

# LCD for Chiropractic Services (L30328)

## Contractor Information

### Contractor Name

Wisconsin Physicians Service Insurance Corporation

### Contractor Number

00951, 00952, 00953, 00954, 05102, 05202, 05302, 05402

### Contractor Type

Carrier - MAC Part B

## LCD Information

### LCD ID Number

L30328

### LCD Title

Chiropractic Services

### Contractor's Determination Number

CHIRO-001

### AMA CPT / ADA CDT Copyright Statement

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### CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Medicare Benefit Policy Manual (MBPM) §100-02-30.5 - Medicare Carrier Manual (MCM) B3-2020.26;

CMS Pub.100.2 Chapter. 15 §240 - 240.1.5;

CMS PUB 100.4 Chapter 12 § 220

MBPM Chapter 15 §240.1.1 - MCM B3-251

Title XVIII of the Social Security Act

Section 1833 (e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1862 (a) (1) (A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Part 411.15., subpart A addresses general exclusions and exclusion of particular services

## **Primary Geographic Jurisdiction**

### **Oversight Region**

Region V

### **Original Determination Effective Date**

For services performed on or after 09/15/2009

### **Original Determination Ending Date**

### **Revision Effective Date**

For services performed on or after 09/15/2009

### **Revision Ending Date**

## **Indications and Limitations of Coverage and/or Medical Necessity**

*Implementation of the chiropractic benefit requires an appreciation of the differences between chiropractic theory and experience and traditional medicine due to fundamental differences regarding etiology and theories of the pathogenesis of disease. Judgments about the reasonableness of chiropractic treatment must be based on the application of chiropractic principles.*

*A. The term "physician" under Part B includes a chiropractor who meets specified qualifying requirements, but only for treatment by means of manual manipulation of the spine to correct a subluxation. Medicare covers limited chiropractic services when performed by a chiropractor licensed by the state or jurisdiction in which he/she resides.*

Reimbursement is based on the physician fee schedule and payment is made to the beneficiary or, on assignment, to the chiropractor.

*B. Manual Manipulation. Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of 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 Medicare recognize an extra charge for the device itself.*

The word "correction" may be used in lieu of "treatment". Also, a number of different terms composed of the following words may be used to describe manual manipulation as defined above:

- Spine or spinal adjustment by manual means;

- *Spine or spinal manipulation;*
- *Manual adjustment; and*
- *Vertebral manipulation or adjustment.*

*Any case in which the term(s) used to describe the service performed suggests that it may not have been treatment by means of manual manipulation, the claim will be referred for professional review and interpretation*

### *C. Utilization Guidelines*

*1. Subluxation. 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.*

*2. Documentation of Subluxation. A subluxation may be demonstrated by an x-ray or by physical examination, as described below.*

#### *a. Demonstrated by X-Ray.*

*- Effective for claims with dates of service on or after January 1, 2000, an x-ray is not required to demonstrate the subluxation.*

*- A x-ray may be used to document subluxation. The x-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific x-ray evidence is warranted, an x-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older x-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. A previous CT scan and/or MRI is acceptable evidence if a subluxation of the spine is demonstrated.*

#### *b. Demonstrated by Physical Examination Evaluation of musculoskeletal/ nervous system to identify (PART = Pain, Asymmetry Range of motion and tissue tone changes):*

*- Pain/tenderness evaluated in terms of location, quality, and intensity*

### **P.A.R.T. Information:**

**Pain** – Most primary neuromusculoskeletal disorders manifest primarily by a painful response. Pain and tenderness findings may be identified through one or more of the following: observation, percussion, palpation, provocation, etc. Furthermore pain intensity may be assessed using one or more of the following: visual analog scales, algometers, pain questionnaires, etc.

*- Asymmetry/misalignment identified on a sectional or segmental level;*

### **P.A.R.T. Information**

**Asymmetry/misalignment** – Asymmetry/misalignment may be identified on a sectional or segmental level through one or more of the following: observation (posture and gait analysis), static palpation for misalignment of vertebral segments, diagnostic imaging, etc.

*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*

### **P.A.R.T. Information**

**Range of motion abnormality** – Range of motion abnormalities may be identified through one or more of the following: motion, palpation, observation, stress diagnostic imaging, range of motion measurements, etc.

*- Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament.*

## P.A.R.T. Information

Tissue/Tone texture may be identified through one or more of the following procedures: observation, palpation, use of instruments, tests for length and strength etc.

*To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under the above physical examination list are required, one of which must be asymmetry/misalignment or range of motion abnormality.*

*The history recorded in the patient record should include the following:*

- Symptoms causing patient to seek treatment;
- Family history if relevant;
- Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history);
- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity, frequency, location and radiation of symptoms;
- Aggravating or relieving factors; and
- Prior interventions, treatments, medications, secondary complaints.

*D. Documentation Requirements: Initial Visit - the following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:*

*1. History as stated above.*

*2. Description of the present illness including:*

- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity, frequency, location, and radiation of symptoms;
- Aggravating or relieving factors;
- Prior interventions, treatments, medications, secondary complaints; and
- Symptoms causing patient to seek treatment.

*These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (itis), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must relate to the spine as such. The subluxation must be causal, i.e., the symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.*

*3. Evaluation of musculoskeletal/nervous system through physical examination.*

*4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.*

*5. Treatment Plan: The treatment plan should include the following:*

- Recommended level of care (duration and frequency of visits);
- Specific treatment goals; and
- Objective measures to evaluate treatment effectiveness.

*6. Date of the initial treatment.*

*E. Documentation Requirements: Subsequent Visits.- the following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:*

*1. History*

- Review of chief complaint;
- Changes since last visit;

- System review if relevant.

## 2. Physical exam

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

3. Documentation of treatment given on day of visit.

## F. Necessity for Treatment.

1. 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, as described above.

Most spinal joint problems may be categorized as follows:

- *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

## 2. Maintenance Therapy

Under the Medicare program, Chiropractic maintenance therapy is not considered to be medically reasonable or necessary, and is therefore not payable. Maintenance therapy is defined as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy. For information on how to indicate on a claim a treatment is or is not maintenance, see §240.1.3

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 reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

3. *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.

a. 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.

b. 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.

*G. Location of Subluxation. The precise level of the subluxation must be specified by the chiropractor to substantiate a claim for manipulation of the spine. This designation is made in relation to the part of the spine in which the subluxation is identified:*

<i>Area of Spine</i>	<i>Names of Vertebrae</i>	<i>Number of Vertebrae</i>	<i>Short Form or Other Name</i>	<i>Subluxation ICD-9 code</i>
<i>Neck</i>	<i>Occiput</i>	<i>7</i>	<i>Occ, CO</i>	<i>739.0</i>
	<i>Cervical</i>		<i>C1-C7</i>	<i>739.1</i>
	<i>Atlas</i>		<i>C1</i>	
	<i>Axis</i>		<i>C2</i>	
<i>Back</i>	<i>Dorsal or Thoracic</i>	<i>12</i>	<i>D1-D12</i>	<i>739.2</i>
	<i>Costovertebral</i>		<i>T1-T12</i>	
	<i>Costotransverse</i>		<i>R1-R12</i>	
			<i>R1-R12</i>	
<i>Low Back</i>	<i>Lumbar</i>	<i>5</i>	<i>L1-L5</i>	<i>739.3</i>
<i>Pelvis</i>	<i>Ilii r and l</i>		<i>I, Si</i>	<i>739.5</i>
<i>Sacral</i>	<i>Sacrum, Coccyx</i>		<i>S, SC</i>	<i>739.4</i>

*In addition to the vertebrae and pelvic bones listed, the Ilii (R and L) are included with the sacrum as an area where a condition may occur which would be appropriate for chiropractic manipulative treatment.*

*There are two ways in which the level of the subluxation may be specified in patient's record.*

- The exact bones may be listed, for example: C 5, 6, etc.
- The area may suffice if it implies only certain bones such as: occipito-atlantal (occiput and C1 (atlas)), lumbo-sacral (L5 and Sacrum) sacro-iliac (sacrum and ilium).

