



**BlueCross BlueShield
of Vermont**

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Corporate Medical Policy

Chiropractic Services

File name: Chiropractic Services

Origination: 7/22/97

Last Review: 11/08

Next Review: 12/09

Effective Date: 7/15/09

Description

“The practice of chiropractic” means the diagnosis of human ailments and diseases related to subluxations, joint dysfunctions, neuromuscular and skeletal disorders for the purpose of their detection, correction or referral in order to restore and maintain health, without providing drugs or performing surgery; the use of physical and clinical examinations, conventional radiologic procedures and interpretation, as well as the use of diagnostic imaging read and interpreted by a person so licensed and clinical laboratory procedures to determine the propriety of a regimen of chiropractic care; adjunctive therapies approved by the board, by rule, to be used in conjunction with chiropractic treatment; and treatment by adjustment or manipulation of the spine or other joints and connected neuromusculoskeletal tissues and bodily articulations.

Policy

Benefits are subject to all terms, limitations and conditions of the subscriber contract.

Prior approval is required for the 13th visit forward per calendar year.

The Plan covers chiropractic services when they are determined to be medically necessary because the medical criteria and guidelines below are met. Chiropractors must be either in the managed care network for our managed care members or participating providers for all other lines of business.

When service or procedure is covered

We cover Acute Care and Supportive Chiropractic Care, including:

- Office visits, spinal and extraspinal manipulations and associated modalities;
- Home, hospital, or nursing home visits; or
- Diagnostic services (e.g., X-rays).

Chiropractic care may be considered medically necessary and is normally a covered benefit for acute neuromusculoskeletal conditions that cause significant pain (VAS >2) or interference with routine activities of daily living (ADLs) and/or persist despite non-interventional treatments such as hot and cold packs and nonsteroidal anti-inflammatory (NSAIDs).

Activities of Daily Living (ADL's) – skills/activities needed in a typical day to perform self care which includes; eating, toileting, bathing, transferring to chair or bed, walking and dressing.

Chiropractic care may be considered medically necessary for acute care. Acute (Care) (treatment of) an illness, injury or condition, marked by a sudden onset or abrupt change of your health status that requires prompt medical attention. Acute care may range from outpatient evaluation and treatment to intensive inpatient care. Acute care is intended to produce measurable improvement or maximum rehabilitative potential within a reasonable and medically predictable period of time, or that is moving the member toward a less restrictive setting. Acute services means services which, according to generally accepted professional standards, are expected to provide or sustain significant, measurable clinical improvement within a reasonable and medically predictable period of time.

Chiropractic care may be considered medically necessary and is normally a covered benefit for supportive care. Supportive care is defined as services provided for a known relapsing or recurring condition to prevent an exacerbation of symptoms that would require additional services to restore an individual to his or her usual state of health or to prevent progressive deterioration. Documentation in the medical record must demonstrate that previously when the member reached therapeutic goals he/she could not sustain this improvement and progressively deteriorated when treatment was withdrawn. This pattern must be clearly documented in the medical record with specific notation made as to the required treatment interval.

Chiropractic care may be considered medically necessary and is normally a covered benefit for a therapeutic trial in long standing neuromusculoskeletal conditions causing significant pain (VAS>2) or interference with routine activities of daily living (ADLs).

Chiropractic care may be considered medically appropriate, but is not a covered benefit for wellness (maintenance) care, is defined as treatment in the absence of an acute event or a known relapsing or recurring condition that is provided when there are minimal or no current symptoms, and which is designed to promote health, enhance quality of life, or prevent the onset over time of future symptoms or disability. Wellness care is usually provided on a regularly scheduled basis.

Flow sheets are considered a component of the documented record but are not sufficient in or of themselves unless they document or note the duration of treatment, modality parameters, and total treatment time, settings and if the provider was in constant attendance or not. This information must be included somewhere in the medical record in either on the flow sheet or in the SOAP note to support both the procedure codes billed and the medical necessity of procedures performed.

