I. Description

Chiropractic manipulative treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

Osteopathic manipulative treatment (OMT) is a form of manual treatment applied by a physician or other qualified health care professional to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

II. Criteria/Guidelines

A. CMT is covered (subject to Limitations and Administrative Guidelines) when the patient has a neuromusculoskeletal disorder related to at least one of the following spinal regions:
   1. Cervical region (includes atlanto-occipital joint);
   2. Thoracic region (includes costovertebral and costotransverse joints);
   3. Lumbar region;
   4. Sacral region; or
   5. Pelvic (sacro-iliac joint) region.

B. OMT is covered (subject to Limitations and Administrative Guidelines) when the patient has a neuromusculoskeletal disorder related to at least one of the following body regions:
   1. Cervical region;
   2. Thoracic region;
   3. Lumbar region;
   4. Sacral region; or
   5. Pelvic region.
C. 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.

IV. Administrative Guidelines

A. Chiropractic manipulative treatment codes include a pre-manipulation patient assessment.

1. Additional evaluation and management services including office or other outpatient services (99201-99215), subsequent observation care (99224-99226), subsequent hospital care (99231-99233), office or other outpatient consultations (99241-99245), subsequent nursing facility services (99307-99310), domiciliary, rest home, or custodial care services (99324-99337), and home services (99341-99350) may be reported separately using modifier 25 if the patient’s condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the procedure.

2. The E/M service may be caused or prompted by the same symptoms or condition for which the CMT service was provided. As such, different diagnoses are not required for the reporting of the CMT and E/M service on the same date.

B. Osteopathic manipulative treatment codes do not include a pre-manipulation patient assessment.

1. Evaluation and Management services including new or established patient office or other outpatient services (99201-99215), hospital observation care (99217-99220, 99224-99226), hospital care (99221-99223, 99231-99233), critical care services (99291, 99292), observation or inpatient care services (99234-99236), office or other outpatient consultations (99241-99245), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), and home services (99341-99350) may be reported separately using modifier 25 if the patient’s condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the procedure.

2. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for the reporting of the OMT and E/M service on the same date.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>98940</td>
<td>Chiropractic manipulative treatment (CMT); spinal, one or two regions</td>
</tr>
<tr>
<td>98941</td>
<td>; spinal, three to four regions</td>
</tr>
<tr>
<td>98942</td>
<td>; spinal, five regions</td>
</tr>
<tr>
<td>98925</td>
<td>Osteopathic manipulative treatment (OMT); 1-2 body regions involved</td>
</tr>
</tbody>
</table>
V. Scientific Background

Low Back Pain
Spinal manipulation is used for the treatment of both acute and chronic low back pain. There are sufficient data to conclude that lumbar spinal manipulation is safe and on average mildly effective for at least some patients with low back pain; the data are strongest for patients with acute uncomplicated low back pain (i.e., without radiculopathy).

A 2011 meta-analysis including 26 randomized trials in patients with chronic low back pain compared spinal manipulation with multiple treatments (general practitioner care, analgesics, physical therapy, exercises, or back school, massage, ultrasound, transcutaneous muscle stimulation, and attending a pain clinic). Spinal manipulation had a statistically significant, but not clinically important, short-term effect on reducing pain and improving functional status, compared to other interventions.

Subsequent randomized trials support the finding of short-term benefit of spinal manipulation in patients with low back pain. A randomized trial of 192 patients with subacute and chronic back-related leg pain evaluated home exercise and advice with or without spinal manipulative therapy. Spinal manipulation modestly improved leg pain at 12 weeks but not 52 weeks. Another randomized trial in 107 adults with acute low back pain found that compared with usual care, manual spinal manipulation improved self-reported short-term disability and pain scores.

It may be possible to define subsets of patients in whom manipulation is likely to be beneficial. A randomized trial found that patients with low back pain were much more likely to benefit from manipulation plus exercise than from exercise alone, if they met at least four of the following criteria:

- Symptoms for fewer than 16 days
- No symptoms distal to the knee
- A score below 19 on the Fear-Avoidance Beliefs Questionnaire
- At least one hypomobile segment in the lumbar spine
- At least one hip with more than 35 degrees of internal rotation

Neck Pain and Headache
After low back pain, neck pain and headache are the next most common symptoms for which spinal manipulative therapy is offered. Together, these symptoms account for about 20 percent of all visits to chiropractors. It is estimated that between 18 and 38 million cervical spine manipulations are performed annually in the United States.
The data supporting the efficacy of spinal manipulation for neck pain are more limited than those for low back pain, and the quality of these studies is insufficient to draw firm conclusions. Studies involving cervical manipulation include the following:

- A systematic review concluded that cervical manipulation and/or mobilization were not beneficial when done alone, but were beneficial when used with exercise. The review found moderate-quality evidence that cervical manipulation and mobilization produced similar effects on pain, function, and patient satisfaction at intermediate-term follow-up, and low-quality evidence that cervical manipulation may provide greater short-term pain relief than a control; there was insufficient evidence about effects in patients with radicular findings. The review acknowledged methodologic limitations in many of the underlying trials.

- A subsequent unblinded randomized trial compared 12 weeks of cervical manipulation, home education and exercise, or medication in 272 persons with nonspecific acute and subacute neck pain. Cervical manipulation or home exercises were both superior to medication in alleviating self-reported pain over short- and long-term follow-up, but there was no difference between the manipulation or education/exercise groups.

Several studies have examined the efficacy of manipulation of the thoracic spine for patients with neck pain.

- A randomized trial compared manipulation of the thoracic spine combined with exercise to exercise alone and concluded that manipulation provided greater short- and long-term improvements in function and greater short-term improvement in pain.

- A systematic review of 10 randomized trials concluded that thoracic spine manipulation may be more beneficial for patients with nonspecific neck pain than interventions including electrotherapy, exercise only, or cervical spine mobilization; but found no difference between manipulation for the cervical or thoracic spine. The review concluded that additional trials are needed.

Since 1988, approximately 20 clinical trials have evaluated the effectiveness of cervical spinal manipulation for the prevention of various types of headache, including migraine, tension-type, or cervicogenic headache. A systematic review concluded that spinal manipulation may be as effective as amitriptyline in the prophylactic treatment of migraine headache. The same review found evidence that spinal manipulation was more effective than no treatment in the prophylaxis of cervicogenic headache. The evidence was not strong enough to evaluate the effectiveness cervical spinal manipulation for tension-type headaches. Studies evaluated were heterogeneous and generally of low quality, so that conclusions were judged to be tentative and subject to change based on findings from higher quality studies.

**VI. Important Reminder**

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.
Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VII. References