PREMERA HMO

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MEDICAL POLICY – 8.03.502

Physical Medicine and Rehabilitation – Physical Therapy and Medical Massage Therapy

Effective Date:	Apr. 1, 2026
Last Revised:	Mar. 9, 2026
Replaces:	8.03.02

RELATED MEDICAL POLICIES:

8.03.501	Chiropractic and Other Manipulation Services
8.03.503	Occupational Therapy
8.03.505	Speech Therapy
11.01.508	Skilled Home Health Care Services

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | DOCUMENTATION REQUIREMENTS | CODING
RELATED INFORMATION | EVIDENCE REVIEW | REFERENCES | HISTORY

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Introduction

Physical therapy is a type of physical medicine and rehabilitation that treats disease, injury, or deformity using massage, heat, and exercise in place of drugs or surgery. It is performed by qualified, licensed providers such as physical therapists. Massage therapy is generally performed by licensed massage therapists. Exercise and massage help make it easier for people to move, decrease pain, and aid in returning people to their daily activities. Each person is given an individualized treatment plan. This policy outlines when these services may be covered.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Note: Benefits are subject to all terms and limitations in the member contract. See **Benefit Application** in **Related Information** for further details.

Type of Therapy	Medical Necessity
Physical medicine and rehabilitation—physical therapy (PM&R–PT)	**Physical medicine and rehabilitation—physical therapy (PM&R–PT), including medical massage therapy services—may be considered medically necessary when ALL of the following criteria are met:** • The individual has a documented condition causing **physical functional impairment**, or disability due to disease, illness, injury, surgery or physical congenital anomaly that interferes with activities of daily living (**ADLs**) **AND** • The individual has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time based on specific diagnosis-related treatment/therapy goals **AND** • Due to the physical condition of the individual, the complexity and sophistication of the therapy and the therapeutic modalities used, the judgment, knowledge, and skills of a qualified PM&R-PT or medical massage therapy provider are required. ○ A qualified provider is one who is licensed where required and performs within the scope of that licensure **AND** • PM&R-PT and/or medical massage therapy services provide specific, effective, and reasonable treatment for the member's diagnosis and physical condition consistent with a detailed plan of care (see **Documentation Requirements**) ○ PM&R-PT and/or medical massage therapy services must be described using standard and generally accepted medical/physical/massage therapy/rehabilitation terminology. The terminology should include objective measurements and standardized tests for strength, motion, functional levels and pain

Type of Therapy	Medical Necessity
	○ The plan should include training for self-management for the condition(s) under treatment ○ Services provided that are not part of a therapy plan of care, or are provided by unqualified staff are not covered
Physical medicine and rehabilitation—physical therapy (PM&R–PT) for Chronic Pain	**Physical medicine and rehabilitation—physical therapy (PM&R–PT), including medical massage therapy services — may be considered medically necessary when ALL of the following criteria are met:** • The individual has intractable or **moderate to severe** chronic pain (e.g., chronic low back pain, complex regional pain syndrome, or fibromyalgia) **AND** • The individual is initially screened and evaluated by a **qualified provider** for associated medical conditions masking as musculoskeletal pain including, but not limited to, tumors, cauda equina syndrome, or a compression fracture and referred for appropriate further evaluation and management if needed **AND** • The initial evaluation establishes a baseline for outcome measures using validated self-report tools such as the Numeric Pain Scale and/or the Oswestry Disability Index. These tools are then used to identify an individual's baseline status relative to pain, function, and disability and monitored for a change in the individual's status throughout the course of treatment **AND** • A plan of care is established and documented based on the evaluation findings and is directed towards improving upon the impairments and functional deficits noted, including the following: ○ Therapeutic treatment to reduce and manage the symptoms with a goal of maximizing function over time ○ Specifically prescribed, directed, and monitored home or self-administered exercise program with documentation of compliance ○ Individual education regarding the use of active pain coping strategies is provided

Type of Therapy	Medical Necessity
Physical medicine and rehabilitation—physical therapy (PM&R–PT) for Chronic Diseases or Conditions	**Physical medicine and rehabilitation—physical therapy (PM&R–PT), including medical massage therapy services—may be considered medically necessary when ALL of the following criteria are met:** • The services are used to treat a disease or **moderate to severe** condition that has lasted at least 3 months and may no longer be expected to resolve or may be slowly progressive over an indefinite period of time (such as cancer [for which active treatment is being provided], lymphedema, multiple sclerosis, Parkinson's disease, or other chronic degenerative diseases, or inherited musculoskeletal disorders) **AND** • The skilled services of a **qualified provider** are required in order to provide reasonable and necessary **corrective or rehabilitative** care to prevent or slow further deterioration of the individual's condition **AND** • A plan of care is established and documented based on the evaluation findings and is directed towards improving upon the impairments and functional deficits noted, including the following: ○ Therapeutic treatment to reduce and manage the symptoms with a goal of maximizing function over time ○ Specifically prescribed, directed, and monitored home or self-administered exercise program or self-care techniques (such as heat or ice) with documentation of compliance ○ Progress Report documentation describes objective measurements which show improvements in function and decrease in severity to justify continued treatment
Medical massage therapy	**Medical massage therapy may be considered medically necessary as the only therapeutic intervention when ALL of the above criteria for physical medicine and rehabilitation—physical therapy (PM&R–PT) are met AND:** • The diagnosis-specific prescription from the attending clinician with prescribing authority, stating the number of medical massage therapy visits, is retained in the member's massage therapy medical record

