruments (devices that are hand-held with the thrust or the force of the device being controlled manually) in performing manual manipulation of the spine and related muscles/tissues.

POLICY:

Paramount Commercial Insurance Plans

- **Chiropractic services & spinal manipulation do not require prior authorization for adults and children 4 years of age and older.**
- **Chiropractic services & spinal manipulation (98940-98943) require prior authorization for children under 4 years of age.**

Elite (Medicare Advantage) Plans

- **Effective 1/1/2021 a Prior Authorization is required for all chiropractic visits exceeding 30 per year. This policy includes all combination of procedure codes 98940, 98941 and 98942.**
- **The allowed visits in the outpatient setting are thirty dates of service per benefit year for a member younger than twenty-one years of age, fifteen dates of service per benefit year for a member twenty-one years of age or older. These limits may be exceeded with prior authorization.**
- **Procedure 98943 is non-covered for Elite (Medicare Advantage) Plans**

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Paramount will cover medically necessary chiropractic services, if covered **as outlined in the member's summary of benefits**. Copayments, deductibles and/or coinsurance will apply pursuant to the terms of the member's benefit plan document. Note: some plans have limitations or exclusions applicable to chiropractic care, therefore the members benefit language should be reviewed before applying the coverage criteria terms of this medical policy.

Coverage is limited to medically necessary services provided by a licensed Doctor of Chiropractic, within the scope of their license.

Paramount Commercial Plans

Chiropractic services & spinal manipulation (98940-98943) require prior authorization for children under 4 years of age. (See below for ICD-10 codes for under 4 years of age.)

Coverage of chiropractic services is limited to manual manipulation (by use of the hands) of the spine for correcting a subluxation for acute or chronic active/corrective treatment.

- 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.
- Chiropractors may use manual devices (those that are hand-held with the thrust of the force of the device being controlled manually) in performing manual manipulation of the spine.

Paramount considers chiropractic services medically necessary when all the following coverage criteria is met:

- The member has a neuromusculoskeletal disorder that may be improved or resolved by standard chiropractic therapy; and
- The medical necessity for treatment is clearly documented (including symptoms/diagnosis being treated, diagnostic procedures and treatment modalities used, results of diagnostic procedures, treatments, anticipated length of treatments and quantifiable, attainable treatment goals); and
- The chiropractic care must be necessary for and appropriate to the diagnosis, treatment, cure, or relief of a neuromusculoskeletal condition, illness, injury, disease, or its symptoms; and
- Improvement is documented within the initial 2 weeks of chiropractic care; and
- Chiropractic care is performed within the scope of the license of a chiropractor.

- If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is

considered not medically necessary unless the chiropractic treatment is modified.
- If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary.
- Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.

Non-Covered:
- Services rendered by non-participating chiropractors,
- Services more than benefit or visit limits,
- Chiropractic manipulation in asymptomatic members without an identifiable clinical condition,
- If therapeutic benefit has reached a plateau,
- Chiropractic services for maintenance programs or supportive care,
- If the patient's condition becomes worse or regresses,
- If the therapeutic goals have been reached,
- If the patient has become asymptomatic,
- If the patient or parent/caregiver can independently practice or self-administer the activities or services safely and effectively
- If the services or activities are for the general good or welfare of the patient, such as exercise to promote overall fitness, flexibility, endurance, aerobic conditioning, maintenance of range of motion or strength, and weight reduction.

Chiropractic manipulation and adjunct therapeutic procedures/modalities (e.g., mobilization, therapeutic exercise, traction) for treatment of non-musculoskeletal conditions are considered experimental, investigational, or unproven.

Elite (Medicare Advantage) Plans

Indications: (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3).
The patient must have a significant health problem in the form of a neuromusculoskeletal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function.

The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam. The primary diagnosis must be subluxation

Most spinal joint problems fall into the following categories:
- 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 as specified above. 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. Once the clinical status has remained stable for a given condition, without expectation of additional objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.