It is also required that documentation demonstrates the progression and improvement of exercises performed, treatment parameters for each, treatment times performed and the total treatment time for the daily sessions and whether the therapist was one-on-one with the patient. When patients are performing independently on exercise equipment (e.g. treadmills, bikes) and a provider is not in constant attendance for evaluation and instruction should not be billing therapeutic procedures.

When service or procedure may not be covered

We cover no chiropractic services for:

- Services rendered, without prior approval, above the initial annual 12 visits or any subsequent visits authorized, unless a Prior Approval Request is submitted and approved within 3 working days of the first unplanned visit above the current authorized visit limit.
- Wellness (maintenance) care.
- Care when there is no clear, measurable progress toward a rehabilitative goal, a less restrictive setting or other Medically Necessary goal;
- Services beyond those needed to restore your ability to perform Activities of Daily Living;
- Care for which there is no therapeutic benefit or likelihood of improvement

- Care, the duration of which is based upon a predetermined length of time rather than the condition of the patient, the results of treatment or the individual's medical progress;
- Obstetrical procedures including prenatal and postnatal care;
- Prescription or administration of drugs;
- Surgery;
- Supplying/dispensing of medical supplies or durable medical equipment (DME). NOTE: Chiropractors may prescribe DME
- The treatment of a mental health condition;
- Treatment of any "visceral condition", that is a dysfunction of the abdominal or thoracic organs, or other condition that are not neuromusculoskeletal in nature;
- Any other procedure not specifically listed as a covered chiropractic service;
- Custodial care;
- Acupuncture;
- Unattended services/modalities
 1. CPT codes 97012- 97028 (application of a modality that does not require direct one on one patient contact by provider) are not covered as they do not require constant attendance during the modality.
 2. CPT code 97032 (application of a modality to one or more areas; electrical stimulation, manual, each 15 minutes) should be reported only if the provider is in constant attendance during the electrical stimulation. Use 97014 for unattended electrical stimulation.
- Massage therapy;
- Services by a provider who is not in network or participating with the Plan;
- Care provided but not documented with clear, legible notes indicating patients symptoms, physical findings, physician's assessment, treatment modalities used (billed), date of treatment, and the signature of the treating provider;
- Low Level Laser Therapy/cold laser, which is considered investigational
- Vertebral axial decompression (i.e. DRS System, DRX Systems,DTS, VAX-D Table, Alpha Spina System, Accuspina, Lordex Lumbar Spine System, Internal Disc Decompression (IDD)), distraction table, which are all considered investigational.(S9090 and 97012, 97112, 97140, 97530,)
- Thermal massage bed, hydro therapy massage, is considered investigational
- Therapeutic Magnetic Resonance (TMR), is considered investigational
- Active Therapeutic movements (ATMs), is considered investigational
- Whole body vibration therapy, wobble chair, is considered investigational
- Whole body advance exercise, is considered investigational
- Oscillating platform therapy, Spineforce, is considered investigational
- Sensory integration therapy is considered investigational
- Ionotphoresis/phonophoresis is considered a medical delivery system and is not within the scope of practice for chiropractors
- Spinal manipulations and other treatment modalities can be provided manually or with the assistance of mechanical or electrical devices. There will be no additional reimbursement for the use of the device or for the device itself. It is considered part of the manipulation and should not be reimbursed separately.

Policy Guidelines

The Plan utilizes Milliman guidelines for chiropractic care. Twelve visits per calendar year for covered chiropractic services are allowed without prior approval. This would allow for an acute episode requiring several visits, or multiple minor acute episodes requiring lesser care.

Chiropractic care may be considered medically necessary and is normally a covered benefit for supportive care (defined as Services provided for a known relapsing or recurring condition to prevent an exacerbation of symptoms which would require additional services to restore an individual to his/her usual state of health or to prevent progressive deterioration). Documentation

in the medical record must demonstrate that previously when the member reached therapeutic goals he/she could not sustain this improvement and progressively deteriorated when treatment was withdrawn. This pattern must be clearly documented in the medical record with specific notation made as to the required treatment interval.