Type of Therapy	Medical Necessity

	AND
	• The Progress Report documentation describes the following:
	  ○ The individual has at least one functional limitation (such as sitting, standing, walking, stair climbing, lifting, working, personal care, driving, or sleeping)
	  ○ The individual has at least one subjective complaint (such as neck, shoulder, arm, wrist/hand, back, hip, leg, ankle/foot pain)
	  ○ Treatment frequency should be commensurate with severity of the chief complaint, natural history of the condition, and expectation for improvement
	  ▪ When improvements in the individual's subjective and objective findings are demonstrated, continued treatment with decreased frequency is appropriate
	  ▪ Progress may be documented by increases in functional capacity and increasingly longer durations of pain relief
	
	Physical Medicine and Rehabilitation: Physical Therapy (PM&R-PT) and medical massage therapy are considered not medically necessary when the above criteria are not met

Home-based skilled rehabilitative physical and medical massage therapy	**Home-based physical therapy (PM&R-PT), including medical massage therapy services may be considered medically necessary when the individual is homebound and other medical necessity criteria detailed in this policy are met**
Duplicate therapy	**Duplicate therapy is considered not medically necessary** • Duplicate therapy is when physical therapy (PT), occupational therapy (OT), and/or medical massage therapy provide the same treatment for the same diagnosis. Services provided concurrently by PT, OT, medical massage therapy may be covered if there are separate and distinct functional goals for different diagnoses
Maintenance therapy programs	**Maintenance therapy programs are considered not medically necessary**
Non-skilled therapy	**Treatment that does not generally require the skills of a qualified physical medicine and rehabilitation-physical therapy (PM&R-PT) and/or medical massage therapy provider is**

Type of Therapy	Medical Necessity
	considered not medically necessary (see definition of non-skilled therapy below)
Plan of care (POC)	**The plan of care must be established prior to the start of treatment in order for services to be covered and must include:** • Specific statements of long-and short-term goals • Measurable objectives • A reasonable estimate of when the goals will be reached • The specific treatment techniques and/or exercises to be used in the treatment • Details about frequency and duration of the planned treatment
POC Update / Recertification	**The plan of care must be updated as the individual's condition changes and must be recertified by the referring licensed healthcare provider at least every 60 days**

Documentation Requirements

The clinical impression, diagnosis and treatment care plan documented for the initial and the follow-up visits must clearly support the medical necessity of the rehabilitation therapy provided

Documentation must be legible and include:

- A key for any symbols, abbreviations or codes that are used by the provider and/or staff
- Brief notations, check boxes, and codes/symbols for treatment are acceptable if the notations refer to a treatment modality that has been described in the current plan of care
- Initials of the provider of service and any staff/employees who provide services

Documentation of objective findings includes the following information:

- A statement of the individual's complaint
- Signs and symptoms of impairment or injury
- Signs or symptoms of the individual's inability to perform activities of daily living (ADLs)

The treatment plan of care:

- Is individual-centered and appropriate for the symptoms, diagnosis, and care of the condition
- Includes objectively measurable short and long-term goals for specific clinical and/or functional improvements in the individual's condition with estimated frequency and length of planned treatment including completion date
- Includes details of the specific modalities and procedures to be used in treatment

Documentation Requirements

- Is approved by the referring physician (if applicable)

A re-evaluation of the individual's progress is completed at each follow-up visit and includes documentation of:

- Objective physical findings of the individual's current status
- The individual's subjective response to treatment
- Measured clinical and/or functional improvement in the individual's condition
- A review of the treatment plan of care along with progress toward the short and long-term goals for discharge from therapy
- Updates to the initial treatment plan of care with new goals that are appropriate to the individual's condition
- Reporting to the referring clinician with prescribing authority (if applicable) about the therapy outcomes and recommendations for follow up

Coding

Code	Description
HCPCS	
G0151	Services performed by a qualified physical therapist in a home health or hospice setting, each 15 minutes
S9131	Physical therapy, in the home, per diem

Related Information

Benefit Application

In some plans, the benefits available for Physical Medicine Rehabilitation–Physical Therapy and Medical Massage Therapy include a fixed number of treatment visits covered per year regardless of the individual's condition or prescribed number of courses of therapy. When the maximum benefit is reached, coverage will stop.

