Mountain State Blue Cross Blue Shield
(Otherwise referred to as the Plan)

CORPORATE POLICY AND PROCEDURES

TITLE: **Approval of Chiropractic Services**

No: MP 12 **Supersedes No.: N/A** **Original Effective Date: 08/20/03**
Standards: **Date of Last Review: 10/15/04**
Related Policies: **Date of Last Revision:**

DRAFT ( ) **INTERIM ( )** **FINAL (x)**

Lines of Business:

Applies To: **FEP (X)** **PPO (X)** **POS (X)** **INDEMNITY (X)**

Variation for: (N/A)

Intended Distribution: **Standard List (X) Secondary Review List ( ) Secondary Distribution List:( )**

POLICY

Chiropractic medicine is a modality of treatment, which is based on the relationship between the structure and function of the human body. Services rendered are intended to support the spinal column and nervous system functions. Mountain State Blue Cross Blue Shield will provide coverage for Chiropractic Services when they are determined to be medically necessary when Plan approved medical criteria and guidelines have been met.

PURPOSE

To ensure consistent and appropriate application of Plan criteria to assess medical necessity and appropriateness of treatment.

PROCEDURES

1. Manipulation/mobilization is a medical necessary service when performed with the expectation of restoring the patient's level of function, which has been lost or reduced, by injury or illness. Manipulation/mobilization should be provided in accordance with an ongoing, written treatment plan. The treatment plan should include:

    - Specific modalities/procedures to be used in treatment
    - Diagnosis
    - Degree of severity (mild, moderate, severe)
    - Impairment characteristics

- Physical examination findings, x-ray or other pertinent findings
- Specific statements of long and short-term goals
- A reasonable estimate of when the goals will be reached (estimated duration of treatment)
- Frequency of treatment

The treatment plan should be updated as the patient's condition changes.

2. Payment may be made for up to 20 (unless contract limit is less) medically necessary outpatient manipulation/mobilization encounters per calendar year (January-December). If the chiropractic provider feels additional treatments are necessary beyond twenty (20) visits, then the provider must submit the information requested on the MSBCBS treatment plan form (copy enclosed) so that it may be reviewed by the utilization management department for medical necessity.

   In addition to the treatment plan mentioned above, documentation may be requested to aid in making a determination of medical necessity for treatment, such as:

   - Provider's pertinent evaluation (exam findings)
   - Progress notes
   - Medical history, as it relates to manipulation/mobilization encounters
   - Dates of aggravation or exacerbation of the condition/injury
   - If patient has transferred their care from a different provider, then any medical information (as available) from the prior provider(s).

3. Chiropractic Services are not covered in any of the following circumstances:

   - **Maintenance program**: A maintenance program consists of activities that preserve the member's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur. Manipulation performed repetitively to maintain a level of function is not eligible for reimbursement.
   - Treatments for condition other than those related to neuromusculoskeletal conditions
   - Diagnostic procedures/tests not within the routine scope of chiropractic, including:

     a. Laboratory test, except urinalysis
     b. X-rays other than spinal or appropriate extremity x-rays

c. EMGs
d. Injections

- The following therapeutic manipulations/modalities (when billed under a separate procedure code):

  a. Physical therapy
  b. Traction (axial or longitudinal)
  c. Acupuncture
  d. Application of hot and cold packs
  e. Counseling (considered integral to the visit)
  f. Mechanical or electric equipment used for manipulations or other treatment modalities (considered integral to a manipulation)

- Nutritional supplements

- Services beyond benefit plan visitation limitations or services that are excluded from the benefit plan

- Vertebral axial traction or decompression

4. The following treatments, procedures and/or diagnostic tests are covered when ordered within standard chiropractic care:

   - **Diagnostic Procedures:**

     a. Routine spinal x-rays (cervical, thoracic, lumbar-sacral) and appropriate extremity x-ray, CT, MRI
     b. Patient interview
     c. Physical examination
     d. Urinalysis (with or without microscopic exam)
     e. Muscle testing with report
     f. Range of motion measurement with report

   - **Treatments**
     a. Spinal adjustment by manual means
     b. Spinal manipulation utilizing techniques taught in an accredited chiropractic college
     c. Manual adjustment or manipulation
     d. Vertebral manipulation or adjustment
     e. Major joint manipulation (shoulder, elbow, wrist, hip, knee and ankle)

f. Trigger point therapy or myofascial release
g. Only one manipulation/mobilization encounter will be eligible per day.

