Primary ICD-9 codes

739.0	NONALLOPATHIC LESIONS OF HEAD REGION NOT ELSEWHERE CLASSIFIED
739.1	NONALLOPATHIC LESIONS OF CERVICAL REGION NOT ELSEWHERE CLASSIFIED
739.2	NONALLOPATHIC LESIONS OF THORACIC REGION NOT ELSEWHERE CLASSIFIED
739.3	NONALLOPATHIC LESIONS OF LUMBAR REGION NOT ELSEWHERE CLASSIFIED
739.4	NONALLOPATHIC LESIONS OF SACRAL REGION NOT ELSEWHERE CLASSIFIED
739.5	NONALLOPATHIC LESIONS OF PELVIC REGION NOT ELSEWHERE CLASSIFIED
739.8	NONALLOPATHIC LESIONS OF RIB CAGE NOT ELSEWHERE CLASSIFIED

Secondary ICD-9 codes

307.81	TENSION HEADACHE
333.83	SPASMODIC TORTICOLLIS
353.1	LUMBOSACRAL PLEXUS LESIONS
353.2	CERVICAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.3	THORACIC ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.4	LUMBOSACRAL ROOT LESIONS NOT ELSEWHERE CLASSIFIED
353.8	OTHER NERVE ROOT AND PLEXUS DISORDERS
353.9	UNSPECIFIED NERVE ROOT AND PLEXUS DISORDER
715.80	OSTEOARTHROSIS INVOLVING OR WITH MORE THAN ONE SITE BUT NOT SPECIFIED AS GENERALIZED AND INVOLVING UNSPECIFIED SITE
715.89	OSTEOARTHROSIS INVOLVING OR WITH MULTIPLE SITES BUT NOT SPECIFIED AS GENERALIZED
719.40	PAIN IN JOINT SITE UNSPECIFIED
719.48	PAIN IN JOINT INVOLVING OTHER SPECIFIED SITES
719.49	PAIN IN JOINT INVOLVING MULTIPLE SITES
719.50	STIFFNESS OF JOINT NOT ELSEWHERE CLASSIFIED INVOLVING UNSPECIFIED SITE
719.59	STIFFNESS OF JOINT NOT ELSEWHERE CLASSIFIED INVOLVING MULTIPLE SITES
720.2	SACROILIITIS NOT ELSEWHERE CLASSIFIED
721.0	CERVICAL SPONDYLOSIS W/O MYELOPATHY
721.1	CERVICAL SPONDYLOSIS WITH MYELOPATHY
721.2	THORACIC SPONDYLOSIS W/O MYELOPATHY
721.3	LUMBOSACRAL SPONDYLOSIS W/O MYELOPATHY
721.41	SPONDYLOSIS WITH MYELOPATHY THORACIC REGION
721.42	SPONDYLOSIS WITH MYELOPATHY LUMBAR REGION
721.5	KISSING SPINE
721.6	ANKYLOSING VERTEBRAL HYPEROSTOSIS
721.7	TRAUMATIC SPONDYLOPATHY
721.8	OTHER ALLIED DISORDERS OF SPINE
721.90	SPONDYLOSIS OF UNSPECIFIED SITE W/O MYELOPATHY
721.91	SPONDYLOSIS OF UNSPECIFIED SITE WITH MYELOPATHY
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC W/O MYELOPATHY
722.10 - 722.11	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC W/O MYELOPATHY - DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC W/O MYELOPATHY
722.2	DISPLACEMENT OF INTERVERTEBRAL DISC SITE UNSPECIFIED W/O MYELOPATHY