Some plans may require medical necessity review of physical medicine rehabilitation–physical therapy and medical massage therapy by eviCore healthcare based on their evidence-based clinical guidelines. Please contact Customer Service to check the member's contract.

Rehabilitation therapy for flat feet except to help recover from surgery to correct flat feet is not covered.

Plan of Care (POC) Update/Recertification

The plan of care must be updated as the individual's condition changes and must be recertified by a physician or appropriate licensed treating professional at least every 60 days.

Definition of Terms

Activities of daily living (ADLs): Self-care activities done daily within a member's place of residence which include:

- Ambulating (walking)
- Dressing/bathing
- Eating
- Hygiene (grooming)
- Toileting
- Transferring (to/from bed or chair)

Fluidized therapy–physical therapy (Fluidotherapy): A dry heat whirlpool using particles (sand-sized ground corn cobs) in a heated air stream. Fluidotherapy treats acute or subacute traumatic or nontraumatic musculoskeletal disorders of the extremities as an alternative to other heat therapy modalities.

Homebound/confined to home: A member may be considered homebound if:

- Their medical condition restricts the ability to leave their place of residence (except with the aid of supportive devices such as wheelchairs and walkers, the use of special transportation, and/or the assistance of another person); or

- Leaving the home would require a taxing effort; or
- Leaving home is medically contraindicated

Homebound status also applies to those members that require assistance when performing ADLs (e.g., transferring, walking or eating, etc.).

A member confined to home may leave their place of residence for medical treatment such as chemotherapy.

Homebound status may be applied to members with compromised immune status or who are in such poor health that reverse isolation precautions are recommended by their providers to avoid exposure to infection(s). Examples of a poor resistance to disease may include but are not limited to:

- Premature infants, or
- Individuals undergoing chemotherapy, or
- Individuals with a chronic disease that has lowered their immune status

Note: Homebound status is not determined by the lack of available transportation, or the inability to drive

Instrumental activities of daily living (IADLs): Activities related to independent living that do not involve personal care activities.[1] Activities that may not always be done on a daily basis include:

- Communication (using the telephone, computer, or other communication devices)
- Housework/home maintenance
- Managing personal finances
- Managing medications
- Preparing meals
- Shopping
- Transportation (driving or using public transit)

Maintenance therapy program: A maintenance therapy program consists of activities that preserve the individual's present level of function and prevents regression of that function rather than provide immediate corrective benefit. Maintenance begins when the therapeutic goals of the Plan of Care have been achieved, or when no additional functional progress is apparent or

expected to occur. This may apply to individuals with chronic and stable conditions where skilled supervision is no longer required and clinical improvement is not expected. The specialized knowledge and judgment of a qualified provider may be required to establish a maintenance program; however, the continuation of PM&R-PT and/or medical massage therapy services to **maintain** a level of function are **not** covered.

Examples of maintenance therapy may include, but are not limited to:

- Additional PM&R-PT and/or medical massage therapy services when the individual's chronic medical condition has reached maximum functional improvement
- PM&R-PT and/or massage therapy services that enhance performance beyond what is needed to accomplish routine functional tasks
- Passive stretching exercises that maintain range of motion and are performed by non-skilled personnel
- A general home exercise program that is not focused on the identified impairments or functional limitations

Corrective or Rehabilitative Care: Corrective or rehabilitative care is the stage of ongoing care beyond the sub-acute phase. This phase of care may last up to 6 months to 12 months from onset. It may also refer to treatment of conditions that are chronic in nature and do not occur in conjunction with an acute or subacute phase. Treatment may be directed towards management of ongoing, unresolved symptoms that may or may not impact functional status. The therapeutic goals of this phase are reduction and management of symptoms with a goal of maximizing function over time, individual/caregiver education, self-management, and to prevent deterioration of physical or functional status. Means and methods include progression of exercise, continued individual education, and transition to self-management. Intensity of care is guided by functional status, focusing on home management, supplemented by therapy visits.

Non-skilled services: Activities that maintain function and could be done safely and effectively by the individual or a non-medical person without the skills or supervision of a qualified provider.

Non-skilled Services may include but are not limited to:

- Activities that the individual performs without direct supervision of a qualified provider such as treadmill, stationary bike, or other aerobic activity for warm-up or general conditioning

- Modalities that the individual self-applies without direct supervision of a qualified provider, such as stretching/resistance exercises with a TheraBand, traction, automobilization tables (Spinalator, Anatomotor, etc.) or Wobble chairs
- Passive range of motion (PROM) treatment, that is not related to restoration of a specific loss of function
- Treatment modalities that the individual self-applies without direct supervision of a qualified provider such as traction
- Unskilled repeated procedures that reinforce previously learned skills to maintain a level of function and/or prevent a decline in function

Physical functional impairment: A limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity (birth defect), pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairments or potential impairments.

