

POLICY AND PROCEDURE

POLICY NAME: Chiropractic Manipulative Therapy Expanded Benefit	POLICY ID: FL.UM.59
BUSINESS UNIT: Sunshine State Health Plan	FUNCTIONAL AREA: Utilization Management
EFFECTIVE DATE: 11-18	PRODUCT(S): Managed Medical Assistance (MMA) and Comprehensive Long-Term Care (LTC), Serious Mental Illness (SMI)
REVIEWED/REVISED DATE: 07/18, 05/19, 06/20, 07/21, 01/22, 01/23, 11/2023	
REGULATOR MOST RECENT APPROVAL DATE(S): Please refer to system of record – Archer	

POLICY STATEMENT:

It is the policy of Sunshine Health to cover Agency for Health Care Administration (AHCA) approved expanded benefit for members that are over the age of 21 when medically necessary, appropriate, and consistent with good medical practice, and after review on an individual basis, for the specific indications outlined in this policy.

PURPOSE:

The purpose of this policy to establish clinical criteria on which to review requests for chiropractic manipulative treatment as an expanded benefit for Sunshine Health's MMA and Comprehensive members. The goal is to provide unlimited chiropractic manipulative treatment (CMT) services when medically necessary, as an expanded benefit and to define criteria and limitations established for the use of CMT. The plan has chosen to administer this benefit without prior authorization (PA).

SCOPE:

Sunshine Health Utilization Department for Managed Medical Assistance (MMA) and Comprehensive Long-Term Care (LTC), and Serious Mental Illness (SMI) members.

This policy applies to all directors, officers, and employees of Centene Corporation, its affiliates, health plans, and subsidiary companies (collectively, the "Company").

DEFINITIONS:

Chiropractic manipulative therapy refers to chiropractic adjustment and spinal manipulation. Specifically, CMT refers to manipulation of the vertebrae that are not in the proper position or that are not functioning properly in an effort to protect the spinal cord and offer the body maximum structural integrity. CMT is often applied to members that are experiencing chronic pain in some part of their musculoskeletal system.

Spinal manipulation is one of several options—including exercise, massage, and physical therapy—that can provide mild-to-moderate relief from low-back pain. Spinal manipulation appears to work as well as conventional treatments such as applying heat and taking pain-relieving medications.

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PROCEDURE:

Review Process: To assist in determining the medical necessity of an expanded benefit, the clinical criteria established in this policy will be applied. A request for medical necessity review is consistent with Sunshine Health medical policies:

- FL.UM.02.01 - Medical Necessity Review and Continuity of Care
- FL.UM.02 – Use of Clinical Criteria
- Any decision to deny, reduce, suspend, or terminate services must be made by a Sunshine Health Medical Director as outlined in the policy Clinical Decision Criteria and Application FL.UM.02
- Determinations and provider notifications will be made according to the expediency of the case as described in the Timeliness of UM Decisions and Notifications FL.UM.05

Specific Clinical Information/Criteria

The requesting practitioner must provide information relative to the expanded benefit service that is being requested.

CMT is considered medically necessary when all of the following criteria are met:

- Member has a neuromusculoskeletal disorder; and
- The medical necessity for treatment is clearly documented; and

- Continued improvements based on current /CMT services are documented

Service Description	Documentation Requirement
Chiropractic manipulative treatment (CMT) involving one to two spinal regions	Medical record must document: <ol style="list-style-type: none"> A complaint involving at least one spinal region; an examination of the corresponding spinal region(s); and a diagnosis and manipulative treatment of a condition involving at least one spinal region.
Chiropractic manipulative treatment (CMT) involving one to three to four spinal regions	Medical record must document: <ol style="list-style-type: none"> A complaint involving at least three spinal regions. an examination of the corresponding spinal region(s); and a diagnosis and manipulative treatment of a condition involving at least three spinal regions.
Chiropractic manipulative treatment (CMT) involving one to five spinal regions	Medical record must document: <ol style="list-style-type: none"> A complaint involving at least five spinal regions. an examination of the corresponding spinal region(s); and a diagnosis and manipulative treatment of a condition involving at least five spinal regions.
Extraspinal, 1 or more regions	Extraspinal (nonspinal) regions are: Head (excluding atlanto-occipital, include temporomandibular joint), lower extremities, upper extremities, rib cage (excluding costotransverse and costovertebral joints), and abdomen. Medical record must document: <ol style="list-style-type: none"> A complaint involving one of these regions. an examination of the corresponding spinal region(s); and a diagnosis and manipulative treatment of conditions involving the affected region(s).

Discharge Criteria

- If continued improvement is not documented with the additional treatment, additional chiropractic treatment is considered not medically necessary unless the chiropractic treatment is modified.
- If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered not medically necessary.
- Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.
- Chiropractic manipulation in asymptomatic persons or in persons without an identifiable clinical condition is considered not medically necessary.
- Chiropractic care in persons, whose condition is neither regressing nor improving, is considered not medically necessary.

Limitations / Exclusions

CMT is considered not medically necessary for the treatment of:

- Non-musculoskeletal disorders, including but not limited to:
- Lungs (e.g., asthma)
- Internal organs (e.g., intestinal)

- Neurological (e.g., headaches)
- Ear, nose, and throat (e.g., otitis media)
- Temporomandibular joint (TMJ) disorder
- Scoliosis
- Manipulation is considered experimental and investigational when it is rendered for non-neuromusculoskeletal conditions (e.g., attention-deficit hyperactivity disorder, asthma, autism spectrum disorder, dysmenorrhea, epilepsy, and gastro-intestinal disorders, and menopause-associated vasomotor symptoms; not an all-inclusive list) because its effectiveness for these indications is unproven.
- Manipulation of infants is considered experimental and investigational for non-neuromusculoskeletal indications (e.g., infants with colic).
- Chiropractic manipulation has no proven value for treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence, unless the member is exhibiting pain or spasm, or some other medically necessary indications for chiropractic manipulation are present.

Coverage that exceeds the benefit limit

REFERENCES: Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline from the American College of Physicians (2017)
 Referral patterns to Spinal Manipulative Therapy by Welsh General Practitioners. (2012). Clinical Chiropractic, 15(2), 91-92. doi:10.1016/j.clch.2012.06.015
 Spinal Manipulation for Low-Back Pain. (2018, March 26). Retrieved from <https://nccih.nih.gov/health/pain/spinemanipulation.htm>
 FL.UM.05_Timeliness of UM Decisions and Notifications
 FL.UM.02 Use of Clinical Criteria
 FL.UM.02.01 Medical Necessity Review and Continuity of Care

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: Utilization Management

REGULATORY REPORTING REQUIREMENTS: State review and approval required for any substantial changes and upon request

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
New Policy Document	Policy created	07/11/2018
Archer reload to fix system issue	No content reviewed or revised	05/16/2019
Annual Review	Updated policy names and numbers and changed approver 3 to VP Medical Affairs.	06/01/2020
Annual Review	No changes needed	07/15/2021
Annual Review	Added SMI and changed verbiage under "Purpose"	01/26/2022
Annual Review	No changes needed	01/09/2023
Annual Review	Updated Policy ID Added Policy ID and Name to "Footer" Made minor grammatical changes	11/2023

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.