



Utilization Management Policy

Reporting Spinal Chiropractic Manipulative Treatment (CMT) Levels

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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 – Pain and tenderness; Asymmetry/misalignment; Range of motion; Tissue/tone changes; Special 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.

*Optum™ Physical Health (“Optum”) includes OptumHealth Care Solutions, LLC; ACN Group IPA of New York, Inc.; ACN Group IPA of California, Inc. d/b/a OptumHealth Physical Health of California; Managed Physical Network, Inc.; and OrthoNet Holdings, Inc. which includes OrthoNet New York IPA, Inc., OrthoNet West, Inc., OrthoNet, LLC, OrthoNet of the South, Inc.

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 and Neck Review Group [6]. 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. Fifty-two 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 [7-16,52,54], neck pain with or without radicular symptoms [17-28,55], mid-back pain [29-31], and lower back pain with or without lower extremity complaints [19,20,28,32-51,56]. Cervicogenic vertigo was the target disorder for a single trial [52]. Thirty-three 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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References

1. American Medical Association, Current Procedural Terminology (CPT), Professional Edition
2. Triano JJ, Budgell B, Bagnulo A, et al. Review of methods used by chiropractors to determine the site for applying manipulation. *Chiropractic & Manual Therapies* 2013, 21:36
3. Walker BF, Buchbinder R. Most commonly used methods of detecting spinal subluxation and the preferred term for its description: a survey of chiropractors in Victoria. *Aust J Manipulative Physiol Ther* 1997; 20:583–589
4. Bergmann TF, Peterson DH. Chapter 3 – Joint assessment principles and procedures. In *Chiropractic Techniques Principles and Procedures* (3rd ed). 2011; St. Louis, MO: Mosby, Inc.
5. Medicare Benefit Policy Manual. Chapter 15 – Covered medical and other health services. *Centers for Medicare & Medicaid Services Rev.* 10269, 08-07-20; Accessed February 2023: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>
6. Furlan AD, Malmivaara A, Chou R, et al. 2015 updated method guideline for systematic reviews in the Cochrane Back and Neck Group. *Spine* 2015;40(21):1660-1673.
7. Bove G, Nilsson N. Spinal manipulation in the treatment of episodic tension-type headache: a randomized controlled trial. *JAMA* 1998;280:1576-1579
8. Chaibi A, Šaltytė Benth J, Bjørn Russell M. Validation of Placebo in a Manual Therapy Randomized Controlled Trial. *Sci Rep* 2015;5:11774
9. Haas M, et al. Dose response for chiropractic care of chronic cervicogenic headache and associated neck pain: a randomized pilot study. *J Manipulative Physiol Ther* 2004;27:547-553
10. Haas M, Aickin M, Vavrek D. A preliminary path analysis of expectancy and patient-provider encounter in an open-label randomized controlled trial of spinal manipulation for cervicogenic headache. *J Manipulative Physiol Ther.* 2010;33:5-13
11. Nelson CF, et al. The efficacy of spinal manipulation, amitriptyline and the combination of both therapies for the prophylaxis of migraine headache. *J Manipulative Physiol Ther* 1998;21:511-519
12. Nilsson N. A randomized controlled trial of the effect of spinal manipulation in the treatment of cervicogenic headache. *J Manipulative Physiol Ther* 1995;18:435-440
13. Nilsson N. The effect of spinal manipulation in the treatment of cervicogenic headache. *J Manipulative Physiol Ther* 1997;20:326-330
14. Parker GB, Tupling H, Pryor DS. A controlled trial of cervical manipulation of migraine. *Aust N Z J Med* 1978;8:589-593
15. Vernon H, Jansz G, Goldsmith CH, McDermaid C. A randomized, placebo-controlled clinical trial of chiropractic and medical prophylactic treatment of adults with tension-type headache: results from a stopped trial. *J Manipulative Physiol Ther* 2009;32:344-351
16. Whittingham W, Ellis WB, Molyneux TP. The effect of manipulation (toggle recoil technique) for headaches with upper cervical joint dysfunction: a pilot study. *J Manipulative Physiol Ther* 1994;17:369-375
17. Bronfort G, Evans R, Nelson B, et al. A randomized clinical trial of exercise and spinal manipulation for patients with chronic neck pain. *Spine* 2001;26:788-799
18. Gemmell H, Miller P. Relative effectiveness and adverse effects of cervical manipulation, mobilisation and the activator instrument in patients with sub-acute non-specific neck pain: results from a stopped randomised trial. *Chiropr Osteopat* 2010;18:20
19. Giles LGF, Muller R. Chronic spinal pain syndromes: A clinical pilot trial comparing acupuncture, a nonsteroidal anti-inflammatory drug, and spinal manipulation. *J Manipulative Physiol Ther* 1999; 22:376-381
20. Giles LGF, Muller R. Chronic spinal pain: a randomized clinical trial comparing medication, acupuncture, and spinal manipulation. *Spine* 2003; 28:1490-1502
21. Jordan A, Bendix T, Nielsen H, et al. Intensive training, physiotherapy, or manipulation for patients with chronic neck pain. A prospective single-blinded randomized clinical trial. *Spine* 1998; 23:311-319
22. Hurwitz EL, Morgenstern H, Harber P, Kominske GF, et al. A randomized trial of chiropractic manipulation and mobilization for patients with neck pain: clinical outcomes from the UCLA neck-pain study. *Amer J Pub Health* 2002; 92:1634-1641
23. Leaver AM, Maher CG, Herbert RD, et al. A randomized controlled trial comparing manipulation with mobilization for recent onset neck pain. *Arch Phys Med Rehabil* 2010;91:1313-8
24. Moodley M, Brantingham JW. The relative effectiveness of spinal manipulation and ultrasound in mechanical pain: Pilot study. *J Chiropr Med* 2002;1:184-188