Plan of care: The goal driven plan of care details the therapeutic interventions to guide health care professionals involved with the individual's care. Goals are linked to the outcomes to be measured in order to assess and monitor the effectiveness of the therapy program (see **Documentation Requirements** section).

Qualified provider: One who is licensed where required and performs within the scope of that licensure. Qualified providers of PM&R-PT services and medical massage therapy may include, but are not limited to:

- Acupuncturist (LAC)
- Advanced Registered Nurse Practitioner (ARNP) (ANP)
- Doctor of Chiropractic/Chiropractor (DC) (see **Related Policies**)
- Doctor of Osteopathy/Osteopathic Physician (DO)
- Doctor of Podiatric Medicine/Podiatrist (DPM) (limited by licensure requirements)
- Licensed massage practitioner/therapist (LMP, LMT) (subject to the member's health plan benefit)
- Medical Doctor (MD)

- Naturopathic Physician (ND)
- Occupational Therapist (OT) (see **Related Policies**)
- Physical Therapist (PT)

Note: Qualified providers of PM&R-PT services and medical massage therapy must meet the definition in the member's health benefit plan contract. Therapy services will not be covered when provided by athletic trainers, and other providers not recognized by the Health Plan. Please refer to the member's benefit booklet or contact a customer service representative for specific language to determine coverage for the provider of service. (See **Scope**).

Therapy visit: A visit is defined as up to a one-hour session of treatment and/or evaluation on any given day. These visits may include, but are not limited to, the following:

- Chiropractic or osteopathic manipulative therapy
- Massage modalities including, but not limited to, effleurage, petrissage, tapping and friction
- Individual and family education in home exercise programs
- Therapeutic exercise programs including coordination and resistive exercises, to increase strength and endurance
- Traction, or mobilization techniques
- Various modalities including, but not limited to, fluidized therapy, thermotherapy, cryotherapy, and hydrotherapy

Note: The initial evaluation, as well as periodic reevaluations and assessments, may be performed as a separate service on the same day as the therapy visit described above.

Physical Medicine and Rehabilitation Therapy Types

Physical Medicine and Rehabilitation

Physical medicine and rehabilitation, or PM&R, is a medical specialty focused on helping individuals recover physical function and improve quality of life after injury, illness, or disability. It uses non-surgical approaches to treat conditions affecting the brain, spinal cord, nerves, muscles, and joints, often relying on coordinated care from a team that may include physical therapists, occupational therapists, and other rehabilitation professionals. PM&R emphasizes holistic recovery by addressing pain, mobility, emotional health, and independence, instead of

curing disease. It focuses on restoring independence and quality of life without relying only on surgery or medications.

Physical Therapy

Physical therapy (PT) is a form of rehabilitation with an established theoretical and scientific base and widespread clinical applications in the restoration, conservation, and promotion of optimal physical function.

Medical Massage Therapy

Medical massage, also called therapeutic massage, is outcome-based massage, using specific treatment modalities targeted to the functional problem(s) or diagnosis provided by the primary licensed clinician with prescribing authority.

Medical massage therapy or therapeutic massage may be provided by various qualified providers (see **Definition of Terms**).

Massage therapists, one type of medical massage provider, are required to be licensed by most states where the service is performed. The individual must be referred to the massage therapist by a licensed clinician with prescribing authority who writes a diagnosis-specific prescription for medical massage and approves the plan of care for a specific number of therapy visits.

Classification of Severity of Conditions

Severity is classified as mild, moderate, and severe conditions. Severity is determined by various factors as noted in the following table.

Table 1. Classification Criteria for Severity of Conditions

Criteria	Mild condition	Moderate condition	Severe condition
Mode of onset	Variable	Variable	Severe

Criteria	Mild condition	Moderate condition	Severe condition
Anticipated duration of care	1-6 weeks	6-10 weeks	10 or more weeks
Functional deficits:			
1. Range of motion	Mild/no loss	Mild to moderate loss	Considerable loss
2. Muscle Strength	Mild/no loss	Mild to moderate loss	Considerable loss
3. Neurologic findings	None	May be present	May be present
4. BADL - Basic activities of daily living include: ambulating (walking), dressing/bathing, eating, hygiene (grooming), toileting, transferring (to/from bed or chair).	Mild/no loss	Mild to moderate	Moderate to severe
Loss of workdays	No loss of workdays	0-4 days of work lost	5 or more days of work lost
Work restriction	None	Possible, depends on occupation; 0-2 weeks	Restriction, depends on occupation; 2 or more weeks

Evidence Review

This policy was originally created in 1997. Since that time, the policy has been reviewed and updated using PubMed literature searches. Following is a summary of the key literature.

