Reporting Spinal Chiropractic Manipulative Treatment (CMT) Levels

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Related Policies

Patient Healthcare Records: Documentation Requirements for Utilization Review and File Audits
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Policy Number	**71**
Original Effective Date:	1/1997
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Category:	Coding

Policy Statement

The reporting of spinal chiropractic manipulative treatment (CMT) levels must be supported by the application of CMT to a region or regions involving an individual patient's neuromusculoskeletal diagnosis(es), which may include an adjacent spinal region(s) having physical findings – **P**ain and tenderness; **A**symmetry/misalignment; **R**ange of motion; **T**issue/tone changes; **S**pecial tests (*PARTS*) – associated with the presence of a manipulable lesion.

Optum* by "OptumHealth Care Solutions, LLC" does not consider preferences pertaining to a particular manipulative "technique" as a basis for determining the level of CMT coding that is reported.

Purpose

This policy describes the criteria approved by Optum for the reporting of spinal chiropractic manipulative treatment (CMT) procedural code levels. This document is intended to inform healthcare provider decision-making concerning the reporting of spinal CMT levels. When applicable, this policy serves as the clinical criteria for utilization review (UR) determinations.

Scope

This policy applies to the reporting of spinal chiropractic manipulative treatment (CMT) procedural codes by network and out-of-network healthcare providers. Extraspinal CMT procedural codes are out-of-scope.

Key Policy Questions

1. *What are the circumstances/requirements that most accurately describe the clinical basis for reporting particular CMT levels?*
2. *What are the spinal regions reportedly manipulated in primary study designs by chiropractors for spine-related disorders?*

Summary

- The hierarchy of CMT codes is described in the Current Procedural Terminology (CPT) manual
- The patient's history and presenting complaints should be considered and correlated with the physical examination (*PARTS* methodology), when locating the site at which to apply manipulative treatment.
- Research evidence provides strong support for the application of spinal CMT to regions that directly correspond with the patient's symptoms and neuromusculoskeletal diagnosis
- Research evidence provides support for the application of spinal CMT to regions adjacent to the symptomatic region
- No research evidence of comparative effectiveness for the different CMT levels in the management of various spinal disorders was identified

Definitions

Operational definitions for application to this policy document:

Manipulable Spinal Lesion – A functional and/or structural alteration of the neuromusculoskeletal system that is conformable to the specific forces and moments produced by manipulation in such a way that mechanical stress concentrations are affected resulting in the modulation of symptoms. Traditionally, the manipulable lesion has been termed "subluxation" by chiropractors. Other common analogous terms include joint or segmental dysfunction/fixation.

Neuromusculoskeletal Diagnosis – The conclusion reached following the analysis of an evaluation of a patient having a neuromusculoskeletal complaint, which is supported by the presenting complaints, pertinent history, and evaluation. A neuromusculoskeletal diagnosis is reported by using a valid ICD diagnostic code.

Background

Overview:
The chiropractic manipulative treatment (CMT) procedural coding scheme was implemented as part of the current procedural terminology (CPT) codes set as of January 1, 1997. These procedural codes, which are patterned after the osteopathic manipulative treatment, segregate the spine into five distinct regions. For purposes of CMT, the five spinal regions referred to are:
- cervical region (includes atlanto-occipital joint)
- thoracic region (includes costovertebral and costotransverse joints)
- lumbar region
- sacral region
- pelvic region (includes sacroiliac joint)

The CPT codebook [1] describes the hierarchy of spinal CMT procedures. CMT codes are based upon the number of regions manipulated. The spinal CMT codes are as follows:
- 98940 Chiropractic manipulative treatment (CMT); spinal, one to two regions
- 98941 spinal, three to four regions
- 98942 spinal, five regions

Physical Examination:
When CMT is being considered as an intervention, the evaluation of the patient includes a series of procedures intended to identify appropriate indications for localizing the site of care [2]. Survey data show chiropractors use multiple exam and testing procedures to identify manipulable lesions [3]. The *PARTS* evaluation of the neuro-musculoskeletal system has been described [4] and implemented [5] as a method commonly used to identify spinal manipulable lesions. The PARTS approach is comprised of six constructs (pain and tenderness; asymmetry; range of motion; tone, tenderness and temperature; and special tests) that inform clinical judgments about where to apply manipulative treatment based upon correlating their relationships with the patient's signs and symptoms.