*Following are some common examples of acceptable descriptive terms for the nature of the abnormalities:*

*Off-centered, Misalignment, Malpositioning, Spacing*

- abnormal
- altered
- decreased
- increased

*Incomplete dislocation, Rotation, Listhesis*

- antero
- postero
- retro
- lateral
- spondylo

*Motion*

- limited
- lost
- restricted
- flexion
- extension
- hyper mobility
- hypomotility
- aberrant

*Other terms may be used. If they are understood clearly to refer to bone or joint space or position (or motion) changes of vertebral elements, they are acceptable.*

#### *H. Treatment Parameters*

*1. The chiropractor should be afforded the opportunity to effect improvement or arrest or retard deterioration of subluxation within a reasonable and generally predictable period of time. Acute subluxation (e.g., strains or sprains) problems may require as many as 3 months of treatment but some require very little treatment. In the first several days treatment may be quite frequent but decreasing in frequency with time or as improvement is obtained.*

*2. Chronic spinal joint condition (e.g., loss of joint mobility or other joint problems) implies, of joints have already "set" and fibrotic tissue has developed. This condition may require a longer treatment time, but not with higher frequency.*

*3. The mere statement or diagnosis of "pain" is not sufficient to support medical necessity for the treatments. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.*

The problem/complaint addressed and precise level of each subluxation treated must be specified in the medical record. The need for an extensive, prolonged course of treatment should be consistent with the reported diagnosis and must be clearly documented in the medical record.

### **Coding Information**

#### **Bill Type Codes:**

**Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.**

#### **Revenue Codes:**

**Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.**

#### **CPT/HCPCS Codes**

##### CPT/HCPCS Codes

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

## ICD-9 Codes that Support Medical Necessity

### ICD-9 Codes that Support Medical Necessity

Note: ICD-9-CM codes must be coded to the highest level of specificity

The level of the subluxation must be specified on the claim and must be listed as the primary diagnosis. The neuromusculoskeletal condition necessitating the treatment must be listed as the secondary diagnosis. All ICD-9 diagnosis codes must be coded to the highest level of specificity, (4th or 5th digit) and the primary diagnosis must be supported by x-ray or documented by physical examination.

These are the only covered ICD-9-CM codes that support medical necessity:

Primary: ICD-9-CM Codes (Names of Vertebrae)

The precise level of subluxation must be listed as the primary diagnosis.

739.0	NONALLOPATHIC LESIONS OF HEAD REGION NOT ELSEWHERE CLASSIFIED
739.1	NONALLOPATHIC LESIONS OF CERVICAL REGION NOT ELSEWHERE CLASSIFIED
739.2	NONALLOPATHIC LESIONS OF THORACIC REGION NOT ELSEWHERE CLASSIFIED
739.3	NONALLOPATHIC LESIONS OF LUMBAR REGION NOT ELSEWHERE CLASSIFIED
739.4	NONALLOPATHIC LESIONS OF SACRAL REGION NOT ELSEWHERE CLASSIFIED
739.5	NONALLOPATHIC LESIONS OF PELVIC REGION NOT ELSEWHERE CLASSIFIED

### SHORT-TERM TREATMENT:

(These conditions generally require short-term treatments.)

ICD-9 CM

Symptom/Condition Codes

(Secondary Diagnosis)

307.81	TENSION HEADACHE
346.00	MIGRAINE WITH AURA, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.01	MIGRAINE WITH AURA, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.10	MIGRAINE WITHOUT AURA, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS
346.11	MIGRAINE WITHOUT AURA, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS
346.20	