Physical therapy consists of treatment modalities prescribed to restore lost functional ability. Some of the therapeutic interventions include heat and cold, electrical stimulation, massage, therapeutic exercises, traction, gait training for ambulation and training in other functional activities.[2]

Physical Therapy

Pivotal trials evaluating physical therapy interventions have increasingly contributed to the evidence base supporting their clinical utility. In a randomized clinical trial involving 220 patients

with recent-onset low back pain, early physical therapy led to a statistically significant reduction in disability scores at 6 months compared to usual care, with a mean difference of −5.4 points on the Oswestry Disability Index. There was also a 60% increase in the likelihood of self-reported treatment success in the early physical therapy group compared to usual care (Fritz et al, 2021).[3] These findings support early PT as an effective strategy with modest but meaningful improvements in functional outcomes.

Liu et al. (2018) in a retrospective study demonstrated that starting physical therapy within 3 days of acute low back pain onset leads to reduced opioid use, and less reliance on imaging and specialists compared to delayed or no physical therapy. The study analyzed commercial insurance claims from 46,914 patients with acute low back pain in New York State between 2009 and 2013, comparing those who received physical therapy (PT) at varying intervals to those who did not. Of the 6,668 patients who received PT, those who initiated treatment within 3 days of onset had the lowest adjusted 1-year healthcare utilization and costs, including fewer advanced imaging procedures (MRI/CT), specialist visits, and opioid prescriptions. Compared to delayed PT (after 30 days), immediate PT was associated with a 60% reduction in advanced imaging, 54% fewer specialist visits, and 87% lower odds of receiving opioids.[4]

Motor control exercise programs offer moderate-certainty evidence of greater short- and medium-term disability reduction in rotator cuff–related shoulder pain compared to nonspecific exercise approaches as demonstrated in a 2024 systematic review and meta-analysis evaluating exercise therapy for rotator cuff–related shoulder pain. The study synthesized data from 22 RCTs involving 1,281 participants. The review found moderate-certainty evidence that motor control exercise programs significantly reduced disability in both short- and medium-term follow-up compared to nonspecific exercise programs, with standardized mean differences of −0.29 and −0.33 respectively (Lafrance S, et al., 2024).[5]

Manual therapy by physical therapists offers a moderate clinical reduction in pain for patients with rotator cuff tendinopathy, supporting its use as an effective intervention as evidenced by a a systematic review by Desjardins-Charbonneau et al. (2015). Manual therapy delivered by physical therapists for rotator cuff tendinopathy resulted in a mean pain reduction of 1.0 cm on a 10-cm visual analog scale (95% CI: 0.7–1.4), which approximates a moderate clinical effect size.[6]

Millar et al. (2006) analyzed data from 878 patients treated for shoulder dysfunction across outpatient physical therapy clinics and found significant functional improvements following therapist-delivered PT. The most common diagnoses were shoulder impingement (35%), rotator cuff disorders (26%), and adhesive capsulitis (19%), with average reductions in pain scores ranging from 2.1 to 3.7 points and functional gains measured on range-of-motion and disability scales sustained through discharge. Treatment duration varied by condition, but the overall

findings support PT as a beneficial standalone intervention for a diverse array of shoulder pathologies.[7] These trials underscore the role of physical therapy as a primary intervention with measurable outcomes across diverse populations and conditions.

A randomized trial evaluating PT for knee osteoarthritis showed twice-weekly sessions over 8 weeks resulted in increase in quadriceps strength, and improvement in 6-minute walk test distance (Alghadir et al., 2019).[8] In a study of 155 patients after total knee arthroplasty, Zeni and Snyder-Mackler (2010) found that stronger quadriceps in the nonoperated limb at initial physical therapy correlated with better mobility at one and two years. Each one newton-meter per kilogram increase in contralateral strength predicted a 0.5-second faster Timed "Up & Go" and 1.2-second faster stair-climbing time, supporting bilateral strength training to improve long-term recovery.[9]

Building on the existing evidence, several high-quality systematic reviews and randomized controlled trials have further reinforced the efficacy of physical therapy across a range of conditions. Targeted physical therapy that builds bilateral quadriceps strength especially in the nonoperated limb can significantly enhance mobility and long-term recovery outcomes in patients with knee osteoarthritis and post-arthroplasty rehabilitation as evidenced by the following two studies. The evidence strongly supports physical therapy approaches that emphasize high-intensity, repetitive, goal-directed, and task-specific exercises across all stages of stroke recovery. These types of interventions consistently yield better functional outcomes when applied early and sustained through rehabilitation. A systematic review by Veerbeek et al., 2014) of 467 randomized controlled trials involving 25,373 stroke survivors found strong evidence for 13 physical therapy interventions targeting gait, 11 for arm-hand function, and 3 for physical fitness, with summary effect sizes (SESs) ranging from 0.17 to 2.47 depending on the intervention. Notably, higher doses of task-specific PT yielded superior outcomes, such as improved muscle strength in the paretic leg (SES 0.61; 95% CI 0.41–0.82) and motor function in the paretic arm (SES 0.21; 95% CI 0.02–0.39), underscoring the importance of intensity and repetition in poststroke rehabilitation.[10]

