

1 **Clinical Practice Guideline:** **Preventive Medicine Assessments, Counseling**
 2 **and Special Services Performed by Doctors of**
 3 **Chiropractic**

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 5 **Date of Implementation:** **June 21, 2012**

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 7 **Effective Date:** **April 16, 2026**

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 9 **Product:** **Specialty**

10 **GUIDELINES**

11 Chiropractic is a health care profession that primarily focuses on musculoskeletal and
 12 related disorders, including but not limited to back pain, neck pain, extremity pain,
 13 headaches as well as the effects of these disorders on general health.
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 16 The body of evidence and training of chiropractors fully supports the long-standing
 17 premise that chiropractors function effectively as portal of entry practitioners (practitioners
 18 to whom members have direct access), and these practitioners (defined as “physicians” in
 19 many states) provide an effective evaluation and management service for patients who seek
 20 their services. Further, since the broadly accepted scientific evidence supports chiropractic
 21 treatment of musculoskeletal and related conditions, most third-party coverage policies
 22 managed by American Specialty Health – Specialty (ASH) cover defined evidence-based
 23 chiropractic diagnostic and treatment services within a practitioner’s scope of practice.
 24 Because chiropractors are portal of entry practitioners and because many conditions present
 25 with musculoskeletal components or primary symptoms, chiropractors perform an
 26 appropriate examination and ensure patients receive evidence-based care by either
 27 appropriately caring for the patient themselves within their scope of practice or by referring
 28 individuals to another practitioner.
 29

30 **APPROPRIATE POINT OF SERVICE**

31 Practitioners should practice only in the areas in which they are competent based on their
 32 education, training, and experience. Levels of education, experience, and proficiency may
 33 vary among individual practitioners. It is ethically and legally incumbent on a practitioner
 34 to determine where they have the knowledge and skills necessary to perform such services
 35 and whether the services are within their scope of practice.
 36

37 It is best practice for the practitioner to appropriately render services to a patient only if
 38 they are trained to competency in delivering the services and are as skilled as others who
 39 are trained to perform the same procedure. If the service would be most competently
 40 delivered by another health care practitioner who has more skill and expert training, it
 41 would be best practice to refer the patient to the more expert practitioner.

1 Best practice can be defined as a clinical, scientific, or professional technique, method, or
2 process that is typically evidence-based and consensus driven and is recognized by a
3 majority of professionals in a particular field as more effective at delivering a particular
4 outcome than any other practice (Joint Commission International Accreditation Standards
5 for Hospitals, 2020).

6 7 **PRACTITIONER SCOPE AND TRAINING**

8 Depending on the practitioner’s scope of practice, training, and experience, a member’s
9 condition and/or symptoms during examination or the course of treatment may indicate the
10 need for referral to another practitioner or even emergency care. In such cases it is prudent
11 for the practitioner to refer the member for appropriate co-management (e.g., to their
12 primary care physician) or if immediate emergency care is warranted, to contact 911 as
13 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* clinical practices
14 guideline for information.

15
16 Routine covered services by chiropractors in musculoskeletal benefit designs include
17 diagnosis and management services for musculoskeletal illness/injury and conditions
18 directly related to musculoskeletal disorders. Referrals to other practitioners may be
19 necessary for further evaluation if said evaluation is outside of the scope of the
20 chiropractor.

21
22 Chiropractors routinely provide evaluation and management services including clinical
23 consultation, plain film radiographs as appropriate, manual and/or instrument spinal and
24 extra-spinal manipulation and mobilization, adjunctive physiotherapeutic modalities and
25 procedures, and active therapy procedures such as therapeutic exercises or activities. They
26 may also provide or order, when appropriate, supports, appliances and orthoses, and
27 clinical laboratory or other diagnostic studies.

28
29 For particular clients and markets, ASH has specified in applicable client summaries an
30 expanded set of covered Current Procedural Terminology (CPT) codes to include specified
31 preventive medicine assessments/consultations and other special services. This recognizes
32 the potential for chiropractors to provide these services when such services are aligned with
33 their state scope of practice and when they are trained to competency in the delivery of
34 those services. Because these services are not routine chiropractic services, ASH may
35 require proof of practitioner competency as well as the following specific documentation
36 within the patient medical record: medical necessity; a detailed explanation of the actual
37 service delivered; and information that supports the delivery of the service in a chiropractic
38 office setting.

1 **MEDICAL RECORD KEEPING AND DOCUMENTATION OF MEDICAL**
 2 **NECESSITY**

3 The provision of specialized services (e.g., assistive technologies assessment, self-
 4 care/home management training, and preventive medicine assessment) requires
 5 documented clinical rationale to validate the necessity of further assessment beyond the
 6 service(s) already included within the evaluation and management (E/M) service, and to
 7 document the clinical rationale to validate the medical necessity of further counseling and
 8 special services. Please refer to the individual specialized services policies for further
 9 documentation criteria needed to validate the medical necessity of these services.

10
 11 The patient’s medical records must document the practitioner’s clinical rationale for the
 12 specific services provided, as well as support that the services provided required the skills
 13 and expertise of a practitioner. For example, performance of self-care/home management
 14 training should include the following:

- 15 • Objective measurements of the patient’s activity of daily living (ADL)/instrumental
 16 activity of daily living (IADL) impairment to be addressed;
- 17 • The specific ADL and/or compensatory training provided, specific safety
 18 procedures addressed, specific adaptive equipment/assistive technology utilized,
 19 instruction given, and assistance required (verbal or physical); and
- 20 • The patient’s response to the intervention.

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 22 ***References***

23
 24 Joint Commission International. Joint Commission International Accreditation Standards
 25 for Hospitals. 7th ed. Oak Brook, IL: Joint Commission Resources; 2020