Literature Summary:
Triano, et al [2] published a comprehensive review in order to identify and appraise, "…the best available evidence as to what methods of assessment can inform the provider as to the localization of treatment." The authors employed standardized methods to appraise studies that described the validity and reliability of the components of the PARTS approach. Their consensus findings included recommendations for determining the anatomical site of manual therapy, the relationship of symptoms to the different aspects of the PARTS evaluation, and the quality of evidence used to achieve consensus. [Table 1]

The evaluation of pain (history, provocation) and range of motion were the only two constructs of the PARTS approach that provided favorable recommendations based on mostly high quality evidence and having established relationships with symptoms. Thermography of the lower limb for sciatica and current perception threshold testing for neuropathy also received favorable recommendations based on high quality evidence. These two components of PARTS constructs also had established relationships to symptoms. The other aspects of the PARTS model received recommendations that were unfavorable for localizing the site of manual therapy and/or there was uncertainty about the relationship to symptoms with evidence ranging from low to high quality. Additionally, integrated PARTS models (ie, a combination of PARTS techniques) received an unclear recommendation regarding decisions to localize treatment.

Pragmatically, the clinical application of the results of this comprehensive report showed the patient's history and presenting complaints should be considered and correlated with the physical examination, when locating the site at which to apply manipulative treatment. In particular, the most consistent sources of diagnostic information for the localization of manipulative treatment may come from maneuvers that replicate the patient's familiar pain.

In addition to the review designed to evaluate literature on the validity and reliability of the more common methods used by doctors of chiropractic to inform the site for applying manipulation, a literature search was conducted to identify research evidence, where the site of manipulative treatment by chiropractors was explicitly described. Biomedical databases were searched in accordance with the recommendations of the Cochrane Back Review Group [6]. A total of 892 [1967 – July 8, 2015] citations were retrieved. Studies were included if they represented primary clinically-based investigations (experimental and observational designs) that reported on spinal manipulation by a chiropractor for a spinal neuromusculoskeletal health disorder and explicitly stated the spinal region(s) manipulated. Forty-six studies (three included both neck and low back pain) were identified as meeting inclusion criteria. [Table 2]

The preponderance of studies investigated spinal manipulative treatment rendered by chiropractors for various types of headache [7-16], neck pain with or without radicular symptoms [17-28], mid-back pain [29-31], and lower back pain with or without lower extremity complaints [19,20,28,32-51]. Cervicogenic vertigo was the target disorder for a single trial [52]. Thirty studies explicitly described manipulation performed solely to the spinal region correlated with the anatomical diagnosis eg, cervical manipulation for neck pain. Another eighteen studies described manipulation to an adjacent spinal region in addition to the spinal region correlated with the anatomical diagnosis eg, cervical and thoracic manipulation for neck pain. A single study [25] on the treatment of neck pain included optional manipulation of the lumbar spine and sacro-iliac joints in addition to the explicit application of CMT to cervical and upper thoracic regions. One study [8] described a specific full-spine manipulative approach (Gonstead technique) for the treatment of headache. [Table 3]

The demonstration of a *direct therapeutic effect* associated with the number and locations of spinal regions receiving CMT requires that the assessment procedures used to detect manipulable lesions lead to improvements in the outcomes of care. While there is abundant research evidence that broadly supports the efficacy of spinal manipulation for a wide range of conditions[53], the current literature search did not identify any studies describing the direct therapeutic effects of manipulation performed to a single region vs. multiple spinal regions on clinical outcomes (eg, pain, function, disability) for a spine-related neuromusculoskeletal disorder.