- An acute exacerbation is a temporary but marked deterioration of the patient's condition that is causing significant interference with activities of daily living due to an acute flare-up of the previously treated condition. The patient's clinical record must specify the date of occurrence, nature of the onset, or other pertinent factors that would support the medical necessity of treatment. As with an acute injury, treatment should result in improvement or arrest of the deterioration within a reasonable period.

Maintenance Therapy
Maintenance therapy includes services that seek 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 be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

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.

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; and
- Radiculopathy with progressive neurological signs. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3B).

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 dislocations with signs of instability;
- An unstable os odontoideum;
- Malignancies that involve the vertebral column;
- Infection of bones or joints of the vertebral column;
- Signs and symptoms of myelopathy or cauda equina syndrome;
- For cervical spinal manipulations, vertebrobasilar insufficiency syndrome, and a significant major artery aneurysm near the proposed manipulation. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3B).

Limitations:
The term “physician” includes a chiropractor but only for treatment by means of manual manipulation of the spine to correct a subluxation. All other services furnished or ordered by chiropractors are not covered.

Coverage of chiropractic service is specifically limited to treatment 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 Paramount recognize an extra charge for the device itself.

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor’s order is covered. This means that if a chiropractor orders, takes, or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test, can be used for claims processing purposes, but Paramount coverage and payment are not available for those services. This prohibition does not affect the coverage of x-rays or other diagnostic tests furnished by other practitioners under the program. For example, an x-ray or any diagnostic test taken for the purpose of determining or demonstrating the existence of a subluxation of the spine is a diagnostic x-ray test covered under §1861(s)(3) of the Act if ordered, taken, and interpreted by a physician who is a Doctor of Medicine or osteopathy. (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.1)

The mere statement or diagnosis of "pain" is not sufficient to support medical necessity for the treatments. The precise level(s) of the subluxation(s) must be specified by the chiropractor to substantiate a claim for manipulation of each spinal region(s). The need for an extensive, prolonged course of treatment should be appropriate to the reported procedure code(s) and must be documented clearly in the medical record.

The following information must be documented in the medical record.

I. History:

- chief complaint including the symptoms present that caused the patient to seek chiropractic treatment.

II. Present Illness: This can include any of the following as appropriate:

- mechanism of trauma;
- quality and character of problem/symptoms;
- intensity of symptoms;
- frequency of symptoms occurring;
- location and radiation of symptoms;
- onset of symptoms;
- duration of symptoms;
- aggravating or relieving factors of symptoms;
- prior interventions, treatments, including medications;
- secondary complaints;
- symptoms causing patient to seek treatment.

III. Family History: If pertinent

IV. Pertinent past health history, which may include:

- general health statement
- prior illness(es)
- surgical history
- prior injuries or traumas
- past hospitalizations (as appropriate)
- medications

V. Physical examination: Evaluation of musculoskeletal/nervous system through physical examination 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 under physical examination are required, one of which must be asymmetry/misalignment or range of motion abnormality.

VII. Treatment Plan: The treatment plan should include the following:

- Therapeutic modalities to effect cure or relief (patient education and exercise training).
- The level of care that is recommended (the duration and frequency of visits).
- Specific goals that are to be achieved with treatment.
- Objective measures to evaluate treatment effectiveness.
- Date of initial treatment.

VIII. Subsequent Visits:

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination for subsequent visits:

- History:
  - Review of chief complaint;
  - Interval history and system review if relevant.
- Physical exam:

    - Exam of area of spine involved in diagnosis;
    - Assessment of change in patient condition since last visit;
    - Evaluation of treatment effectiveness.
- Documentation of treatment given on day of visit

The five extraspinal regions referred to are:

- head (including, temporomandibular joint, excluding atlantooccipital) region;
- lower extremities;
- upper extremities;
- rib care (excluding costotransverse and costovertebral joints) and
- abdomen.

Medicare does not cover chiropractic treatments to extraspinal regions (CPT 98943). Paramount Elite/ProMedica Medicare Plan product lines do not cover chiropractic treatments to extraspinal regions (CPT 98943), which includes the head, upper and lower extremities, rib cage and abdomen.