25. Murphy B, Taylor HH, Marshall P. The effect of spinal manipulation on the efficacy of a rehabilitation protocol for patients with chronic neck pain: a pilot study. *J Manipulative Physiol Ther*. 2010;33:168-77
26. Palmgren PJ, Sandström PJ, Lundqvist FJ, Heikkilä H. Improvement after chiropractic care in cervicocephalic kinesthetic sensibility and subjective pain intensity in patients with nontraumatic chronic neck pain. *J Manipulative Physiol Ther* 2006;29:100-106
27. Saayman L, Hay C, Abrahamse H. Chiropractic manipulative therapy and low-level laser therapy in the management of cervical facet dysfunction: a randomized controlled study. *J Manipulative Physiol Ther* 2011;34:153-63
28. Dougherty P, Bajwa S, Burke J, Dishman JD. Spinal manipulation postepidural injection for lumbar and cervical radiculopathy: a retrospective case series. *J Manipulative Physiol Ther* 2004;27:449-456
29. Chung CL, Mior SA. Use of spinal manipulation in a rheumatoid patient presenting with acute thoracic pain: a case report. *J Can Chiropr Assoc* 2015;59:143-9
30. Schiller L. Effectiveness of spinal manipulative therapy in the treatment of mechanical thoracic spine pain: a pilot randomized clinical trial. *J Manipulative Physiol Ther* 2001;24:394-401
31. Stockkendahl MJ, Christensen HW, Vach W, et al. Chiropractic treatment vs self-management in patients with acute chest pain: a randomized controlled trial of patients without acute coronary syndrome. *J Manipulative Physiol Ther* 2012;35:7-17
32. Beyerman KL, Palmerino MB, Zohn LE, et al. Efficacy of treating low back pain and dysfunction secondary to osteoarthritis: chiropractic care compared with moist heat alone. *J Manipulative Physiol Ther* 2006;29:107-114
33. Bishop PB, Quon JA, Fisher CG, Dvorak MF. The Chiropractic Hospital-based Interventions Research Outcomes (CHIRO) study: a randomized controlled trial on the effectiveness of clinical practice guidelines in the medical and chiropractic management of patients with acute mechanical low back pain. *Spine J* 2010;10:1055-64
34. Bronfort G, Maiers MJ, Evans RL, et al. Supervised exercise, spinal manipulation, and home exercise for chronic low back pain: a randomized clinical trial. *Spine J* 2011;11:585-98
35. Cambron JA, Schneider M, Dexheimer JM, et al. A pilot randomized controlled trial of flexion-distraction dosage for chiropractic treatment of lumbar spinal stenosis. *J Manipulative Physiol Ther* 2014;37:396-406
36. Cherkin DC, Deyo RA, Battie M, et al. A comparison of physical therapy, chiropractic manipulation, and provision of an educational booklet for the treatment of patients with low back pain. *N Engl J Med* 1998; 339:1021-1029
37. Goertz CM, Long CR, Hondras MA, et al. Adding chiropractic manipulative therapy to standard medical care for patients with acute low back pain: results of a pragmatic randomized comparative effectiveness study. *Spine* 2013;38:627-34
38. Gudavalli MR, Cambron JA, McGregor M, et al. A randomized clinical trial and subgroup analysis to compare flexion-distraction with active exercise for chronic low back pain. *Eur Spine J* 2006;15:1070-1082
39. Haas M, Group E, Kraemer D. Dose-response for chiropractic care of chronic low back pain. *Spine J* 2004;4:574-583
40. Harvey E, Burton AK, Moffett JK, Breen A. Spinal manipulation for low-back pain: a treatment package agreed to by the UK chiropractic, osteopathy and physiotherapy professional associations. *Man Ther* 2003;8:46-51
41. Hondras MA, Long CR, Cao Y, et al. A randomized controlled trial comparing 2 types of spinal manipulation and minimal conservative medical care for adults 55 years and older with subacute or chronic low back pain. *J Manipulative Physiol Ther* 2009;32:330-343
42. Hsieh CY, Adams AH, Tobias J, et al. Effectiveness of four conservative treatments for subacute low back pain: a randomized clinical trial. *Spine* 2002; 27:1142-1148
43. Kruse RA, Cambron J. Chiropractic management of postsurgical lumbar spine pain: a retrospective study of 32 cases. *J Manipulative Physiol Ther* 2011;34:408-12
44. McMorland G, Suter E, Casha S, et al. Manipulation or microdiscectomy for sciatica? A prospective randomized clinical study. *J Manipulative Physiol Ther* 2010;33:576-84
45. Murphy DR, Hurwitz EL, Gregory AA, Clary R. A non-surgical approach to the management of lumbar spinal stenosis: a prospective observational cohort study. *BMC Musculoskelet Disord* 2006;7:16
46. Peterson CK, Leemann S, Lechmann M, et al. Symptomatic magnetic resonance imaging-confirmed lumbar disk herniation patients: a comparative effectiveness prospective observational study of 2 age- and sex-matched cohorts treated with either high-velocity, low-amplitude spinal manipulative therapy or imaging-guided lumbar nerve root injections. *J Manipulative Physiol Ther* 2013;36:218-25