5. Medical necessity criteria - The chiropractor must justify medical necessity for continued chiropractic treatments and must be able to document the following:

- Continued improvement
- Improved range of motion (ROM) measurements but still impaired.
- Reduction in pain as per the pain scale (1 would be mild 10 would be severe)
- Improvement in ability to perform activities of daily living, (e.g. bathing, dressing, driving, etc.).
- Reasons that the recovery has extended beyond normal range.
- Patient has not reached long or short-term goals.

Therapy may be extended 1.5-2x due to prior episode, exacerbation, duration of onset prior to receiving treatment, arthritides, congenital abnormalities.

Table 1: Severity Grading for Chiropratic Conditions

FACTOR	**MILD (1)**	**MODERATE (2)**	**SEVERE (3)**
Pain/discomfort intensity by visual analog scale (VAS) 0=no pain 10= most severe pain ever	1-3	4-7	8-10
Activities of daily living (ADL) limitations	Annoying, To some limitations	Significant limitations (specify)	Precludes ADLS
Co-morbidities impending patient recovery	**Not a factor**	**Somewhat a factor**, i.e. congestive heart failure, COPD, neuropathy	**Significant Factor**, i.e. arthritis, other musklosketal conditions affecting same area of injury
OVERALL SEVERITY	Mild (1)	Moderate (2)	Severe (3)

Overall severity takes into consideration the above three factors. Once the severity of each component has been determined, the clinician should use the overall severity to determine the number of visits or weeks of treatment.

Standard Treatment Duration for Chiropractic Care

For any diagnosis not listed, treatment plans may be reviewed on an individual consideration basis.

Cervical

Primary ICD-9	Description	Severity	Treatment Plan Weeks	Treatment	X-Ray
847.0	Cervical Strain/Sprain	1 2 3	4 6 8	10 16 20	72040-22 72050 72052
739.1	Cervical Segmental Dysfunction	1 2 3	4 6 8	10 16 16	72040-22 72050 72050
722.0	Cervical Intervertebral Disc Syndrome	1 2 3	6 10 12	16 22 24	72040-22 72050 72052
723.2	Cervico-cranial Syndrome	1 2 3	4 6 8	12 16 20	72040-22 72040-22 72050
723.3	Cervico-brachial syndrome	1 2 3	5 7 9	12 18 21	72040-22 72050 72050
723.4	Brachial Radiculitis/neuritis	1 2 3	5 7 9	14 18 21	72040-22 72050 72050

Thoracic

Primary ICD-9	Description	Severity	Treatment Plan Weeks	Treatment	X-Ray
847.1	Thoracic Strain/Sprain	1 2 3	4 6 6	12 16 17	72070 72070 72070
739.2	Thoracic Segmental Dysfunction	1 2 3	2 5 8	6 14 20	72070 72070 72070
722.11	Thoracic Intervertebral Disc Syndrome	1 2 3	4 6 8	12 16 20	72070 72070 72074
729.2/353.8	Intercostal Neuralgia/neuritis	1 2 3	4 5 7	12 14 18	72070 72070 72074

739.8	Costo-vertebral Dysfunction	1 2 3	2 5 8	6 14 20	72070 72070 72070
353.0	Thoracic Outlet Syndrome	1 2 3	2 5 8	6 14 20	72070 72070 72070

Lumbar

Primary ICD-9	Description	Severity	Treatment Plan Weeks	Treatment	X-Ray
847.2	Lumbar Strain/Sprain	1 2 3	4 6 6	12 16 17	72100 72110 72114
846.0	Lumbosacral train/Sprain	1 2 3	4 6 6	12 16 17	72100 72110 72114
846.9	Sacroiliac Strain/Sprain	1 2 3	4 6 6	12 16 17	72100 72110 72114
739.3	Lumbar Segmental Dysfunction	1 2 3	2 5 8	6 14 20	72100 72100 72110
739.4	Sacroiliac Segmental Dysfunction	1 2 3	2 5 8	6 14 20	72100 72100 72110
724.8	Lumbar Facet Syndrome	1 2 3	2 6 8	6 16 20	72100 72110 72110
724.3	Sciatic Neuralgia	1 2 3	4 6 8	12 16 20	72110 72110 72110
722.10	Lumbar Interverbral Disc Syndrome	1 2 3	4 8 10	14 20 24	72100 72110 72110

Prior episode, exacerbation, duration of onset prior to receiving treatment, Arthritides, congentital anomities may extend recovery 1.5-2x. The Chiropractor must be able to document continued improvement and show reason for the recovery being extended beyond normal range.

