

Medical Policy

Chiropractic Services

Policy Number: 013

	Commercial and Qualified Health Plans [±]	Mass General Brigham ACO	Medicare Advantage	OneCare	Senior Care Options (SCO)
No Prior Authorization Visits 1-20	X	X	X	X	X
Authorization required Visits 21 and beyond	X		X		
Authorization required Visits 1-20 for member under 2 years old		X		X	X
Not Covered Visits 21 and beyond		X		X	X

*MassHealth plans limit coverage for chiropractic services to a total of 20 office visits per benefit year.

[±]Commercial and Qualified health plans with a chiropractor benefit; please refer to plan materials for PA requirements and benefit limit.

Overview

The purpose of this document is to describe the guidelines Mass General Brigham Health Plan uses to determine medical necessity for chiropractic services as a treatment for neuromuscular and/or musculoskeletal conditions.

Coverage Guidelines

Mass General Brigham Health Plan covers chiropractic services for medically necessary examination, evaluation, and diagnosis of the presence or absence of neuromuscular and/or musculoskeletal conditions. Mass General Brigham Health Plan covers medically necessary chiropractic services for the treatment of neuromuscular and/or musculoskeletal illnesses, injuries, conditions, or disorders including:

1. The administration of chiropractic adjustments or manipulations, either by hand or by instrumentation, to the body for the purpose of maintaining, restoring, or improving biomechanical and/or neurological integrity or functioning in the human body; and
2. The administration, dispensing, or prescribing of supportive procedures and therapies.

Coverage Criteria

Medical necessity for chiropractic services is determined through InterQual® criteria, which Mass General Brigham Health Plan has customized to increase the list of codes covered and reflect the exclusions listed below. To access the criteria, log into Mass General Brigham Health Plan's provider website at MassGeneralBrighamHealthPlan.org and click the InterQual® Criteria Lookup link under the Resources Menu.

Exclusions

1. Chiropractic services are not covered for Commercial and Qualified Health Plan members 0 to 24 months of age.
2. Maintenance therapy, treatment of a condition that is not improving or resolving.

Medicare Variation

Mass General Brigham Health Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for medical necessity determinations for its Medicare Advantage plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and documentation included in the Medicare manuals are the basis for medical necessity determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan's medical policies are used for medical necessity determinations. **At the time of Mass General Brigham Health Plan's most recent policy review, Medicare includes coverage guidelines for the following:**

- [Medicare Policy Benefit Manual, Chapter 15, section 240.1 "Coverage of Chiropractic Services."](#)
- [LCA: Chiropractic Services-Medical Policy Article \(A57889\)](#)
- [LCD - Chiropractic Services \(L37254\)](#)
- [LCD - Chiropractic Services \(L37387\)](#)

For Medicare Advantage plan members, Mass General Brigham Health Plan criteria are superseded by criteria in the Policy Benefit Manual, LCA, and/or LCDs above.

MassHealth Variation

Mass General Brigham uses guidance from MassHealth for medical necessity determinations for its Mass General Brigham ACO members. When there is no guidance from MassHealth for the requested service, Mass General Brigham Health Plan's medical policies are used for medical necessity determinations. **As of Mass General Brigham Health Plan's most recent policy review, MassHealth has no medical necessity guidelines for chiropractic services, but it does specify criteria in [Subchapter 4 of the Chiropractic Services Manual \(130 CMR 441.000\)](#).**

OneCare and SCO Variation

Mass General Brigham Health Plan uses guidance from CMS for medical necessity determinations for its OneCare and SCO plan members. NCDs, LCDs, LCAs, and documentation included in the Medicare manuals are the basis for medical necessity determinations. When there is no guidance from CMS for the requested service, Mass General Brigham Health Plan uses medical necessity guidelines from MassHealth. When there is no guidance from CMS or from MassHealth, Mass General Brigham Health Plan's medical policies are used for medical necessity determinations.

Definitions

Chiropractic Services: Services rendered by a licensed chiropractor that consist of manual technique where the hands are used to manipulate, mobilize, adjust, stimulate, or otherwise influence the synovial joints and paraspinal tissues in the spinal column. The goal is to restore joint mobility by manually applying a controlled force into joints that have become hypomobile, or restricted in their movement, as a result of a tissue injury.

Chiropractic Manipulative Treatment: The correction of misalignments, subluxations, or segmental joint dysfunction of the bony articulations of the vertebral column, the pelvis, and adjacent areas.

Maintenance Therapy: A treatment plan that seeks 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.