722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51 - 722.52	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC - DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.6	DEGENERATION OF INTERVERTEBRAL DISC SITE UNSPECIFIED
722.70 - 722.73	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY UNSPECIFIED REGION - INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION
722.80 - 722.83	POSTLAMINECTOMY SYNDROME OF UNSPECIFIED REGION - POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
722.90 - 722.93	OTHER AND UNSPECIFIED DISC DISORDER OF UNSPECIFIED REGION - OTHER AND UNSPECIFIED DISC DISORDER OF LUMBAR REGION
723.0	SPINAL STENOSIS IN CERVICAL REGION
723.1	CERVICALGIA
723.2	CERVICOCRANIAL SYNDROME
723.3	CERVICOBRACHIAL SYNDROME (DIFFUSE)
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
723.5	TORTICOLLIS UNSPECIFIED
723.8	OTHER SYNDROMES AFFECTING CERVICAL REGION
723.9	UNSPECIFIED MUSCULOSKELETAL DISORDERS AND SYMPTOMS REFERABLE TO NECK
724.01	SPINAL STENOSIS OF THORACIC REGION
724.02	SPINAL STENOSIS OF LUMBAR REGION
724.1	PAIN IN THORACIC SPINE
724.2	LUMBAGO
724.3	SCIATICA
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
724.5	BACKACHE UNSPECIFIED
724.6	DISORDERS OF SACRUM
724.79	OTHER DISORDERS OF COCCYX
724.8	OTHER SYMPTOMS REFERABLE TO BACK
724.9	OTHER UNSPECIFIED BACK DISORDERS
728.81	INTERSTITIAL MYOSITIS
728.85	SPASM OF MUSCLE
729.1	MYALGIA AND MYOSITIS UNSPECIFIED
729.82	CRAMP OF LIMB
736.81	UNEQUAL LEG LENGTH (ACQUIRED)
737.10	KYPHOSIS (ACQUIRED) (POSTURAL)
737.20 - 737.29	LORDOSIS (ACQUIRED) (POSTURAL) - OTHER LORDOSIS ACQUIRED
737.30 - 737.39	SCOLIOSIS (AND KYPHOSCOLIOSIS) IDIOPATHIC - OTHER KYPHOSCOLIOSIS AND SCOLIOSIS
737.40 - 737.43	UNSPECIFIED CURVATURE OF SPINE ASSOCIATED WITH OTHER CONDITIONS - SCOLIOSIS ASSOCIATED WITH OTHER CONDITIONS
737.8	OTHER CURVATURES OF SPINE ASSOCIATED WITH OTHER CONDITIONS
738.2	ACQUIRED DEFORMITY OF NECK
738.4	ACQUIRED SPONDYLOLISTHESIS
738.5	OTHER ACQUIRED DEFORMITY OF BACK OR SPINE
738.6	ACQUIRED DEFORMITY OF PELVIS
754.2	CONGENITAL MUSCULOSKELETAL DEFORMITIES OF SPINE
756.11	CONGENITAL SPONDYLOLYSIS LUMBOSACRAL REGION
756.12	SPONDYLOLISTHESIS CONGENITAL

756.13	ABSENCE OF VERTEBRA CONGENITAL
756.14	HEMIVERTEBRA
756.15	FUSION OF SPINE (VERTEBRA) CONGENITAL
781.2	ABNORMALITY OF GAIT
781.92	ABNORMAL POSTURE
784.0	HEADACHE
846.0	LUMBOSACRAL (JOINT) (LIGAMENT) SPRAIN
846.1	SACROILIAC (LIGAMENT) SPRAIN
846.2	SACROSPINATUS (LIGAMENT) SPRAIN
846.3	SACROTUBEROUS (LIGAMENT) SPRAIN
846.8	OTHER SPECIFIED SITES OF SACROILIAC REGION SPRAIN
846.9	UNSPECIFIED SITE OF SACROILIAC REGION SPRAIN
847.0	NECK SPRAIN
847.1	THORACIC SPRAIN
847.2	LUMBAR SPRAIN
847.3	SPRAIN OF SACRUM
847.4	SPRAIN OF COCCYX
847.9	SPRAIN OF UNSPECIFIED SITE OF BACK

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The record must include the physician or non-physician practitioner responsible for and providing the care of the patient.
3. The submitted medical record should support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code should describe the service performed.

Documentation of a subluxation may be demonstrated by an X-ray or by a physical examination. All levels of subluxation identified must be documented in the patients' medical record, regardless of the current treatment plan.