For further coding and billing documentation information, see Attachment A
References:

Guideline for Chiropractic Quality Assurance and Practice Parameters; Proceedings of a Consensus Conference by the Congress of Chiropractic State Associations at the Mercy Conference Center; January 25-30, 1992

InterQual Level of Care Criteria 2002
Highmark Medical Policy Bulletin Y-9
Blue Cross Blue Shield of North Carolina Medical Policy
ACA's Official Chiropractor Coding Solutions 2001

This policy is designed to address medical guidelines that are appropriate for the majority of individuals with a particular disease, illness, or condition. Each person's unique clinical circumstances may warrant individual consideration, based on review of applicable medical records.

Medical policies are designed to supplement the terms of a member's contract. The member's contract defines the benefits available; therefore, medical policies should not be construed as overriding specific contract language. In the event of conflict, the contract shall govern.

Medical policies do not constitute medical advice, nor the practice of medicine. Rather, such policies are intended only to establish general guidelines for coverage and reimbursement under Mountain State Blue Cross Blue Shield plans. Application of a medical policy to determine coverage in an individual instance is not intended and shall not be construed to supercede the professional judgment of a treating provider. In all situations, the treating provider must use his/her professional judgment to provide care he/she believes to be in the best interest of the patient, and the provider and patient remain responsible for all treatment decisions.

ATTACHMENT A

Billing/Coding/Physician Documentation Information:

Applicable codes; 99201-99205, 99211-99215, 97010-97028, 97032-97039, 97110-97799, 98940-98943, S9090, 95831-95904

Constant Attendance Modalities, 97110-97036, and Theraputic Procedures, 97110-97542, will be limited to a maximum of one hour (4 units) for the combinations of codes submitted.

97140 services will be denied as intergral of mutually exclusive 98940-98943 services unless submitted with a 59 modifier, indicating a distinct procedural service.

MSBCBS may request medical records for determination of medical mecessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentations unless all specific information needed to make a medical necessity determination is included.

Medical records may be requested when the scope, duration or frequency of chiropractic care exceeds the guidelines above: or if a modifier (e.g., 59) is used more frequently than expeceted or may not be consistent with claims history.

Records requested should include:
Office visit notes:

- patient name, identifying number, and date of visit
- physical exam
- diagnostic studies and results
- results of previous treatments
- planned treatments and/or diagnostic studies
- communication to referral souce (when appropriate)
- follow-up

Diagnostic x-rays and/or x-ray reports:

- patient name, identifying number and date of procedure
- name of provider performing and interpreting the study
- clear directional markers
- specific description and diagnosis of x-ray findings
- overall treatment plan

The most commonly used and recognized codes are:

99201 New Patient-OV Brief
99202 New Patient-OV Limited
99203 New Patient-OV Intermediate
99204 New Patient-OV Extensive
81000 Urinalysis with microscopy
81002 Urinalysis without microscopy
95831 Muscle testing, manual with report
95851 Range of motion measurement w/ report
98940 Chiropractic manipulative treatment; spinal 1 to 2 regions
98941 Chiropractic manipulative treatment; spinal 3 to 4 regions
98942 Chiropractic manipulative treatment; spinal 5 regions
98943 Chiropractic manipulative treatment; extra spinal
97012 Mechanical traction (does not include axial or longitudinal traction)
97014 Electrical muscle stimulation, unattended
97140 Manual therapy techniques (only trigger point therapy and myofascial release. Mobilization and traction are considered integral to the manipulation.)

FEP: For the FEP Basic Option benefit, only the following codes are covered spinal manipulative services:

- 98940-chiropractic manipulative treatment; spinal one to two regions
- 98941-spinal, three to four regions
- 98942-spinal, five regions

Payment will be made for 20 manipulations per calendar year.

SIGNATURE PAGE

Approval: _____ Approval: _____

Title: _____ Title: _____

Date: _____ Date: _____