Clinical Review Criteria
Spinal Manipulations – Chiropractic and Osteopathic

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Criteria
For Medicare Members

<table>
<thead>
<tr>
<th>Source</th>
<th>Policy</th>
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<tbody>
<tr>
<td>CMS Coverage Manuals</td>
<td>None</td>
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<tr>
<td>National Coverage Determinations (NCD)</td>
<td>None</td>
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<tr>
<td>Local Coverage Determinations (LCD)</td>
<td>LCD L34009, Chiropractic Services</td>
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<tr>
<td>Local Coverage Article</td>
<td>Medicare Coverage for Chiropractic Services – Medical Record Documentation Requirements for Initial and Subsequent Visits</td>
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For Non-Medicare Members

When considering clinical information submitted for medical necessity review, the following data elements and corresponding details are evaluated to ensure correlation to the presenting diagnosis and proposed care plan:

- Chief Complaint(s)
- Past Medical History
- Mechanism of Onset
- Duration of Symptoms (acute or chronic)
- Examination Findings
- Results of Diagnostic Testing
- Diagnostic Impression
- Complicating Factors (conditions or circumstances that may affect the patient’s response to care)
- Prior and/or Concurrent History of Treatment
- Prognosis and Provider Comments

Coverage is typically not provided for those categories of services commonly described as “custodial care”, “maintenance care”, “wellness care”, “supportive care”, “palliative care”, or “preventive care”. For instance, when the status of a patient has remained stable for a given illness/condition/injury over approximately four (4) weeks, without functional improvement in a patient’s net health outcome or expectation of additional objectively measurable clinical improvement, further treatment is considered non-covered care. Ongoing care after a patient’s condition has stabilized or reached a clinical plateau, called Maximum Medical Improvement (MMI), does not qualify for coverage. Such care may be described as “custodial care”, “maintenance care”, “wellness care”, “supportive care”, “palliative care”, or “preventive care”.

Determination of medical necessity is also dependent upon the following:

- The diagnosis should be substantiated by history, symptoms and objective clinical information;
- The diagnosis should be for a condition, which the provider of record can effectively treat, based on scope of license.
- That all body regions of treatment must coincide with a diagnosis established and supported within the clinical record.
When a provider determines that additional or continued treatment is indicated within an episode of care, the following criteria are reviewed:

- Initial and current symptoms as described by the patient including severity, frequency, and character;
- Quantifiable examination and re-examination findings, results of diagnostic tests, daily office notes, and other objective data submitted by the provider;
- The complete initial and current diagnostic impression.

Determination of medical necessity for requested services is based upon review of a member’s overall clinical improvement (i.e., response to care) following a course of treatment or authorized trial of care. A comprehensive review of the clinical outcomes specific to the condition for which services are requested is considered in making this decision.

In determining the clinical outcome of a prescribed course of treatment for a specific condition and episode of care, the following factors, as indicated in a Problem Oriented Medical Record (POMR), are evaluated:

1. Clinically significant reduction in symptom severity, frequency, and/or changes in the character of the symptoms to indicate positive clinical results, confirmation of the healing process, and stabilization of the condition.
2. Clinically significant improvement as established by a reduction in the actual number of positive orthopedic tests and neurologic signs.
3. Clinically significant improvement in range of motion as established through valid objective measurement methods; reduction in movement related pain findings (severity and/or character); and reduction in movement induced area of radiation if present.
4. Clinically significant reduction in palpable muscle spasm with associated improvement in muscle strength metrics for the affected spinal region or extremity joint.
5. Clinically significant reduction of tenderness on palpation of the involved spinal or extremity joint and surrounding soft tissue support structures.
6. Clinically significant reduction of paresthesia as established by severity and/or extent of radiation from the spinal nerve root.
7. Clinically significant improvement in the ability to perform a previously identified and specific functional task and/or activity of daily living (ADL) which was quantified during the initial evaluation and/or in a subsequent re-evaluation. For example: an improvement of at least 3 points in a single activity score using the Patient Specific Functional Scale (PSFS).
8. Clinically significant improvements in patient reported scores as demonstrated on appropriately applied outcome-assessment questionnaires. For example: A minimal detectable change of at least 2 points in the average score of all activities or at least a 3 point change in a single activity score using the Patient Specific Functional Scale (PSFS) in a follow-up score over the reported baseline within a 2 to 4 week time frame.
9. Measurable clinically significant improvements from chiropractic procedural care are reasonably expected within a 4-week period from the onset of care for an acute condition or an acute exacerbation of a chronic condition.
10. In the event an individual patient’s response or lack of response to chiropractic care or other manual and physical medicine treatment for their condition is less than expected based on the clinical presentation, additional consideration will be given to best practices for management of that condition. In cases where best practices include medical, rehabilitative, or psychological management, the clinical records should indicate that there has been consideration of these other treatment modalities and/or referral for additional evaluation by the patient’s primary care physician or medical specialty source of care for coordinated management of that condition.

Clinically significant improvement is defined as objectively measurable clinical and functional improvement in a patient’s net health outcome as reflected by a decrease in symptoms, positive correlation in improvement of objective findings, and an increase in function. Each patient and each case is uniquely different, but in general, improvement is recognized by a corresponding reduction in subjective symptoms as measured by PSFS scores; measured improvement in objective findings (i.e., orthopedic tests, neurologic signs, range of motion, muscle strength metrics); and a qualitative and/or quantifiable improvement in the patient’s ability to perform functional tasks and/or activities of daily living.

The expected level of improvement, rate of change, and required duration and frequency of care vary by diagnosis in concert with the age of the patient, participation and effort of the patient, mechanism of onset, duration of condition, contributing past history, and the presence or absence of complicating factors.