1. Demonstrated by X-ray: An X-ray may be used to document a subluxation but is not required. The X-ray must have been taken at a time reasonably proximate to the initiation of a course of treatment. Unless more specific X-ray evidence is warranted, an X-ray is considered reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment. In certain cases of chronic subluxation (e.g., scoliosis), an older X-ray may be accepted provided the beneficiary's health record indicates the condition has existed longer than 12 months and there is a reasonable basis for concluding that the condition is permanent. (For more specific information on the coverage/noncoverage guidelines of chronic conditions and maintenance therapy see the "Indications and Limitations of Coverage and/or Medical Necessity" section of this policy). A previous CT scan and/or MRI of the spine may be used, in lieu of an X-ray, when a subluxation of the spine is demonstrated. The time frames specified for X-rays are also applicable for MRIs and CT scans.
2. Demonstrated by Physical Examination: A physical examination may be used to document a subluxation. Evaluation of musculoskeletal/nervous system to identify:

(P) Pain/tenderness evaluated in terms of location, quality, and intensity;

(A) Asymmetry/misalignment identified on a sectional or segmental level;

(R) Range of motion abnormality (changes in active, passive, and accessory joint movements resulting in an increase or decrease of sectional or segmental mobility); and

(T) Tissue, tone changes in the characteristics of contiguous, or associated soft tissues, including skin, fascia, muscle, and ligament;

To demonstrate a subluxation based on physical examination, two of the four criteria mentioned under the "Demonstrated by Physical Examination" section of this policy are required, one of which must be asymmetry/misalignment or range of motion abnormality.

The history recorded in the patient's medical record should include the following:

- Symptoms causing patient to seek treatment;
- Family history if relevant;
- Past health history (general health, prior illness, injuries, or hospitalizations; medications; surgical history)
- Mechanism of trauma;
- Quality and character of symptoms/problem;
- Onset, duration, intensity frequency, location and radiation of symptoms;
- Aggravating or relieving factors; and
- Prior interventions, treatments, medications, secondary complaints.

In addition to the above documentation requirements the following documentation requirements apply whether the subluxation is demonstrated by X-ray or by physical examination:

For the Initial Visit:

1. History as stated above;
2. Description of the present illness including:
   - Quality and character of symptoms/problem;
   - Onset, duration, intensity frequency, location and radiation of symptoms;
   - Aggravating or relieving factors; and
   - Prior interventions, treatments, medications, secondary complaints.
   - Symptoms causing patient to seek treatment. These symptoms must bear a direct relationship to the level of subluxation. The symptoms should refer to the spine (spondyle or vertebral), muscle (myo), bone (osseo or osteo), rib (costo or costal) and joint (arthro) and be reported as pain (algia), inflammation (it is), or as signs such as swelling, spasticity, etc. Vertebral pinching of spinal nerves may cause headaches, arm, shoulder, and hand problems as well as leg and foot pains and numbness. Rib and rib/chest pains are also recognized symptoms, but in general other symptoms must be related to the level of the subluxation that has been cited. A statement on a claim that there is "pain" is insufficient. The location of pain must be described and whether the particular vertebra listed is capable of producing pain in the area determined.
3. Evaluation of musculoskeletal/nervous system through physical examination.
4. Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so stated or identified by a term descriptive of subluxation. Such terms may refer either to the condition of the spinal joint involved or to the direction of position assumed by the particular bone named.
5. Treatment Plan: The treatment plan should include the following:
   - Recommended level of care (duration and frequency of visits);
   - Specific treatment goals; and
   - Objective measures to evaluate treatment effectiveness.
6. Date of the initial treatment.

For Subsequent Visits:

1. History
   - Review of chief complaint;
   - Changes since last visit;
   - System review if relevant.
2. Physical exam
   - Exam of area of spine involved in diagnosis;
   - Assessment of change in patient condition since last visit;
   - Evaluation of treatment effectiveness.
3. Documentation of treatment given on day of visit

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice. If a national or local policy identifies a frequency expectation, a claim for a test/service that exceeds that expectation may be denied as not reasonable and necessary, unless it is submitted with documentation justifying increased frequency.