Coding Information

Note: The Current Procedural Terminology (CPT) codes listed in this policy may not be all inclusive and are for reference purposes only. The listing of a service code in this policy does not imply that the service described by the code is a covered or non-covered health service. Coverage is determined by the member's benefit document.

Code	Description
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions
98942	Chiropractic manipulative treatment (CMT); spinal, five regions

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Tables

P.A.R.T.S. evaluation methods **Table 1**

Evaluation Method	Relationship to Symptoms	Recommendation*	Quality of Evidence
Pain (P)			
• Pain history	Established	Favorable	Moderate
• Pain on provocation – tenderness	Established	Favorable	High
• Pain provocation by orthopedic maneuvers	Established	Favorable	High
Asymmetry (A)			
• Postural assessment	Uncertain	Unfavorable	High
• Stiffness – manual assessment	Uncertain	Unclear	High
• Stiffness – instrumented	Uncertain	Favorable with limitations	Low
• Static palpation	Uncertain	Unclear	High
• Motion palpation	Mixed	Favorable with limitations	High
• Leg length inequality (LLI)	Uncertain	Favorable with limitations	High
• Manual muscle testing	Mixed	Unfavorable	Moderate
Range of Motion (R)			
• Passive & active	Established	Favorable	High
Tissue temperature, texture and tone (T)			
• Thermography of lower limb for sciatica	Established	Favorable	High
• Thermography of paraspinal region	Uncertain	Unfavorable	High
• Palpation – skin rolling	Uncertain	Favorable	Moderate
Special tests (S)			
• Current perception threshold (CPT) for neuropathy	Established	Favorable	High
• Current perception threshold for localizing the site of manual treatment	Uncertain	N/A	N/A
• Galvanic skin response (GSR)	Uncertain	Unfavorable	Low/Moderate
• Surface electromyography (SEMG)	Established	Unfavorable	High
• Radiographic imaging (RI)	Mixed	Unfavorable	High

*Recommendation for determining the anatomical site of manual therapy

Primary studies where SMT by chiropractors was explicitly described **Table 2**

Ref #	Author	Disorder	Regions CMT Performed
52	Bracher	Cervicogenic vertigo	Cervical & Thoracic
7	Bove	Headache	Cervical
8	Chaibi	Headache	Full spine (Gonstead method)
9	Haas	Headache	Cervical
10	Haas	Headache	Cervical & upper Thoracic
11	Nelson	Headache	Cervical & Thoracic
12	Nilsson	Headache	Cervical
13	Nilsson	Headache	Cervical
14	Parker	Headache	Cervical
15	Vernon	Headache	Cervical
16	Whittingham	Headache	Cervical
17	Bronfort	Neck pain	Cervical
18	Gemmell	Neck pain	Cervical & upper Thoracic
19	Giles	Neck pain	Cervical
20	Giles	Neck pain	Cervical
21	Jordan	Neck pain	Cervical
22	Hurwitz	Neck pain	Cervical & upper Thoracic
23	Leaver	Neck pain	Cervical
24	Moodley	Neck pain	Cervical
25	Murphy	Neck pain	Cervical & upper Thoracic [Lumbar & SIJ optional]
26	Palmgren	Neck pain	Cervical & Cervico-thoracic junction
27	Saayman	Neck pain	Cervical
28	Dougherty	Cervical radiculopathy	Cervical
29	Chung	Thoracic pain 2° to RA	Thoracic (costovertebral)
30	Schiller	Mid-back pain	Thoracic
31	Stochkendahl	Nonspecific mid-back pain	Thoracic & Cervical
32	Beyerman	Low back pain	Lumbar (flexion-distraction)
33	Bishop	Low back pain	Lumbosacral
34	Bronfort	Low back pain	Lumbar & SIJ
35	Cambron	Lumbar spinal stenosis	Lumbar (flexion-distraction)
36	Cherkin	Low back pain	Lumbar & SIJ
28	Dougherty	Lumbar radiculopathy	Lumbar
19	Giles	Low back pain	Lumbar
20	Giles	Low back pain	Lumbar
37	Goertz	Low back pain	Lumbar or SIJ
38	Gudavalli	Low back pain	Lumbar (flexion-distraction)
39	Haas	Low back pain	Lumbar & SIJ
40	Harvey	Low back pain	Lumbar & SIJ
41	Hondras	Low back pain	Lumbar & SIJ
42	Hsieh	Low back pain	Lumbar & SIJ
43	Kruse	Post-lumbar surgery	Lumbar (flexion-distraction)
44	McMorland	Sciatica	Lumbar & Pelvis (side-posture)
45	Murphy	Lumbar spinal stenosis	Lumbar (distraction manipulation)
46	Peterson	Lumbar herniated disc	Lumbar
47	Pope	Low back pain	Lumbar & SIJ
48	Sanders	Low back pain	Lumbar
49	Shearar	SIJ pain	SIJ (symptomatic side)
50	Triano	Low back pain	Lumbar & SIJ
51	Xia	Low back pain	Lumbar & Pelvis (side-posture)