47. Pope MH, Phillips RB, Haugh LD, et al. A prospective randomized three-week trial of spinal manipulation, transcutaneous muscle stimulation, massage and corset in the treatment of subacute low back pain. *Spine* 1994; 22:2571-2577
48. Sanders GE, Reinert O, Tepe R, Maloney P. Chiropractic adjustive manipulation on subjects with acute low back pain: visual analog pain scores and plasma beta-endorphin levels. *J Manipulative Physiol Ther* 1990; 13:391-395
49. Sheerar KA, Colloca CJ, White HL. A randomized clinical trial of manual versus mechanical force manipulation in the treatment of sacroiliac joint syndrome. *J Manipulative Physiol Ther* 2005;28:493-501
50. Triano JJ, McGregor M, Hondras MA, Brennan PC. Manipulative therapy versus education programs in chronic low back pain. *Spine* 1995;20:948-955
51. Xia T, Wilder DG, Gudavalli MR, et al. Study protocol for patient response to spinal manipulation - a prospective observational clinical trial on physiological and patient-centered outcomes in patients with chronic low back pain. *BMC Complement Altern Med* 2014;14:292
52. Bracher ES, Almeida CI, Almeida RR, et al. A combined approach for the treatment of cervical vertigo. *J Manipulative Physiol Ther* 2000;23:96-100
53. Clar C, Tsertsvadze A, Court R, et al. Clinical effectiveness of manual therapy for the management of musculoskeletal and nonmusculoskeletal conditions: systematic review and update of UK evidence report. *Chiropractic & Manual Therapies* 2014;22:12
54. Corum M, Aydin T, Ceylan CM, Kesiktas FN. The comparative effects of spinal manipulation, myofascial release and exercise in tension-type headache patients with neck pain: a randomized controlled trial. *Complementary Therapies in Clinical Practice* 2021;43:101319.
55. Lohman EB, Pacheco GR, Gharihvand L, et al. The immediate effects of cervical spine manipulation on pain and biochemical markers in females with acute non-specific mechanical neck pain: a randomized clinical trial. *Journal of Manual & Manipulative Therapy* 2019;27(4):186-196.
56. Ghasabmahaleh SH, Rezasoltani Z, Dadarkhah A, et al. Spinal manipulation for subacute and chronic lumbar radiculopathy: a randomized controlled trial. *The American Journal of Medicine* 2021;134(1):135-141.