After 12 visits in a calendar year, prior approval is required for additional chiropractic treatment with the same or a different chiropractic physician. A request for prior approval must contain the date of the event requiring care, the ICD-9 diagnosis, the VAS pain scale, functional impairment in ADLs, response to treatment, and the prospective treatment plan. If care is transitioning to a different chiropractic physician due to a lack of response, there must be an explanation of the new treatment plan. The new treating chiropractic physician should request copies of records from prior chiropractic care. Either the Chiropractic Plan of Treatment (CPT) form or detailed clinical notes outlining the proposed care plan may be submitted to medical services for approval. Supporting medical records may be requested if additional information is required for Plan decision-making. If continued chiropractic care is considered medically necessary, up to 6 additional visits will be allowed, after which prior approval will again be required for additional visits. No more than 6 additional visits will be allowed without a clinical update of a member's status.

Although prior approval is required for chiropractic care that is either over the initial 12 visits in a calendar year or after completion of additional visits authorized under a chiropractic plan of treatment, an acute episode may occur at a time when no visits are currently authorized and there is insufficient time to obtain approval prior to treatment. In this setting, one additional visit for medically necessary care may be approved retroactively if the request is made within 3 business days of the visit. This request must specify the date of the additional visit. If further care beyond this visit is medically necessary, approval will be granted up to six visits, including the visit authorized retroactively.

Continued chiropractic care may be considered medically necessary as long as there is demonstrable and documented progress toward the achievement of the approved therapeutic goals, which normally will include a reduction of the VAS pain scale to a level of 2 or less associated with improved function in routine activities of daily living. After treatment of an acute injury, care required to establish or reestablish capabilities over and above routine activities of daily living required for specific occupational, hobbies, sports, leisure and recreational activities are not covered benefits by the Plan. Once the approved therapeutic goal has been achieved, continued care may be appropriate and beneficial, but is not considered medically necessary. Members may choose to continue care at their own expense.

Chiropractic treatment may be considered medically necessary for an exacerbation of symptoms under treatment, and additional chiropractic care may be considered medically necessary. However, if there are more than two exacerbations during an episode of care additional chiropractic care will not be authorized without a clear explanation of the cause or consultation with another chiropractic physician or an allopathic or osteopathic physician with the training and experience appropriate for the member's condition.

If there has not been an exacerbation of symptoms and VAS does not show continued improvement over a course of therapy, chiropractic care will be considered unsuccessful and additional therapy will not be authorized without consultation with a second chiropractic physician or an allopathic or osteopathic physician of the appropriate specialty for the member's condition.

Members may pay at their own expense for wellness/preventative chiropractic care or care designed to prepare them for specific occupational, hobbies, sports, and leisure and recreational activities as well as for any other non-covered services such as acupuncture or massage therapy at their own expense. A self-pay agreement must be entered into prior to rendering these services and must be maintained as part of the medical record.

The medical benefit under chiropractic care and physical therapy is designed to alleviate pain and/or correct a functional impairment, and to build endurance for activities to a level that would constitute normal household distances (up to 150 ft). Once the ability to lift more than 15 pounds, to independently walk household distances, or to run more than 50 yards is restored, performance enhancement to restore the ability to lift specific weights; to walk or run greater distances or more rapidly; or to engage in sporting activities is not considered medically necessary. In this setting, the services of a physical therapist, occupational therapist, athletic trainer, or chiropractic physician may still be desirable to enhance performance. In this case, the member should be advised that such services are not covered under BCBSVT and that further services in this regard require a self-pay agreement. Documentation to this effect must be entered in the medical record to avoid the "hold harmless" clause of contracted BCBSVT providers

A waiver providing specific details of services and member liability will need to be secured and placed into the member medical record prior to services being rendered.

Constant Attendance Procedures/Modalities

When documentation supports constant attendance therapeutic procedures or modalities (i.e. 97110, 97112) are being performed, time documentation is not required unless billing two or more units. The amount of time versus the appropriate number of units to bill are as follows:

- If less than 8 minutes use modifier 52 for reduced services
- If 8-22 minute bill 1 unit
- If 23-37 minutes bill 2 units, etc.