Chiropractors must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However, the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, Paramount may deny if appropriate after medical review. Modifier AT must only be used when the chiropractic manipulation is “reasonable and necessary.” Modifier AT must not be used when maintenance therapy has been performed.

Paramount Commercial Plans and Elite (Medicare Advantage) Plans

Members may NOT be eligible for chiropractic care for any of the following indications, not limited to:

- Adjustments/manipulations in asymptomatic individuals or for those without an identifiable clinical condition; or
- Adjustments/manipulations in individuals 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; or
- Cold therapy devices/heating devices/combination heat and cold therapy devices (convenience items); or
- Cost of supplies (e.g., theraband, electrodes) used in furnishing chiropractic care is included in the general services with which they are associated; or
- Graston technique; or
- Internal manipulation (i.e., 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 consists of activities that are intended to preserve the individual’s present level of function and/or prevent regression of that level of function; or
- Non musculoskeletal or nonneuromusculoskeletal conditions; or
- Treatments for sports related rehabilitation or other similar avocational activities such as, but not limited to: (Refers to continued treatment for sports related injuries 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.)
    - 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.

Paramount considers the following procedures experimental and investigational, not an all-inclusive listing:

- Manipulation when it is rendered for non-neuromusculoskeletal conditions; not an all-inclusive list:
  - Attention-deficit hyperactivity disorder;
  - Asthma;
  - Autism spectrum disorder;
  - Depression;
  - Dizziness / vertigo;
  - Dysmenorrhea;
  - Epilepsy;
  - Female infertility;
  - Gastro-intestinal disorders;
  - Improvement of brain function; and
  - Menopause-associated vasomotor symptoms;
- Manipulation of infants for non-neuromusculoskeletal indications (see examples below, not an all-inclusive list):
  - Infants with gastro-intestinal disorders including constipation;
  - Excessive intestinal gas; and
  - Gastroesophageal reflux disease;
- Chiropractic procedures:
  - Active Release Technique;
  - Active Therapeutic Movement (ATM2);
  - Advanced Biostructural Correction (ABC) Chiropractic Technique;
  - Applied Spinal Biomechanical Engineering;
  - Atlas Orthogonal Technique;
  - Bioenergetic Synchronization Technique;
  - Biogeometric Integration;
  - Blair Technique;
  - Bowen Technique;
  - Chiropractic Biophysics Technique / Chiropractic BioPhysics Methods;
  - Coccygeal Meningeal Stress Fixation Technique;
  - ConnecTX (an instrument-assisted connective tissue therapy program);
  - Cox decompression manipulation/technique;
  - Cranial Manipulation;
  - Directional Non-Force Technique;
  - Dry hydrotherapy (i.e., Aquamed, Sidmar);
  - FAKTR (Functional and Kinetic Treatment with Rehab) Approach;
  - Gonzalez Rehabilitation Technique;
  - Inertial traction (inertial extensilizer decompression table;
  - IntraDiscNutrosis program;
  - Koren Specific Technique;
  - Manipulation for infant colic;
  - Manipulation for internal (non-neuromusculoskeletal) disorders (Applied Kinesiology);
  - Manipulation Under Anesthesia;
  - Moire Contourographic Analysis;
  - Network Technique;
  - Neural Organizational Technique;
  - Neuro Emotional Technique;
  - NUCCA (National Upper Cervical Chiropractic Association) procedure;
  - Origin insertion release technique;
  - Positional release therapy;
  - Sacro-Occipital Technique;

- Spinal Adjusting Devices (ProAdjuster, PulStarFRAS, Activator);
- Therapeutic (Wobble) Chair;
- Upledger Technique and Cranio-Sacral Therapy;
- Webster Technique (for breech babies);
- Whitcomb Technique

Use of any of the following treatments are considered **experimental, investigational, or unproven** (this list may not be all-inclusive):

- Non-invasive Interactive Neurostimulation (e.g., InterX®)
- Microcurrent Electrical Nerve Stimulation (MENS)
- H-WAVE ®
- Interferential Stimulation
- Dry Needling
- Low-level laser therapy (LLLT)
- MedX lumbar/cervical machines
- Cybex back system/Biodex
- Digital radiographic mensuration
- Digital postural analysis
- Thermography
- Spinal/paraspinal ultrasound
- Surface electromyography /paraspinal electromyography
- Iontophoresis or phonophoresis

CODING/BILLING INFORMATION:
The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES for Chiropractic Services:	
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low-level medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate-level medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high-level medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.