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)
54	Corum	Headache	Cervical
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
55	Lohman	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
56	Ghasabmahaleh	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

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Location of SMT by disorder

Table 3

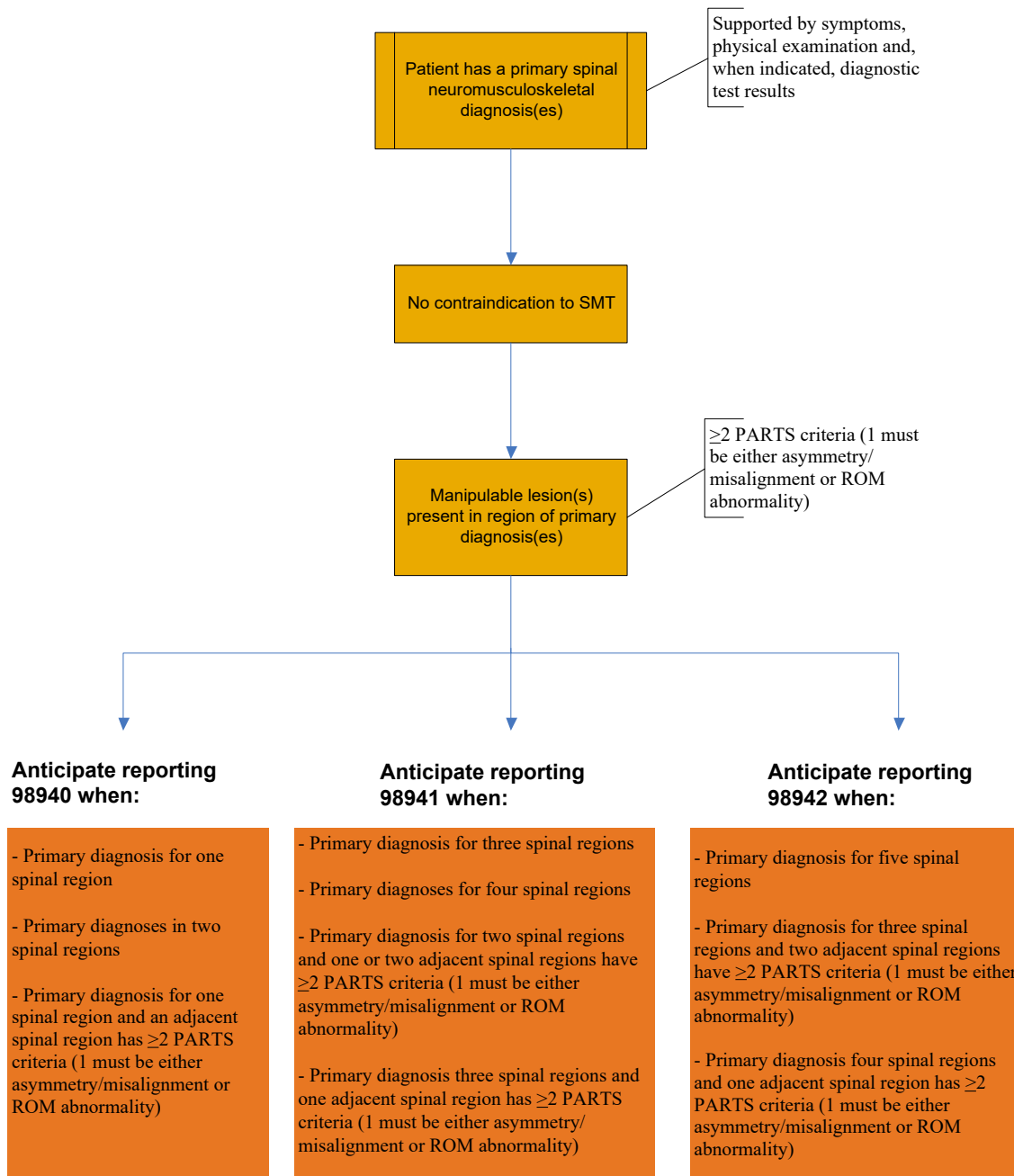
Disorder	# Studies	Cervical	Cervical & Thoracic	Thoracic	Lumbar	Pelvis	Lumbar & Pelvis	Full Spine
Vertigo	1	1	-	-	-	-	-	-
Headache	11	8	2	-	-	-	-	1
Neck pain [§]	13	9	4*	-	-	-	-	1*
Mid-back pain	3	-	1	2	-	-	-	-
Low back pain [‡]	24	-	-	-	12	1	11	-

