Cohere Medical Policy - Chiropractic Treatment

Clinical Policy for Medical Necessity Review

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Important Notices

Notices & Disclaimers:

GUIDELINES ARE SOLELY FOR COHERE'S USE IN PERFORMING MEDICAL NECESSITY REVIEWS AND ARE NOT INTENDED TO INFORM OR ALTER CLINICAL DECISION-MAKING OF END USERS.

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Other Notices:

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Policy Information:

Specialty Area: Musculoskeletal Care
Policy Name: Cohere Medical Policy - Chiropractic Treatment
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Chiropractic Treatment

Cohere Health takes an evidence-based approach to reviewing musculoskeletal procedure requests, meaning that sufficient clinical information must be provided at the time of submission to determine medical necessity. Documentation must include a recent and detailed history, physical examination related to the onset or change in symptoms, relevant lab results, prior imaging, and details of previous treatments. Musculoskeletal procedures should be requested after a clinical evaluation by the treating provider, which may include referral to a specialist.

- When a specific clinical indication is not explicitly addressed in the Cohere Health medical policy, medical necessity will be determined based on established clinical best practices, as supported by evidence-based literature, peer-reviewed sources, professional society guidelines, and state or national recommendations, unless otherwise directed by the health plan.
- Requests submitted without clinical documentation, or those that do not align with the provided clinical information—such as mismatched procedure, laterality, body part, or CPT code—may be denied for lack of medical necessity due to insufficient or inconsistent clinical information.
- When there are multiple procedures requested simultaneously or within the past three months, each will be reviewed independently. Clinical documentation must clearly justify all of the following:
    - The medical necessity of each individual request
    - Why prior imaging or procedures were inconclusive, or why additional/follow-up studies are needed
    - How the results will impact patient management or treatment decisions

Description

Chiropractic healthcare focuses on the relationship between the body's structure and function, primarily focusing on the spine. Care also includes diagnosing and treating mechanical disorders and how joint dysfunction can impact the nervous system.[1] The primary modality is manipulation and typically involves the spine however, other extremities and joints can be involved. Individual States govern the scope of practice of chiropractic services and other modalities (e.g., electric stimulation, therapeutic ultrasound, traction, exercise, manual/massage therapy).

Medical Necessity Criteria

Indications

Chiropractic treatment is considered appropriate if **ALL** of the following are **TRUE**[2-7]:

- Treatment is to be performed by a licensed Doctor of Chiropractic (DC); **AND**
- Treatment occurs in an outpatient setting; **AND**
- The patient is experiencing **AT LEAST TWO** of the following[8]:
  - Pain; **OR**
  - Tenderness, **OR**
  - Asymmetry/misalignment identified by observation or palpation; **OR**
  - Limited range of motion; **OR**
  - Tissue tone or texture abnormality; **OR**
  - Functional deficits; **AND**
- The patient has a musculoskeletal or neuro-musculoskeletal condition that is creating a functional impairment, necessitating evaluation and treatment that affects **ANY** of the following[9,10]:
  - Neck[9,11]; **OR**
  - Cervicogenic headache[9]; **OR**
  - Mid-back/thoracic region[12]; **OR**
  - Lower back/lumbar region[9]; **OR**
  - Pelvis; **OR**
  - Shoulder; **OR**
  - Hip; **OR**
  - Knee; **OR**
  - Foot and ankle; **AND**

- The plan of care includes appropriate documentation to demonstrate medical necessity, including **ALL** of the following:
  - Long- and short-term goals that are specific, quantifiable (measurable), and objective; **AND**
  - Estimated time to achieve goals; **AND**
  - Frequency and duration of treatments; **AND**
  - Treatments provided with applicable procedure codes listed, and body regions treated (specify the precise level of subluxations that bear a direct causal relationship to symptoms); **AND**
  - Objective measures at the beginning, during, and after treatment to quantify progress, support continued treatment; **AND**
  - Home recommendations, as applicable; **AND**
  - To support the onset and continuation of treatment, there must be a reasonable expectation of recovery or improvement in function.