When physical therapy therapeutic procedures (CPT 97110-97535) are billed by any provider (including a chiropractic physician) these services will apply to the defined benefit limit for PT, ST, OT combined. This visit will also count against the initial 12 or subsequent approved chiropractic visits.

The modality codes 97032 – 97039 are generally considered to be an adjunct to a variety of therapies and when billed by an allopathic, osteopathic, or chiropractic physician, these services do not count against the defined benefit limit for PT, ST, OT combined

The modality codes 97032 – 97039 will only count as an individual Chiropractic visit if no other chiropractic services are rendered at the same visit.

Information required (if plan approval required)

The request for additional visits must be accompanied by supporting documentation of medical necessity, which includes; the initial, current, and interim chiropractic plans of treatment, diagnosis, diagnostic testing, initial evaluation, and treatment plans defining the type, number, frequency and duration of treatment. Medical notes may be requested for review and clarification. Additional visits will not be authorized without clear documentation as to the medical necessity of these visits.

Billing and Coding/Physician Documentation Information

See attachment I and II

Eligible Providers

Benefits will be provided for care by a chiropractor that is:

1. A duly licensed Doctor of Chiropractic, when acting within the scope of his/her license;

2. Treatment for a “neuromusculoskeletal” condition (condition of the bones, joints, or muscles), and
3. A participating or network provider with BCBSVT/TVHP that is credentialed by and contracted with the Plan.

Policy Implementation/Update information

2/03 reformatted, 1/02 updated to include new prior approval requirement - visit limit from six to 12 visit, 13th visit forward requires prior approval; codes reviewed 01/01& updated. 9/03 language added to reflect current certificate language and regulatory requirements. 01/05 Major revision defining acute, supportive, and maintenance care; eliminating chronic care as a specific exclusion; and adding criteria for medical necessity for acute and supportive care and therapeutic trials for problems of long standing duration. Included provisions for members to pay for chiropractic care for non-covered conditions.

10/05 minor word additions, additional diagnosis codes added based on input from VCA.

10/06 reviewed by VCA panel. LLLT and VAD and Work Hardening added as not covered/investigational. CPT codes updated.

10/07 updated to include current certificate language. Reviewed by the CAC 1/08. Reviewed by The Vermont Chiropractic Insurance Panel

10/08 updated . Reviewed by The Vermont Chiropractic Insurance Panel 12/04/08. Reviewed by the CAC 1/09

26 V.S.A. § 521

8 V.S.A. § 4088a

Scientific Background and Reference Resources

Milliman guidelines for Chiropractic Care
The Vermont Chiropractic Insurance Panel

Approved by BCBSVT Medical Director

Stephen E. Perkins, M.D.

Date Approved:

**Attachment I
Chiropractic Covered Procedure Codes**

<i>Office Visits</i>	Description
99201	<i>Office/outpatient visit; new</i>
99202	Office/outpatient visit; new
99203	Office/outpatient visit; new
99204	Office/outpatient visit; new
99205	Office/outpatient visit; new
99211	Office/outpatient visit; est
99212	Office/outpatient visit; est
99213	Office/outpatient visit; est
99214	Office/outpatient visit; est
99215	Office/outpatient visit, est
99251	Initial inpatient consultation, new or established patient
99252	Initial inpatient consultation, new or established patient
99253	Initial inpatient consultation, new or established patient
99254	Initial inpatient consultation, new or established patient
99255	Initial inpatient consultation, new or established patient
99341	Home visit; new patient,
99342	Home visit; new patient,
99343	Home visit; new patient,
99344	Home visit; new patient,
99345	Home visit; new patient,
99347	Home visit, established patient
99348	Home visit, established patient
99349	Home visit, established patient
99350	Home visit, established patient
<i>Manipulation</i>	
98940	Chiropractic manipulative treatment (cmt); spinal one to two regions
98941	Chiropractic manipulative treatment; spinal three to four regions
98942	Chiropractic manipulative treatment; spinal five regions
98943	Chiropractic manipulative treatment (cmt) Extraspinal, one or more regions
Physical Therapy	
97032	Electical Stimulation
97035	Ultrasound therapy
97039	Physical therapy treatment
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises
97112	Neuromuscular re-education
97140	Manual therapy techniques, one or more regions, each 15 minutes
97530	Kinetic therapy
97535	Self care/home management training