99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low-level medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high-level medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
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, one or more regions
ICD-10 codes may be covered <u>with required prior authorization</u> if selection criteria are met (under 4 years of age):	
G24.3	Spasmodic torticollis
G54.0 - G55	Nerve root and plexus disorders
G71.0 - G72.9	Primary disorders of muscles and other myopthies
G80.0 - G80.9	Cerebral palsy
M05.00 - M08.99	Rheumatoid arthritis and other inflammatory polyarthropathies
M40.00 - M40.51 **M42.00 - M54.9**	Deforming dorsopathies, spondylitis and other dorsopathies [excluding scoliosis]
M91.10 - M94.9	Chondropathies
Q65.00 - Q68.8	Congenital musculoskeletal deformities
Q72.70 - Q72.73 **Q74.1 - Q74.2**	Congenital malformations of lower limb, including pelvic girdle
Q74.0 **Q74.9** **Q87.89**	Congenital malformations of upper limb, including shoulder girdle
Q76.0 - Q76.49	Congenital malformations of spine
Q77.0 -Q77.1 **Q77.4 - Q77.5** **Q77.7 - Q77.9** **Q78.9**	Osteochrondrodysplasia

S03.4xx+	Sprain of jaw
S13.0xx+ - S13.9xx+ S23.0xx+ - S23.9xx+ S33.0xx+ - S33.9xx+ S43.001+ - S43.92X+ S53.001+ - S53.499 S63.001+ - S63.92X+ S73.001+ - S73.199+ S83.001 - S83.92X+ S93.01X+ - S93.699+	Dislocation and sprains of joint and ligaments
S14.2xx+ - S14.9xx+ S24.2xx+ - S24.9XX+ S34.21x+ - S34.9XX+	Injury to nerve roots, spinal plexus, and other nerves
S16.1xx+	Strain of muscle, fascia, and tendon at neck level
S23.41x+ - S23.429+ S33.4xx+ S33.8xx+ - S33.9xx+	Sprain of other ribs, sternum, and pelvis
S39.002+ S39.012+ S39.092+	Injury or strain of muscle, fascia, and tendon of lower back
S44.00x+ - S44.92x+	Injury of nerves at shoulder and upper arm level
S46.011+ - S46.019+ S46.111+ - S46.119+ S46.211+ - S46.219+ S46.311+ - S46.319+ S46.811+ - S46.819+ S46.911+ - S46.919+	Injury of muscle, fascia and tendon at shoulder and upper arm level
S74.00x+ - S74.92x+	Injury of nerves at hip and thigh level
S76.011+ - S76.019+ S76.111+ -	Injury and strain of muscle, fascia and tendon at hip and thigh level

S76.119+ S76.211+ - S76.219+ S76.311+ - S76.319+ S76.811+ - S76.819+ S76.911+ - S76.919+	
S84.00x+ - S84.92x+	Injury of nerves at lower leg level
S86.001+ - S86.019+ S86.111+ - S86.119+ S86.211+ - S86.219+ S86.311+ - S86.319+ S86.811+ - S86.819+ S86.911+ - S86.919+	Injury of muscle, fascia, and tendon at lower leg level
S94.00x+ - S94.92x+	Injury of nerves at ankle and foot level
S96.001+ - S96.019+ S96.111+ - S96.119+ S96.211+ - S96.219+ S96.811+ - S96.819+ S96.911+ - S96.919+	Injury of muscle, fascia and tendon at ankle and foot level
ICD-10 codes covered if selection criteria are met for adults and children (4 years of age and older):	
G24.3	Spasmodic torticollis
G43.001 - G43.919	Migraine
G44.001 - G44.89	Tension and other headaches
G54.0 - G55	Nerve root and plexus disorders
G56.00 - G56.93	Mononeuritis of upper limb
G57.00 - G59	Mononeuritis of lower limb
G71.0 - G72.9	Muscular dystrophies and other myopathies
G80.0 - G80.9	Cerebral palsy
M05.00 - M08.99	Rheumatoid arthritis and other inflammatory polyarthropathies
M12.00 - M13.89	Other and unspecified arthropathies