Manual therapy led by physical therapists outperforms oral pain medications for neck pain in both short- and long-term relief, with fewer adverse effects as evidence din the 2024 systematic review and meta-analysis by Makin et al. (2024) with 9 trials and 779 subjects, evaluated manual therapy interventions for neck pain, and all included treatments were delivered by licensed physical therapists. The study compared PT-led manual therapy to oral pain medications across nine randomized trials and found that manual therapy was more effective for pain reduction in both the short term (SMD −0.39; 95% CI −0.66 to −0.11) and long term (SMD −0.36; 95% CI −0.55 to −0.17), with a lower risk of adverse events.[11]

Combining manual therapy with exercise delivers greater short-term and long-term improvements in pain, function, and overall patient outcomes compared to exercise alone or no treatment in adults with neck pain per a 2010 systematic review of 17 RCTs by Miller et al., (2010) . Manual therapy combined with exercise delivered by physical therapists delivered significantly greater short-term pain relief than exercise alone for adults with neck pain with a pooled standardized mean difference of −0.50 (95% CI: −0.76 to −0.24). The review also reported clinically important long-term improvements in pain (pSMD −0.87; 95% CI: −1.69 to −0.06), function, and global perceived effect when compared to no treatment, supporting the efficacy of PT-led multimodal care.[12]

Incorporating behavior change strategies like goal setting and motivational support into physical therapy significantly improves patient adherence, underscoring the value of psychosocial approaches for lasting rehabilitation success. This is shown by examining adherence to physical therapy in a 2024 panoramic meta-analysis of 205 RCTs by Let, et al., 2024). The study revealed that behavior change techniques such as booster sessions, goal setting, and motivational interventions yielded a small but statistically significant overall effect (SMD 0.24, 95% CI 0.13–0.34), with no statistical heterogeneity.[13] These findings highlight the importance of integrating psychosocial and behavioral strategies into PT protocols to enhance long-term engagement and outcomes. These data-rich studies collectively strengthen the case for physical therapy as a first-line, evidence-based intervention with broad applicability across clinical settings.

Medical Massage Therapy

Massage therapy was used by 6.0% of US adults for pain and 8.5% for general health restoration in a 2022 national survey of 27,651 civilians in real-world settings. Engagement in other integrative health practices strongly predicted use, and users were predominantly female and socioeconomically advantaged, these groups are common in complementary medicine studies. These patterns underscore massage therapy's validity as a mainstream, evidence-supported modality aligned with medical massage criteria (Levin & Bradshaw, 2022).[14]

In a US-based systematic review, Mak et al. (2024) analyzed randomized trials of massage therapy for pain in outpatient settings from 2018–2023. Seven studies showed moderate-certainty evidence that myofascial release, acupressure, and standard massage yielded up to a 1.8-point reduction on the Visual Analog Scale and a 25% improvement in functional scores, supporting medical massage as an effective intervention for chronic low back pain and fibromyalgia.[15]

Massage therapy, including both structural and relaxation types, offers significantly more pain relief and functional improvement for chronic low back pain compared to usual care as demonstrated by a 2011 RCT trial by Cherkin et al. . About 60 percent of participants reported meaningful symptom reduction over a six-month period. The 401 adults with longstanding chronic low back pain, most of whom had symptoms for over a year. Participants received either structural massage, relaxation massage, or usual care, with outcomes measured at 10 and 26 weeks. Roughly 60% of those who received massage, regardless of type, improved by about 30%, including a 2-point pain reduction on a 10-point scale compared to just 1 point in the usual care group.[16]

Combining deep transverse frictional massage (DTFM) with conventional physiotherapy yields significantly better pain relief and functional recovery for tendinopathy patients than physiotherapy alone, according to a 2025 systematic review by Siva et al., 2025. The review analyzed 13 randomized controlled trials involving 842 participants and found that deep transverse frictional massage (DTFM) combined with conventional physiotherapy significantly improved outcomes for tendinopathies. Pain reduction showed a pooled standardized mean difference (SMD) of −0.92 (95% CI: −1.45 to −0.50), and elbow-specific improvements reached an SMD of −2.67 (95% CI: −3.38 to −1.96). The results indicate that integrating deep transverse frictional massage (DTFM) with conventional therapy provides markedly greater improvements in pain relief and functional outcomes compared to conventional therapy alone in treating tendinopathies.[17]

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in **Table 2**.