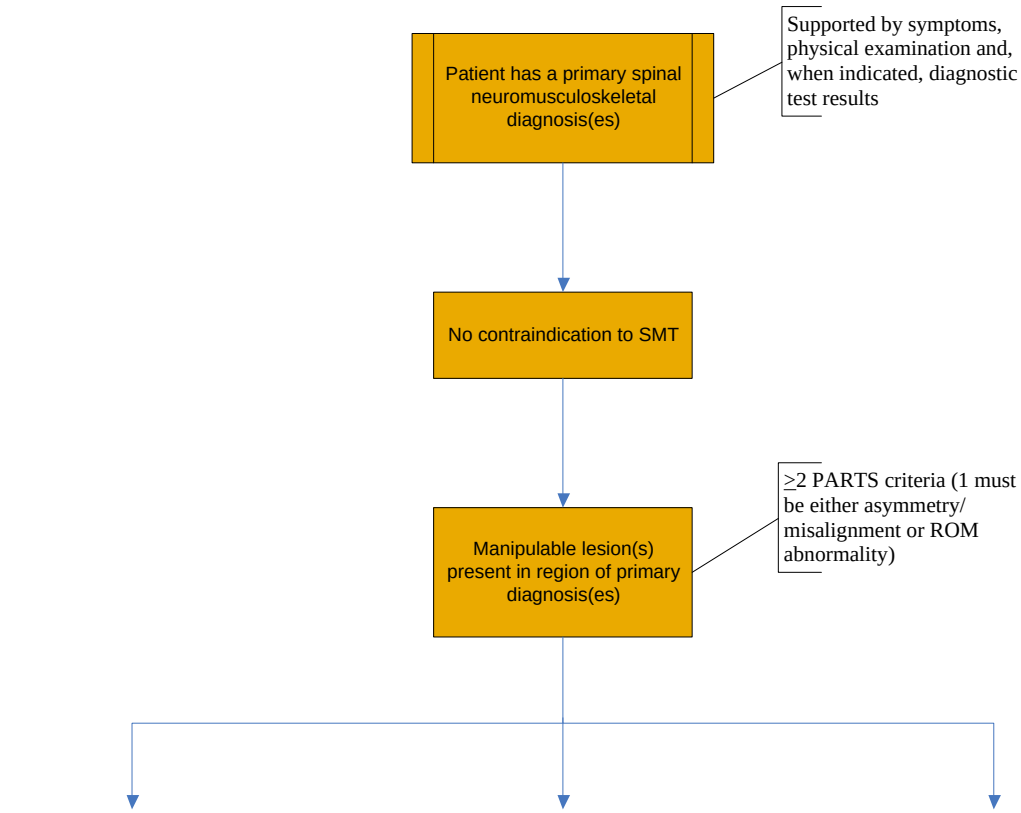
Legend: RA – rheumatoid arthritis; SMT – spinal manipulative therapy; SIJ – sacroiliac joint