M15.0 - M19.93	Osteoarthritis and allied disorders
M20.001 - M25.9	Other joint disorders
M26.601 - M26.69	Temporomandibular joint disorders
M35.3 M75.00 - M79.9	Rheumatism, shoulder lesions and enthesopathies [excludes back]
M40.00 - M40.51 M42.00 - M54.9	Deforming dorsopathies, spondylitis and other dorsopathies [excluding scoliosis]
M85.30 - M85.39	Osteitis condensans
M89.00 - M89.09	Algoneurodystrophy
M91.10 - M94.9	Osteochondropathies
M95.3	Acquired deformity of neck
M95.5	Acquired deformity of pelvis
M95.8	Other specified acquired deformities of musculoskeletal system
M95.9	Acquired deformities of musculoskeletal system, unspecified
M99.00 - M99.09	Segmental and somatic dysfunction [allowed by CMS]
M99.10 - M99.19	Subluxation complex (vertebral)
M99.83 - M99.84	Other acquired deformity of back or spine
Numerous options	Other, mulitple, and ill-defined dislocations [including vertebra]
Q65.00 - Q68.8	Congenital musculoskeletal deformities
Q74.1 - Q74.2	Congenital malformations of lower limb, including pelvic girdle
Q74.0 Q74.9 Q87.89	Congenital malformations of upper limb, including shoulder girdle
Q76.0 - Q76.49	Congenital malformations of spine
Q77.0 -Q77.1 Q77.4 - Q77.5 Q77.7 - Q77.9 Q78.9	Osteochrondrodysplasia
R51	Headache
S03.40x+ - S03.42x+	Sprain of jaw
S13.0xx+ - S13.9xx+ S23.0xx+ - S23.9xx+ S33.0xx+ - S33.9xx+ S43.001+ -	Dislocation and sprains of joints and ligaments

S43.92X+ S53.001+ - S53.499 S63.001+ - S63.92X+ S73.001+ - S73.199+ S83.001 - S83.92X+ S93.01X+ - S93.699+	
S14.2xx+ - S14.9xx+ S24.2xx+ - S24.9XX+ S34.21x+ - S34.9xx+	Injuries to nerve root(s), spinal plexus(es) and other nerves
S16.1xx+	Strain of muscle, fascia, and tendon at neck level
S23.41x+ - S23.429+ S33.4xx+ S33.8xx+ - S33.9xx+	Sprain of other ribs, sternum, and pelvis
S39.002+ S39.012+ S39.092+	Injury or strain of muscle, fascia, and tendon of lower back
S44.00x+ - S44.92x+	Injury of nerves at shoulder and upper arm level
S46.011+ - S46.019+ S46.111+ - S46.119+ S46.211+ - S46.219+ S46.311+ - S46.319+ S46.811+ - S46.819+ S46.911+ - S46.919+	Injury of muscle, fascia and tendon at shoulder and upper arm level
S74.00x+ - S74.92x+	Injury of nerves at hip and thigh level
S76.011+ - S76.019+ S76.111+ - S76.119+ S76.211+ - S76.219+ S76.311+ - S76.319+ S76.811+ - S76.819+	Injury and strain of muscle, fascia and tendon at hip and thigh level