Table 2. Summary of Key Clinical Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT03804853	Immediate Accelerated Shoulder Rehabilitation Versus a Standard Protocol Following Reverse Total Shoulder Arthroplasty: A Randomized Controlled Trial	74	Dec 2026

NCT No.	Trial Name	Planned Enrollment	Completion Date
NCT04826757	Effectiveness of Coordinated Care to Reduce the Risk of Prolonged Disability Among Patients Suffer from Subacute or Recurrent Acute Low Back Pain in Primary Care	500	Nov 2027
NCT06256016	Application of Massage to the Dorsal Paravertebral Muscles and Its Efficacy in the Treatment of Neck Pain	60	Feb 2026
NCT04720846	Assessment of a Categorized Physical Therapy Protocol for Non-arthritic Hip and Groin Pain: a Randomized Controlled Study	70	Feb 2026
NCT05450510	Effects of Slow and Accelerated Rehabilitation Protocols After Latissimus Dorsi Transfer in Massive, Irreparable Rotator Cuff Tears	38	Dec 2025

Practice Guidelines and Position Statements

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the policy conclusions.

Guidelines or position statements will be considered for inclusion if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Physical Therapy Association (APTA)

The APTA publishes positions and policies, and the most recent revisions are available at **www.apta.org**. It includes Guidelines for Physical Therapy Documentation:

> It is the position of the APTA that "physical therapist examination, evaluation, diagnosis, and prognosis shall be documented, dated, and authenticated by the physical therapist that performs the service. Interventions provided by the physical therapist or selected interventions provided by the physical therapist assistant under direction and supervision of the physical therapist are documented, dated, and authenticated by the physical therapist or, when permissible by the law, the physical therapy assistant."[18]

The APTA publishes Clinical Practice Guidelines (CPGs)[19] through its specialty sections such as orthopedics and geriatrics. These guidelines are based on systematic reviews, include evidence ratings, and follow rigorous development protocols. One example is the guideline on rotator cuff tendinopathy, which presents graded recommendations for exercise-based management and discloses conflicts of interest. Another guideline addresses fall risk in older adults, emphasizing multifactorial assessment and interventions suitable for outpatient settings.

Academy of Orthopaedic Physical Therapy (AOPT) and the American Academy of Sports Physical Therapy (AASPT)

The AOPT and the AASPT have published evidence-based clinical practice guidelines. These guidelines are based on systematic reviews, include evidence ratings, and follow rigorous development protocols. One example is the guideline on rotator cuff tendinopathy, which presents graded recommendations for exercise-based management and discloses conflicts of interest. This clinical practice guideline provides evidence-based recommendations for the diagnosis, nonsurgical medical care, and rehabilitation of adults with rotator cuff tendinopathy. It emphasizes accurate clinical assessment, discourages routine use of diagnostic imaging in early management, and supports therapeutic exercise and functional rehabilitation strategies (Desmeules et al., 2025).[20]

Medicare National Coverage

Physical Therapy

Part A covers medically necessary physical therapy services that are ordered by a physician under home health services if the individual is homebound.[21] Part B helps pay for medically necessary outpatient physical therapy services that are ordered by a physician.[22] "Physical therapy services: include testing, measurement, assessment and treatment of the function, or dysfunction, of the neuromuscular, musculoskeletal, cardiovascular, and respiratory systems, and establishment of a maintenance therapy program for an individual whose restoration potential has been reached".[23] "Skilled therapy services may be necessary to:

- Improve an individual's current condition,
- Maintain the individual's current condition, or
- Prevent or slow further deterioration of the individual's condition".[24]

Medical Massage Therapy

Medical massage therapy is not covered by Medicare.[25]

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History

Date	Comments
05/05/97	Add to Therapy Section - New Policy

Date	Comments
12/10/02	Replace Policy - Policy reviewed without literature review; new review date only.
05/13/03	Replace Policy - Policy reviewed; text deleted from Policy Guidelines; no criteria changes.
06/23/06	Update Scope and Disclaimer - No other changes.
07/10/07	New PR Policy - Policy updated with literature review; policy statement on maintenance programs added as not medically necessary. Benefit Application and codes updated. Policy changed from AR status to PR, replacing AR.8.03.02.
10/09/07	Cross References Updated - No other changes.
11/09/07	Reference added - No other changes.
05/13/08	Cross References Updated - No other changes.
08/12/08	Replace Policy - Policy updated with literature search. Policy statement updated to add the language "functional limitation or disability" under the medically necessary indication. Title updated to add "medicine and rehabilitation". Codes and references added.
02/10/09	Replace Policy - Policy updated with literature search. Policy statement remains unchanged.
11/10/09	Cross Reference Update - No other changes.
02/09/10	Replace Policy - Policy updated with literature search. No change to policy statement.
12/21/10	Cross Reference Update - No other changes.
02/08/11	Replace Policy - Policy updated with literature search. No change to policy statement. Policy Guidelines updated, along with the Benefit Application; no change to policy statements. Reference number one removed and replaced.
05/10/11	Replace Policy - The title has been updated to include "Massage Therapy." Massage therapy has been incorporated to be part of the medically necessary policy statement when used in as part of PM&R-PT. An additional policy statement has been added indicating that massage therapy is considered not medically necessary as a stand-alone procedure; a medically necessary policy statement has been added for home-based occupational therapy and the definition of "homebound" has been added to the Policy Guidelines section. Approved with 90-hold for notification; effective date is November 9, 2011.
11/07/11	Minor Update – Clarification to policy statement that massage therapy may be considered medically necessary as the sole procedure when criteria are met. Massage therapy that is not part of a written Plan of Care remains not medically necessary.
02/27/12	Related Policies updated with 1.01.523.
10/26/12	Replace Policy. Added "Medical" to massage therapy in the title. Medical Necessity criteria moved to policy statement from policy guidelines section. Related policies revised with Chiropractic Services policy added. Revised wording of policy guidelines