Attachment II
Chiropractic Covered Diagnosis Codes

ICD – 9 Code	Description
353 - 355.9	Nerve root and plexus disorders
524.6 – 524.69	TMJ disorders
715 - 716.99	Osteoarthritis, generalized & Other and unspecified arthropathies
717 - 717.9	Internal derangement of the knee
718 - 718.99	Other derangement of joint, recurrent dislocation of joint
719.3 – 719.99	Palindromic rheumatism, pain in joint, unspecified disorder of joint
720 - 721.91	Ankylosing spondylitis and other inflammatory spondylopathies, Spondylosis and allied disorders
722 - 724.9	Intervertebral disc disorders, Other disorders of cervical region, Other and unspecified disorders of back
725	Polymyalgia
726 - 727.09	Peripheral enthesopathies and allied syndromes
727.1	Bunion
727.2 – 728.9	Specific bursitides often of occupational origin, Disorders of muscle, ligament, and fascia
729.1	Myalgia and myositis, unspecified
729.2	Neuralgia, neuritis, and radiculitis, unspecified
729.5	Pain in limb
729.81 - 729.9	Other musculoskeletal symptoms referable to limbs, Other and unspecified disorders of soft tissue
733.00	Osteoporosis
735.- 737.9	Acquired deformities of limb
738.3 – 738.6	Acquired deformity of chest and rib, acquired spondylolisthesis, other acquired deformity of back or spine, acquired deformity of pelvis
738.8 – 738.9	Acquired deformity of other specified site, acquired deformity of unspecified site
739.1 – 739.9	Nonallopathic lesions, not elsewhere classified
754.61	Congenital pes planus
755 – 755.02	Other congenital anomalies of limbs
755.22 – 755.56	Longitudinal deficiency of upper limb, not elsewhere classified – Accessory carpal bones
755.59 – 756.0	Other congenital musculoskeletal anomalies, of face and face bones
756.1 – 756.19	Anomalies of spine
756.2 – 756.9	Cervical rib – other and unspecified anomalies of musculoskeletal system
805.2	Fracture of trunk and neck – dorsal closed
805.4	Fracture of trunk and neck – lumbar closed
815 – 815.09	Fracture of metacarpal bones
831.0 – 831.19	Dislocation of shoulder – closed - open
832 – 832.19	Dislocation of elbow –closed - open
833 – 833.09	Dislocation of wrist – closed - open
837 – 838.09	Dislocation of ankle, Dislocation of foot

839 – 839.08	Other, multiple, and ill-defined dislocations
839.2 – 839.21	Thoracic and lumbar vertebra, closed
839.4 – 839.49	Other vertebra, closed
839.6 – 839.69	Other location, closed
840 – 847.9	Sprains and strains of joints and adjacent muscles
848.1	Jaw sprain/strain
848.3	Rib sprain/strain
848.9	Unspecified site of sprain and strain
905.1 – 905.9	Late effects of musculoskeletal and connective tissue injuries
922.31	Contusion with intact skin surface - back
924.11	Contusion of lower limb and of other unspecified sites - knee

**Attachment III
Chiropractic Covered X-RAYS**

71100	X-ray exam of ribs
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine
72052	X-ray exam of neck spine
72070	X-ray exam of thorax spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72170	X-ray exam of pelvis
72200	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
73000	X-ray exam of collarbone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder
73030	X-ray exam of shoulder
73040	Contrast x-ray of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73090	X-ray exam of forearm
73100	X-ray exam of wrist
73115	Contrast x-ray of wrist
73120	X-ray exam of hand
73140	X-ray exam of finger(s)
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73550	X-ray exam of thigh
73560	X-ray exam of knee
73562	X-ray exam of knee
73564	X-ray exam of knee
73590	X-ray exam of lower leg
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)