VARIANTS OF MIGRAINE, NOT ELSEWHERE CLASSIFIED, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS

346.21

VARIANTS OF MIGRAINE, NOT ELSEWHERE CLASSIFIED, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS

346.80

OTHER FORMS OF MIGRAINE, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS

346.81

OTHER FORMS OF MIGRAINE, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS

346.90

MIGRAINE, UNSPECIFIED, WITHOUT MENTION OF INTRACTABLE MIGRAINE WITHOUT MENTION OF STATUS MIGRAINOSUS

346.91

MIGRAINE, UNSPECIFIED, WITH INTRACTABLE MIGRAINE, SO STATED, WITHOUT MENTION OF STATUS MIGRAINOSUS

355.1

MERALGIA PARESTHETICA

718.48

CONTRACTURE OF JOINT OF OTHER SPECIFIED SITES

721.0

CERVICAL SPONDYLOSIS WITHOUT MYELOPATHY

721.2

THORACIC SPONDYLOSIS WITHOUT MYELOPATHY

721.3

LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY

721.6

ANKYLOSING VERTEBRAL HYPEROSTOSIS

721.90

SPONDYLOSIS OF UNSPECIFIED SITE WITHOUT MYELOPATHY

723.1

CERVICALGIA

724.1

PAIN IN THORACIC SPINE

724.2

LUMBAGO

724.5

BACKACHE UNSPECIFIED

728.85

SPASM OF MUSCLE

784.0

HEADACHE

Moderate-Term Treatment

353.0

BRACHIAL PLEXUS LESIONS

353.1

LUMBOSACRAL PLEXUS LESIONS

353.2	CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3	THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4	LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.8	OTHER NERVE ROOT AND PLEXUS DISORDERS
355.0	LESION OF SCIATIC NERVE
355.2	OTHER LESION OF FEMORAL NERVE
355.8	MONONEURITIS OF LOWER LIMB UNSPECIFIED
715.00	OSTEOARTHRISIS GENERALIZED INVOLVING UNSPECIFIED SITE
715.15	OSTEOARTHRISIS LOCALIZED PRIMARY INVOLVING PELVIC REGION AND THIGH
715.80	OSTEOARTHRISIS INVOLVING OR WITH MORE THAN ONE SITE BUT NOT SPECIFIED AS GENERALIZED AND INVOLVING UNSPECIFIED SITE
715.90 - 715.98	OSTEOARTHRISIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING UNSPECIFIED SITE - OSTEOARTHRISIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING OTHER SPECIFIED SITES
719.01 - 719.09	EFFUSION OF JOINT OF SHOULDER REGION - EFFUSION OF JOINT OF MULTIPLE SITES
719.11 - 719.19	HEMARTHROSIS INVOLVING SHOULDER REGION - HEMARTHROSIS INVOLVING MULTIPLE SITES
719.21 - 719.29	VILLONODULAR SYNOVITIS INVOLVING SHOULDER REGION - VILLONODULAR SYNOVITIS INVOLVING MULTIPLE SITES
719.31 - 719.39	PALINDROMIC RHEUMATISM INVOLVING SHOULDER REGION - PALINDROMIC RHEUMATISM INVOLVING MULTIPLE SITES
719.41 - 719.49	PAIN IN JOINT INVOLVING SHOULDER REGION - PAIN IN JOINT INVOLVING MULTIPLE SITES
719.51 - 719.59	STIFFNESS OF JOINT NOT ELSEWHERE CLASSIFIED INVOLVING SHOULDER REGION - STIFFNESS OF JOINT NOT ELSEWHERE CLASSIFIED INVOLVING MULTIPLE SITES
719.61 - 719.69	OTHER SYMPTOMS REFERABLE TO JOINT OF SHOULDER REGION - OTHER SYMPTOMS REFERABLE TO JOINT OF MULTIPLE SITES
719.7	DIFFICULTY IN WALKING
719.81 - 719.89	