Date	Comments
	for clarity. Revised rationale section. References 5-8 added. Other references renumbered. Policy statement changed as noted, intent unchanged.
12/21/12	Minor update: add ARNPs and ANPs to the list of approved practitioners.
08/16/13	Replace policy. Rationale section updated based on literature review through June 2013; section reformatted for usability. Reference 2 added; others renumbered to match the reformatted rationale. Policy statement unchanged.
09/09/13	Replace policy. Removed policy requirement for submission of prescription and POC for massage therapy. Changed attending "physician" to attending "clinician with prescribing authority". Policy guideline changed to say massage therapists *are required* to be licensed in most states instead of *must be* licensed in the state where service is performed. Changed "sessions" to "visits" to match wording in benefit booklets. Policy statement changed as noted. Update is subject to 90-day provider notification and will be effective 2/15/14.
01/21/14	Update Related Policies. Add 7.01.551.
03/17/14	Update Related Policies. Remove 1.01.523 as it was archived.
05/19/14	Update Related Policies. Remove 1.01.517 as it was archived.
09/03/14	Annual Review. Policy reviewed. Literature search through June 2014 did not prompt addition of new references. Policy statements unchanged.
08/11/15	Annual Review. IADLs added to Definition of Terms. Policy reviewed with a literature search through June, 2015. Reference 1, 9 added. Policy statements unchanged. ICD-9 procedure codes, HCPCS codes G0157, G0159 and S8950 removed; informational only. CPT code 97755 removed; no longer reviewed. Other information CPT codes also removed.
02/09/16	Annual Review. Policy reviewed. Policy statements unchanged.
07/01/16	Interim Update, approved June 14, 2016. Policy reviewed. Policy statements reformatted, intent is unchanged. Definitions in Benefit Application section moved to Definitions section in Policy Guidelines. Changed "sessions" to "visits" to match wording in benefit booklets. Added Classification of Severity of Conditions table. Added Benefit Application information that some member health plans may require review using eviCore guidelines. References added.
02/10/17	Policy moved to new format; no changes to policy statement.
05/01/17	Annual Review, approved April 11, 2017. Policy reviewed; no change to policy statement. Reference 14 added.
02/01/18	Annual Review, approved January 16, 2018. Criteria was added regarding services performed to address chronic pain and chronic diseases or conditions. Clarification provided regarding documentation requirements for medical massage therapy services. Removed CPT codes 97022, 97039, 97124, 97139, 98140.
06/07/18	Minor update. Clarified language in the Benefit Application section.

Date	Comments
02/01/19	Interim Review, approved January 4, 2019. Added statement to benefit application "Rehabilitation therapy for flat feet except to help you recover from surgery to correct flat feet is not covered".
09/01/19	Annual Review, approved August 6, 2019. References updated. Reference 13 added. Policy statements unchanged.
12/01/20	Annual Review, approved November 19, 2020. References updated. Reference 14 added. Policy statements unchanged.
12/01/21	Annual Review, approved November 18, 2021. Policy reviewed. References updated. References added. Added policy statement for recertification requirement every 60 days.
05/01/22	Interim Review, approved April 11, 2022. Added licensed acupuncturist to list of qualified providers who may provide PM&R-PT services within the scope of their license.
12/01/22	Annual Review, approved November 7, 2022. Policy reviewed. No new references added. Policy statement unchanged. Changed the wording from "patient" to "individual" throughout the policy for standardization.
02/01/23	Update Related Policies. 8.03.501 – title changed from "Chiropractic Services" to "Chiropractic and Other Manipulation Services"
08/01/23	Annual Review, approved July 10, 2023. Policy reviewed. Reference added. Policy statements unchanged.
10/01/24	Annual Review, approved September 23, 2024. Policy reviewed. Reference added. Policy statements unchanged.
09/01/25	Annual Review, approved August 25, 2025. Policy reviewed. Reference added and deleted. Policy statements unchanged.
04/01/26	Annual Review, approved March 9, 2026. Policy reviewed. References updated. Policy statements unchanged.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member

benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy does not apply to Medicare Advantage.