*Healthways Clinical Criteria for Chiropractic Services.*
Take home equipment and supplies must follow Kaiser Permanente coverage rules and guidelines.

See Devices, Equipment and Supplies Clinical Review Criteria
See Compression Garments
See Magna Bloc Criteria
See OrthoTrac Criteria
See Anodyne Therapy Criteria

The following information was used in the development of this document and is provided as background only. It is provided for historical purposes and does not necessarily reflect the most current published literature. When significant new articles are published that impact treatment option, KPWA will review as needed. This information is not to be used as coverage criteria. Please only refer to the criteria listed above for coverage determinations.

Background

Spinal manipulation is defined by chiropractors as “a specific form of direct articular manipulation utilizing a short lever and characterized by a dynamic, forceful, high velocity thrust of controlled amplitude” (Janse, 1975, as cited by Coulehan. 1985, p. 355). Chiropractors distinguish between chiropractic adjustments and spinal manipulation. Spinal manipulation is a generic term that refers to techniques used by osteopathic physicians, physiatrists (rehabilitation specialists), physiotherapists, or orthopedic surgeons. Spinal adjustment therapy usually involves more frequent visit than medical treatment for the same condition. (Coulehan, 1985).

Manual manipulation of the spine is composed of four elements: patient positioning, location of applied load, peak velocity of the load that is achieved, and peak load developed. The total displacement of the body segments is believed to be properly controlled by a combination of patient positioning and peak load. Techniques used by chiropractors to augment the manipulation may include mobilization, manual traction, soft-tissue massage, and pressure-point techniques (Haldeman, 1983).

Spinal manipulation and adjunct therapies (physical therapy) have been demonstrated to be effective when delivered alone, but no therapy has been consistently demonstrated to be more effective than the other modalities. A 2011 Cochrane Back Group review of 26 randomized controlled trials with 6070 participants (9 studies with low bias) found high quality evidence that spinal manipulative therapy for low back pain indicates provides clinically relevant, statistically significant short term effect on pain relief as compared to other interventions, including exercise therapy, standard medical care or physical therapy. (Rubinstein, 26Feb2011) The reviewers note that spinal manipulation appears to be no better or no worse than other existing therapies for pain relief. This review affirms the 2008 Cochrane Database Review of Spinal Manipulative Therapy for low-back pain results indicating no evidence that spinal manipulative therapy is superior to other standard treatments (physical therapy, exercises, back school, general physician care) for pain relief or improved functional outcomes. (Assendelft, et al., Cochrane Library Review, 8Oct2011)

There is mixed evidence on the clinical effectiveness of adjunct modalities, including physical therapy and rehabilitative services and durable medical equipment and supplies, when delivered concurrently with spinal manipulation.

An April 2010 Cochrane Back Group Review of combined chiropractic interventions demonstrated slightly improved pain and disability for patients with acute and subacute back pain in the short term. No difference was demonstrated for combined chiropractic interventions for chronic lower back pain and for studies that had a mixed population of lower back pain. Any demonstrated differences were small and were only seen in studies with a high risk of bias. For acute and subacute LBP, chiropractic interventions improved short- and medium-term pain (SMD -0.25 (95% CI -0.46 to -0.04) and MD -0.89 (95%CI -1.60 to -0.18)) compared to other treatments, but there was no significant difference in long-term pain (MD -0.46 (95% CI -1.18 to 0.26)). Short-term improvement in disability was greater in the chiropractic group compared to other therapies (SMD -0.36 (95% CI -0.70 to -0.02)). However, the effect was small and all studies contributing to these results had high risk of bias. There was no difference in medium- and long-term disability. (Walker, 14APR2010)

In a randomized controlled trial of chiropractic care (flexion distraction) or physical therapy (exercise program), Cambron found that subjects in both groups had decreased pain and disability regardless of which therapy was utilized (p<.002). During the year after care, chiropractic subjects had significantly lower pain scores (p=.002) and received fewer visits but experienced no difference in timing of care following intervention when compared to than those in physical therapy treatment. Physical therapy subjects attended significantly more health care visits than subjects who received chiropractic care only. (Cambron, Cochrane Register of Controlled Trials, Chiropractic care vs medical care for low back pain: Assessment of long-term follow-up data, 2005).

Evidence and Source Documents

Hayes Report, Chiropractic Treatment of Low Back Pain, May 26, 1999
Walker B, French S, Grant W, Green S, Cochrane Library Review of Combined Chiropractic Interventions for Low Back Pain, 14APR2010 online publication.

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<th>Date Created</th>
<th>Date Reviewed</th>
<th>Date Last Revised</th>
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<td>10/05/2010MDCRPC, 08/02/2011MDCRPC, 06/05/2012MDCRPC, 10/02/2012MDCRPC, 08/06/2013MPC, 06/03/2014MPC, 04/07/2015MPC, 03/01/2016MPC, 01/03/2017MPC, 11/07/2017MPC, 09/04/2018MPC</td>
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MDCRPC Medical Director Clinical Review and Policy Committee
MPC Medical Policy Committee

<table>
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<tr>
<th>Revision History</th>
<th>Description</th>
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<tr>
<td>05/05/2015</td>
<td>The chiropractic policy was modified. The Healthways Clinical Criteria for Chiropractic Services was adopted as GHC policy.</td>
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<tr>
<td>09/08/2015</td>
<td>Revised LCD L34009</td>
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**Codes**
CPT: 98925, 98926, 98927, 98928, 98929, 98940, 98941, 98942, 98943