Location of SMT by disorder **Table 3**

Disorder	# Studies	Cervical	Cervical & Thoracic	Thoracic	Lumbar	Pelvis	Lumbar & Pelvis	Full Spine
Vertigo	1	1	-	-	-	-	-	-
Headache	10	7	2	-	-	-	-	1
Neck pain	12	8	4*				-	1*
Mid-back pain	3	-	1	2	-	-		-
Low back pain	23	-	-	-	11	1	11	-

* Cervical and thoracic manipulation stipulated; lumbo-pelvic manipulation optional

Spinal CMT Coding Levels
Reporting Guide



Anticipate reporting 98940 when:

- Primary diagnosis for one spinal region

- Primary diagnoses in two spinal regions

- Primary diagnosis for one spinal region and an adjacent spinal region has ≥2 PARTS criteria (1 must be either asymmetry/misalignment or ROM abnormality)

Anticipate reporting 98941 when:

- Primary diagnosis for three spinal regions

- Primary diagnoses for four spinal regions

- Primary diagnosis for two spinal regions and one or two adjacent spinal regions have ≥2 PARTS criteria (1 must be either asymmetry/misalignment or ROM abnormality)

- Primary diagnosis three spinal regions and one adjacent spinal region has ≥2 PARTS criteria (1 must be either asymmetry/ misalignment or ROM abnormality)

Anticipate reporting 98942 when:

- Primary diagnosis for five spinal regions

- Primary diagnosis for three spinal regions and two adjacent spinal regions have ≥2 PARTS criteria (1 must be either asymmetry/misalignment or ROM abnormality)

- Primary diagnosis four spinal regions and one adjacent spinal region has ≥2 PARTS criteria (1 must be either asymmetry/misalignment or ROM abnormality)

Policy History/Revision Information

Date	Action/Description
1/1997	Original effective date
3/24/1998	Annual review completed
1/28/1999	Annual review completed
2/23/2000	Annual review completed
3/07/2001	Annual review completed
9/04/2001	Updated approval - policy references updated
9/20/2002	Annual review completed
11/11/2003	Annual review completed
3/30/2004	Updated approval - policy references updated
11/18/2004	Annual review completed
2/14/2006	Annual review completed
12/04/2006	Annual review completed
4/10/2008	Annual review completed
11/11/2008	Policy header rebranded, "Optum Care Solutions – Physical Health
1/15/2009	Policy placed into new format
4/30/2009	Annual review completed
10/08/2009	Revised policy approved by QIC. *Title* updated. *Purpose* and *Background* sections completely revised. *Scope* and *Definitions* sections added. *Table 1* and *Reporting Guide* added.
4/08/2010	Annual review and approval completed
10/26/2010	Policy rebranded to "Optum Care Solutions, Inc. (Optum)"
4/07/2011	Annual review and approval completed
4/19/2012	Annual review and approval completed
4/18/2013	Annual review and approval completed; references updated
4/17/2014	Annual review and approval completed; references updated; Policy rebranded "Optum* by OptumHealth Care Solutions, Inc."
4/16/2015	Annual review and approval completed; references updated
10/15/2015	Policy revised (eg, added PARTS methodology) following updated literature summary
4/21/2016	Annual review and approval completed
4/20/2017	Annual review and approval completed; Legal entity name changed from "OptumHealth Care Solutions, Inc." to "OptumHealth Care Solutions, LLC."
4/26/2018	Annual review and approval completed; no significant changes made to the document
4/25/2019	Annual review and approval completed; no significant changes made to the document
4/23/2020	Annual review and approval completed; no significant changes made to the document

Contact Information

Please forward any commentary or feedback on Optum utilization management policies to: policy.inquiry@optumhealth.com with the word "Policy" in the subject line.

The services described in Optum* by OptumHealth Care Solutions, LLC policies are subject to the terms, conditions and limitations of the Member's contract or certificate. Optum reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Optum's administrative procedures.

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