Non-Indications

Chiropractic treatment is not considered appropriate if **ANY** of the following is **TRUE**:

- Unattended electrical stimulation when used for peripheral neuropathy; **OR**
- If no improvement is documented within 30 days despite modifying treatment, treatment is not considered medically necessary; **OR**
- Internal manipulation; **OR**
- Procedures considered experimental or investigational and not adequately supported by peer-reviewed medical literature; **OR**
- Structured interventions to improve the patient's overall physical fitness (e.g., training, conditioning); **OR**
- Services are for maintenance care, including **ANY** of the following:
  - Preserving the present level of function; **OR**
  - Begins when the goal is achieved and no further progress is occurring; **OR**
- Machine-based decompression/traction device (e.g., Accu-Spina System; Decompression Reduction Stabilization (DRS) System; DRX 9000; DX2 Decompression System; Integrity Spinal Care System; Intervertebral Differential Dynamics Therapy (IDD Therapy); Lordex Lumbar Spine System; MTD 4000 Mettler Traction Decompression System; SpineRx-LDM; VAX-D Spinal Decompression System); **OR**

- The patient has **ANY** of the following absolute contraindications for dynamic thrust techniques[13]:
  - Acute fracture; **OR**
  - Dislocation; **OR**
  - Unstable os odontoideum; **OR**
  - Malignancies of the spine; **OR**
  - Infection of bones, joints of spine (e.g., osteomyelitis, septic discitis, and tuberculosis of the spine); **OR**
  - Signs and symptoms of cauda equina; **OR**
  - Signs and symptoms of myelopathy; **OR**
  - Vertebrobasilar insufficiency syndrome when cervical manipulation is requested; **OR**
  - Major artery aneurysm near proposed manipulation; **OR**
  - Rheumatoid arthritis; **OR**
  - Psoriatic arthritis; **OR**
  - Osteoporosis.

Level of Care Criteria

Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
97012	Application of modality to one or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97140	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions

98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

Medical Evidence

Systematic reviews and meta-analyses of randomized clinical trials (RCTs) have been performed to study the efficacy of spinal manipulation for neck pain and chronic low back pain. Chaibi et al. (2021) evaluated 6 studies with a total of 446 patients who experienced neck pain for 6 weeks or less. The primary outcome measure was pain intensity, which was determined by the visual analogue scale (VAS) or numeric rating scale (NRS). Secondary outcomes included measures of quality of life, adverse effects, and disability. The authors concluded that SMT is effective alone or with an additional modality to treat neck pain with minimal adverse effects.[14] Rubinstein et al. (2019) analyzed the benefits of spinal manipulation for low back pain. A total of 47 RCTs were included with 9211 participants (average age 35-60) with or without referred chronic low back pain. When compared to other therapies, SMT had similar effects for short-term pain relief and a minimal improvement in function. Mild to moderate adverse effects were reported.[15]

Haas et al. (2018) performed a dual-center randomized controlled trial focused on the dose-response and efficacy of spinal manipulation for the care of cervicogenic headache, as the optimal number of visits for spinal manipulative therapy was unknown. A total of 256 participants were studied three times per week for six weeks and received a focused light-massage control when a session did not include spinal manipulation. The highest and most effective dose was 18 visits for spinal manipulation, resulting in half the number of days when a patient experienced a cervicogenic headache.[1]

In a practice-based randomized controlled trial, Haas et al. (2014) examined dose-response and efficacy of spinal manipulation for the care of chronic lower back pain. Previously, there were no full-scale trials of the optimal number of visits to care for any condition with spinal manipulation. 400 patients with chronic low back pain participated in the study, in which they were treated with spinal manipulation by a chiropractor three times per week for six weeks. It was concluded that the number of spinal manipulation visits had a modest effect on chronic lower back pain above 18 visits. 12 visits were determined to yield the most favorable results.[16]

Masaracchio et al. (2013) investigated the short-term effects of thoracic spine thrust manipulation combined with cervical spine non-thrust manipulation (experimental group) versus cervical spine non-thrust manipulation alone (comparison group) in patients with mechanical neck pain. Of the 64 participants in the randomized clinical trial, the experimental group members demonstrated significantly greater improvements in pain and function.[12]

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Policy Revision History/Information

Original Date: September 19, 2024		
Review History		
Version 2	10/16/2025	Annual review. Changed title from “Chiropractic Manipulative Treatment” to “Chiropractic Treatment.” Moved “rheumatoid arthritis, psoriatic arthritis, severe osteoporosis, or malignant tumor in the region of manipulation” from the Indications to Non-Indications section. Updated requirements for plan of care. Added non-indication for experimental and investigational procedures. Updated the non-indication for structured interventions. Added non-indication for machine-based decompression/traction devices. Expanded on the non-indications for acute fracture and infection (for dynamic thrust techniques). Added CPT 97014, 97112, 97530. Expanded the Medical Evidence section; added 2 citations.