OTHER SPECIFIED DISORDERS OF JOINT OF  
SHOULDER REGION - OTHER SPECIFIED  
DISORDERS OF JOINT OF MULTIPLE SITES

720.1 SPINAL ENTHESOPATHY

722.91 OTHER AND UNSPECIFIED DISC DISORDER OF  
CERVICAL REGION

722.92 OTHER AND UNSPECIFIED DISC DISORDER OF  
THORACIC REGION

722.93 OTHER AND UNSPECIFIED DISC DISORDER OF  
LUMBAR REGION

723.2 CERVICOCRANIAL SYNDROME

723.3 CERVICOBACHIAL SYNDROME (DIFFUSE)

723.4 BRACHIAL NEURITIS OR RADICULITIS NOS

723.5 TORTICOLLIS UNSPECIFIED

724.4 THORACIC OR LUMBOSACRAL NEURITIS OR  
RADICULITIS UNSPECIFIED

724.6 DISORDERS OF SACRUM

724.79 OTHER DISORDERS OF COCCYX

724.8 OTHER SYMPTOMS REFERABLE TO BACK

729.1 MYALGIA AND MYOSITIS UNSPECIFIED

729.4 FASCIITIS UNSPECIFIED

738.4 ACQUIRED SPONDYLOLISTHESIS

756.11 CONGENITAL SPONDYLOLYSIS LUMBOSACRAL  
REGION

846.0 LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN

846.1 SACROILIAC (LIGAMENT) SPRAIN

846.2 SACROSPINATUS (LIGAMENT) SPRAIN

846.3 SACROTUBEROUS (LIGAMENT) SPRAIN

846.8 OTHER SPECIFIED SITES OF SACROILIAC  
REGION SPRAIN

847.0 NECK SPRAIN

847.1 THORACIC SPRAIN

847.2 LUMBAR SPRAIN

847.3 SPRAIN OF SACRUM

847.4 SPRAIN OF COCCYX

Long-Term Treatment

721.7 TRAUMATIC SPONDYLOPATHY

722.0 DISPLACEMENT OF CERVICAL  
INTERVERTEBRAL DISC WITHOUT  
MYELOPATHY

722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82	POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
723.0	SPINAL STENOSIS IN CERVICAL REGION
724.01	SPINAL STENOSIS OF THORACIC REGION
724.02	SPINAL STENOSIS OF LUMBAR REGION
724.3	SCIATICA
756.12	SPONDYLOLISTHESIS CONGENITAL

### **Diagnoses that Support Medical Necessity**

Those diagnoses listed in this policy

### **ICD-9 Codes that DO NOT Support Medical Necessity**

### **ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation**

### **Diagnoses that DO NOT Support Medical Necessity**

Those diagnoses not listed in this policy.

### **General Information**

### **Documentation Requirements**

Documentation supporting the medical necessity of this item, such as ICD-9 codes, must be submitted with each claim. Claims submitted without ICD-9 codes will be denied as being not medically necessary. Documentation in the form of progress notes need not be submitted with each claim but be available upon request.

Claims submitted for Chiropractic manipulative treatment (CMT) CPT codes 98940, 98941, or 98942, for services rendered on or after October 1, 2004, must contain an AT modifier or they will be considered not medically necessary.

## **Appendices**

### **Utilization Guidelines**

See C of the Section on Indications and Limitations of Coverage and/or Medical Necessity.

Once the maximum therapeutic benefit has been achieved for a given condition, ongoing maintenance therapy is not considered to be medically necessary under the Medicare program.

### **Sources of Information and Basis for Decision**

Guidelines for Chiropractic Quality Assurance and Practice Parameters (1993);

### **Advisory Committee Meeting Notes**

Wisconsin: 01/16/2009

Illinois: 01/28/2009

Michigan: 01/07/2009

Minnesota: 01/22/2008

J-5 MAC (IA,KS,MO, NE) 02/12/2009

This policy does not reflect the sole opinion of the contractor or the contractor medical director(s). Although the final decision rests with the contractor, this policy was developed in cooperation with the carrier advisory committee(s), which include representatives of various medical specialty societies.

### **Start Date of Comment Period**

02/12/2009

### **End Date of Comment Period**

03/30/2009

### **Start Date of Notice Period**

08/01/2009

### **Revision History Number**

**Revision History Explanation**

08/01/2009, one, merged all current Chiropractor LCDs including L26621 MAC J-5, L8469 WI, L10881 IL, L11054 MI, L11054 MN;

6/29/09 Removed contractor number 05392 because as of 8/1/09 E MO will join with the current number for W MO

05/22/2009 Posted as Draft

08/08/2009 - This policy was updated by the ICD-9 2009-2010 Annual Update.

**Reason for Change**

**Last Reviewed On Date**

08/01/2009

**Related Documents**

This LCD has no Related Documents.

**LCD Attachments**

[Coding and Billing Guidelines \(PDF - 46,832 bytes\)](#)

**All Versions**

Updated on 04/16/2010 with effective dates 09/15/2009 - N/A

Updated on 03/05/2010 with effective dates 09/15/2009 - N/A

Updated on 08/08/2009 with effective dates 09/15/2009 - N/A

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