

Clinical Policy: Chiropractic Manipulative Therapy Expanded Benefit

Reference Number: FL.CP.MP.17
Effective Date: 11/25

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Description

This policy describes medical necessity requirements for chiropractic manipulative therapy (CMT) as an expanded benefit for Sunshine Health's Managed Medical Assistance (MMA), Comprehensive Long-term Care (LTC), HIV/AIDS, and Serious Mental Illness (SMI) members.

Policy/Criteria

- I. It is the policy of Sunshine Health that chiropractic manipulative therapy as an expanded benefit is **medically necessary** when all of the following criteria are met:
 - A. Member must be ≥ 21 years of age;
 - B. Member has a neuromusculoskeletal disorder;
 - C. The medical necessity for treatment is clearly documented;
 - D. Continued improvements based on current/CMT services are documented, one of the following:
 1. Chiropractic manipulative treatment (CMT) involving one to two spinal regions, the medical record must document all of the following:
 - a. A complaint involving at least one spinal region;
 - b. An examination of the corresponding spinal region(s);
 - c. A diagnosis and manipulative treatment of a condition involving at least one spinal region.
 2. Chiropractic manipulative treatment (CMT) involving one to three to four spinal regions, the medical record must document all of the following:
 - a. A complaint involving at least three spinal regions;
 - b. An examination of the corresponding spinal region(s);
 - c. A diagnosis and manipulative treatment of a condition involving at least three spinal regions.
 3. Chiropractic manipulative treatment (CMT) involving one to five spinal regions, the medical record must document all of the following:
 - a. A complaint involving at least five spinal regions;
 - b. An examination of the corresponding spinal region(s);
 - c. A diagnosis and manipulative treatment of a condition involving at least five spinal regions.
 4. Extraspinal, one or more regions, (Head (excluding atlanto-occipital, include temporomandibular joint), lower extremities, upper extremities, rib cage, (excluding costotransverse and costovertebral joints), and abdomen); the medical record must document all of the following:
 - a. A complaint involving one of these regions;
 - b. An examination of the corresponding spinal region(s);

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- c. A diagnosis and manipulative treatment of conditions involving the affected region(s).
- II.** It is the policy of Sunshine Health that *discharge* from chiropractic manipulative therapy (CMT) is appropriate when one or more of the following criteria are met:
- A. Continued improvement is not documented with the additional treatment, unless the chiropractic treatment is modified;
 - B. There is no documented improvement within 30 days despite modification of chiropractic treatment;
 - C. Maximum therapeutic benefit has been achieved;
 - D. Condition is neither regressing nor improving.
- III.** It is the policy of Sunshine Health that chiropractic manipulative therapy is considered **not medically necessary** for the following indications:
- A. Asymptomatic persons or in persons without an identifiable clinical condition;
 - B. 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.
 - C. Osteopathic manipulative treatment (OMT), typically performed by Doctors of Osteopathy (DO).
- IV.** It is the policy of Sunshine Health that current evidence does not support the use of chiropractic manipulation 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.
- V.** It is the policy of Sunshine Health that current evidence does not support chiropractic manipulation of infants (e.g., infants with colic) because its effectiveness for this indication is unproven.
- VI.** It is the policy of Sunshine Health that current evidence does not support chiropractic manipulation for treatment of idiopathic scoliosis or for treatment of scoliosis beyond early adolescence because its effectiveness for this indication is unproven, unless the member is exhibiting pain or spasm, or some other medically necessary indications for chiropractic manipulation.

Background

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.^{2,6}

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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.⁴

Expanded benefits are services offered by health plans that exceed state Medicaid benefits. The services are offered at no additional cost to the state and supplement the standard Medicaid benefit package. Plans are not required to offer all expanded benefits; however, Sunshine Health offers many expanded benefits, including chiropractic manipulative therapy. Expanded benefits offered by Sunshine Health are listed in the member/enrollee handbook.^{1,7}

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description

HCPCS Codes	Description

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		07/18
Archer reload; no review or revisions		05/19
Annual review; updated policy names and numbers		06/20
Annual review; no changes		07/21
Annual review; added SMI and changed verbiage under “Purpose”.		01/22
Annual review; no changes		01/23
Transitioned policy onto state specific template and sent to market for approval; policy number changed from FL.UM.59.00 to FL.CP.MP.17.	08/23	
Annual review; minor grammatical changes with no impact to criteria.	11/23	1/24
Annual review. Added HIV/AIDS to description. I.A. > changed to ≥ for clarity. Added III.C. “Osteopathic manipulative treatment”. Note regarding not exceeding benefit limit removed. Background updated. References reviewed and updated.	11/25	

References

1. Agency for Health Care Administration. Statewide Medicaid Managed Care Expanded Benefits. https://ahca.myflorida.com/content/download/9113/file/Expanded-Benefits_Program_Highlight_Final_101618.pdf. Effective October 16, 2018. Accessed November 3, 2025.
2. Agency for Health Care Administration. Florida Medicaid: Chiropractic services coverage policy. https://ahca.myflorida.com/content/download/5940/file/59G-4.040_ChiropracticServices.pdf. Published January 2019. Accessed November 3, 2025.
3. Qaseem A, Wilt TJ, McLean RM, et al. Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians. *Ann Intern Med.* 2017;166(7):514 to 530. doi:10.7326/M16-2367
4. U.S. Department of Health and Human Services. National Institutes of Health. Spinal manipulation: what you need to know. <https://www.nccih.nih.gov/health/spinal-manipulation-what-you-need-to-know>. Updated September 2022. Accessed November 3, 2025.
5. Rubinstein SM, de Zoete A, van Middelkoop M, Assendelft WJJ, de Boer MR, van Tulder MW. Benefits and harms of spinal manipulative therapy for the treatment of chronic low back pain: systematic review and meta-analysis of randomised controlled trials. *BMJ.* 2019;364:l689. Published 2019 Mar 13. doi:10.1136/bmj.l689
6. Centers for Medicare & Medicaid Services (CMS). Chiropractic services fact sheet L37254. <https://www.cmsmedicare.com/partb/mr/pdf/chiropractic.pdf>. Revised December 12, 2017. Accessed November 3, 2025.
7. Agency for Health Care Administration (AHCA). State of Florida Medicaid. Expanded benefits RPA grid 2020. https://ahca.myflorida.com/content/download/25560/file/SMMC%203.0%20Expanded%20Benefits%20Grid_Health%20Plan_02012025v2.pdf. Effective February 1, 2025. Accessed November 4, 2025.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

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decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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