Supportive Procedures and Therapies: Modes of care which may be administered, dispensed or prescribed in addition to the primary Chiropractic procedure (i.e., Chiropractic adjustments or techniques/manipulative techniques). Such supportive procedures and therapies include but are not limited to the use of braces, casting,



supports, traction, thermal modalities, ultrasound, electrical modalities, hydrotherapy, myotherapy, dietary and nutritional advice and/or supplementation, and rehabilitative exercise therapy. The purpose of supportive procedures and therapies is to aid the chiropractor in assisting a patient to achieve a timely and favorable clinical outcome. A chiropractor shall not be required to apply supportive procedures and therapies in the practice of chiropractic.

Categories of Spinal Joint Problems:

1. Acute: A patient's condition is considered to be acute when the patient is being treated for a new injury, identified by x-ray or physical exam. The result of chiropractic treatment is expected to be an improvement in, or arrest of progression of the patient's condition. This result should be obtained within a reasonable and generally predictable period of time. Some patients with acute conditions may require several weeks of treatment, (e.g., up to three months), while others require a much shorter duration of treatment. Initially, services may be more frequent, but Mass General Brigham Health Plan would expect to see a decrease in frequency as a result of the improvement in the patient's condition.
2. Chronic: 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 continued therapy can be expected to result in some functional improvement.
3. Exacerbation: A temporary marked deterioration of the patient's condition due to an acute flare-up of the condition being treated. This must be documented in the patient's medical record, including the date of occurrence, nature of the onset, or other patient factors that will support the medical necessity of treatments for this condition.
4. Recurrence: A return of symptoms of a previously treated condition that has been quiescent for 30 or more days. This may require the re-institution of therapy.

Codes

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage.

CPT/HCPCS Codes	Code Description
97010	Application of a modality to one or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97022	Application of a modality to one or more areas; whirlpool
97024	Diathermy (e.g. microwave)
97026	Infrared
97028	Application of a modality to one or more areas; ultraviolet



97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Ultrasound
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97140	Manual therapy techniques (e.g. mobilization/manipulation, manual lymphatic drainage, manual traction), one 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
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
98940	CMT, spinal, one to two regions
98941	CMT, spinal, three to four regions
98942	CMT, spinal, five regions
98943	CMT, extraspinal, 1 or more regions
99202	Office or other outpatient visit for the evaluation and management of a new patient, low to moderate severity. Physicians typically spend 20 minutes face to face with the patient and/or family.
99203	Office or other outpatient visit for the evaluation and management of a new patient, moderate severity. Physicians typically spend 30 minutes face to face with the patient and/or family.
99204	Office or other outpatient visit for the evaluation and management of a new patient, moderate to high severity. Physicians typically spend 45 minutes face to face with the patient and/or family.



99205	Office or other outpatient visit for the evaluation and management of a new patient, moderate to high severity. Physicians typically spend 60 minutes face to face with the patient and/or family.
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
99212	Office or other outpatient visit for the evaluation and management of an established patient, self-limited or minor. Physicians typically spent 10 minutes face to face with the patient and/or family.
99213	Office or other outpatient visit for the evaluation and management of an established patient, low to moderate severity. Physicians typically spent 15 minutes face to face with the patient and/or family.
99214	Office or other outpatient visit for the evaluation and management of an established patient, moderate to high severity. Physicians typically spent 25 minutes face to face with the patient and/or family.
99215	Office or other outpatient visit for the evaluation and management of an established patient, moderate to high severity. Physicians typically spent 40 minutes face to face with the patient and/or family.

Related Policies

- [Chiropractic Services Provider Payment Guidelines](#)

Effective

January 2026: Off-cycle update. Updated prior authorization at top of policy and added variation for OneCare and SCO members. Fixed code disclaimer and typos. References updated.

June 2025: Annual update. Added LCDs to Medicare variation. References updated.

May 2025: Off-cycle update. Updated Medicare and MassHealth variations. Updated references.

January 2025: Off-cycle update. Prior authorization table updated. MassHealth variation language added.

InterQual® customization described. References reorganized.

August 2024: Annual update. Added exclusion for Maintenance Therapy.

June 2023: Annual update. Medicare language added. Medicare Variation language added. References updated.

June 2022: Annual update.

June 2021: Annual update. References updated.

June 2020: Annual update. Minor formatting in Table on page 1.

June 2019: Annual update. References updated.

October 2018: Off-cycle update. Revised exclusion language to reflect not covered age 0-24 months.

July 2018: Annual Update. Revised language under authorization table. Added exclusion: *Chiropractic Services for newborns under the age of 1 are considered experimental/investigational and not covered.*

April 2018: Off-cycle update. Added codes.

February 2017: Annual update. McKesson's InterQual® criteria replaced the chiropractic services criteria in the policy.

November 2016: Effective Date.

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