[§] Includes neck pain defined as mechanical and nonspecific, and radiculopathy

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

[‡] Includes low back pain defined as mechanical, nonspecific, specific etiologies (eg, herniated disc, spinal stenosis), and radiculopathy

Spinal CMT Coding Levels *Reporting Guide*



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Utilization Management Policy

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. <i>Title</i> updated. <i>Purpose</i> and <i>Background</i> sections completely revised. <i>Scope</i> and <i>Definitions</i> sections added. <i>Table 1</i> and <i>Reporting Guide</i> 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
4/22/2021	Annual review and approval completed; Removed URAC from the reference list
5/03/2022	Annual review and approval completed; Updated the literature review, Tables 2 and 3, and the references
6/29/2022	Updated legal entity name "OptumHealth Care Solutions, LLC." to *Optum™ Physical Health ("Optum") includes OptumHealth Care Solutions, LLC; ACN Group IPA of New York, Inc.; ACN Group IPA of California, Inc. d/b/a OptumHealth Physical Health of California; Managed Physical Network, Inc.; and OrthoNet Holdings, Inc. which includes OrthoNet New York IPA, Inc., OrthoNet West, Inc., OrthoNet, LLC, OrthoNet of the South, Inc.
4/27/23	Annual review and approval completed; no significant changes made to the document. Updated contact email from policy.inquiry@optumhealth.com to phpolicy_inquiry@optum.com.

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Utilization Management Policy

Contact Information

Please forward any commentary or feedback on Optum utilization management policies to: phpolicy_inquiry@optum.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.

Certain internal policies may not be applicable to self-funded members and certain insured products. Refer to the member's Summary Plan Description (SPD) or Certificate of Coverage (COC) to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member's SPD or COC, the member's SPD or COC will govern.

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