S76.911+ - S76.919+	
S84.00x+ - S84.92x+	Injury of nerves at lower leg level
S86.001+ - S86.019+ S86.111+ - S86.119+ S86.211+ - S86.219+ S86.311+ - S86.319+ S86.811+ - S86.819+ S86.911+ - S86.919+	Injury of muscle, fascia, and tendon at lower leg level
S94.011+ - S94.019+ S94.111+ - S94.119+ S94.211+ - S94.219+ S94.311+ - S94.319+ S94.811+ - S94.819+ S94.911+ - S94.919+	Injury of nerves at ankle and foot level
S96.001+ - S96.019+ S96.111+ - S96.119+ S96.211+ - S96.219+ S96.811+ - S96.819+ S96.911+ - S96.919+	Injury of muscle, fascia and tendon at ankle and foot level
ICD-10 codes not covered for indications listed (not all-inclusive):	
F07.81	Post-concussional syndrome
F84.0 – F84.9	Pervasive developmental disorder
F90.0 – F90.9	Attention deficit hyperactivity disorder
G40.001 – G40.919	Epilepsy and recurrent seizures
J45.20 – J45.998	Asthma
K00.0 – K95.89	Diseases of the digestive system
M41.00 – M41.9	Scoliosis [and kyphoscoliosis], idiopathic; resolving infantile idiopathic scoliosis; and progressive infantile idiopathic scoliosis
N94.4 – N94.6	Dysmenorrhea

N95.1	Menopausal and female climacteric states [not covered for menopause-associated vasomotor symptoms]
O32.1xx0 – O32.1xx9	Maternal care for breech presentation
R10.83	Colic
R56.1	Post traumatic seizures
R56.9	Unspecified convulsions [seizure disorder NOS]

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 01/13/2015

Date	Explanation & Changes
01/13/15	• Reviewed OAC 5160-8-11 and CMS L31862 guidelines. Policy created to reflect most current clinical evidence per Medical Policy Steering Committee
06/14/16	• Per the Medicare Tactical Team Meeting review and determination, code 98943 is non-covered for Elite per CMS guidelines • Removed codes 97010, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97110, 97112, 97113, 97116, 97124, 97140, 97530 from this policy and added to PG0158 • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
10/11/16	• Changed verbiage for prior authorization requirement from “children 0-3 years of age” to “children under 4 years of age” per administrative direction
04/10/18	• Removed ICD-9 diagnosis codes and replaced with ICD-10 codes • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
12/01/2020	• Policy update, effective 1/1/2021, Elite/ProMedica Medicare Plan, a Prior Authorization is required for all chiropractic visits exceeding 30 per year. This policy includes all combination of procedure codes 98940, 98941, 98942 and 98943
12/07/2020	• Placed medical policy on the new Paramount Medical Policy Format
07/01/2022	• Policy reviewed and updated to reflect most current clinical evidence • Advantage Product Line ○ Ohio House Bill 136 approved the Ohio Department of Medicaid to cover evaluation and management services provided by a chiropractor licensed under Ohio law, effective June 13, 2022 ○ Removed the non-coverage of Evaluation and Management services when performed or ordered by the chiropractor ○ Added the supporting documentation: Effective June 13, 2022, the Ohio Department of Medicaid (ODM) will cover low- and moderate-level E&M services represented by CPT codes 99202, 99203, 99211, 99212, and 99213 when performed by a chiropractor (Provider Type 27). ODM will cover four E&M services per benefit year. These changes will be reflected in updates to Ohio Administrative Code (OAC) rule 5160-8-11, entitled “Spinal manipulation and related diagnostic imaging services”, currently targeted to be effective October 1, 2022. ○ Paramount will cover four E&M CPT codes 99202, 99203, 99211, 99212, and 99213 per year, any combination, when performed by a chiropractor effective 06/13/2022, when documentation is supportive of the services. ○ Paramount will deny E&M CPT codes 99204, 99205, 99214, and 99215 as noncovered services, provider liability.
01/26/2023	• Updated the E&M codes revised text
02/09/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023
02/21/2024	• Medical Policy placed on the new Paramount Medical Policy format
12/01/2024	• Medical Policy reviewed and

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/

Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review