

MEDICAL POLICY – 8.03.502


Physical Medicine and Rehabilitation – Physical Therapy and Medical Massage Therapy

Effective Date: Oct. 1, 2024
Last Revised: Sept. 23, 2024
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)	<p>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:</p> <ul style="list-style-type: none"> • 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) <p>AND</p> <ul style="list-style-type: none"> • 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 <p>AND</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ○ A qualified provider is one who is licensed where required and performs within the scope of that licensure <p>AND</p> <ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> ○ 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
	<ul style="list-style-type: none"> ○ 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	<p>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:</p> <ul style="list-style-type: none"> • The individual has intractable or moderate to severe chronic pain (e.g., chronic low back pain, complex regional pain syndrome, or fibromyalgia) <p>AND</p> <ul style="list-style-type: none"> • 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 <p>AND</p> <ul style="list-style-type: none"> • 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 <p>AND</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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
<p>Physical medicine and rehabilitation—physical therapy (PM&R-PT) for Chronic Diseases or Conditions</p>	<p>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:</p> <ul style="list-style-type: none"> 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) <p>AND</p> <ul style="list-style-type: none"> 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 <p>AND</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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
<p>Medical massage therapy</p>	<p>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:</p> <ul style="list-style-type: none"> 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
	<p>AND</p> <ul style="list-style-type: none"> The Progress Report documentation describes the following: <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <p>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</p>
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	<p>Duplicate therapy is considered not medically necessary</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> • 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
<p>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</p> <p>Documentation must be legible and include:</p> <ul style="list-style-type: none"> • 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 <p>Documentation of objective findings include the following information:</p> <ul style="list-style-type: none"> • 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) <p>The treatment plan of care:</p> <ul style="list-style-type: none"> • 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

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

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 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
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

Criteria	Mild condition	Moderate condition	Severe condition
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 There are case studies found, however, few RCTs exist that address physical therapy modalities/manual medicine treatment as distinct from a comprehensive rehabilitation program.

In 2007 Taylor and colleagues³ summarized the benefits of therapeutic exercise based on a systematic review of the literature published from 2002-2005. The review extracted 36 studies that were classified into groups based on condition. The conditions were 6-cardiopulmonary, 6-neurology, 20-musculoskeletal (including: spinal n=7; peripheral n=9, arthritis n=4), and 4-other. Therapeutic exercise was found to be effective for individuals with multiple sclerosis, osteoarthritis, subacute and chronic low back pain, chronic heart failure, coronary heart disease, chronic obstructive pulmonary disease (COPD), intermittent claudication, and after lumbar disc surgery. Outcomes measured the effect of therapeutic exercise in terms of physical impairment, and restriction or limitation to active participation in ADLs. The conclusions state that focused, individual-centered therapeutic exercise programs were effective; however, some of the trials were of poor quality.

In 2011, Cherkin and colleagues published results from a parallel-group randomized control trial (RCT) ([NCT00371384](#)) on the effects of two types of massage and usual care on chronic low back pain. Individuals (n=401) with low back pain of no identified cause lasting at 3 months were randomly assigned to get relaxation massage (n=136), structural massage (n=132) or usual medical care (analgesic, anti-inflammatory, muscle relaxing drugs) without massage (n=133). Individuals assigned to the massage groups received 1 hour of massage once a week for 10

weeks. The researchers measured individuals' symptoms and ability to perform daily activities using the Roland Disability Questionnaire (RDQ) and symptom bothersomeness scores before starting the interventions and again after completing the 10 massage treatments, and then at 6 months and 1 year after starting massage therapy.⁴ The researchers found that individuals who received massage had less pain and were able to perform daily activities better after 10 weeks than those who received usual care. The benefits of massage lasted for 6 months but were less clear at 1 year, when both pain and functional improvement were about equal in all 3 groups. The type of massage did not seem to make a difference. Symptoms and ability to perform activities improved about the same in the 2 massage groups. Study limitations were that the individuals were not blinded to the treatment and the individuals were mostly middle-aged, female, and white which may limit applicability of the research findings to the general population.

In 2012, Perlman et. al. published the results of an RCT to determine the optimal "dose" of Swedish massage therapy for study participants identified with painful osteoarthritis (OA) of the knee. ([NCT00970008](#)) "The researchers defined optimal, practical dose as producing the greatest ratio of desired effect compared to costs in time, labor, and convenience".⁵ Participants (n=125) with OA of the knee were randomly assigned to one of four 8-week doses of a standardized regimen of Swedish massage therapy (30 or 60 minutes weekly or biweekly) or to a Usual Care control group. The Usual Care control group continued with their current treatment plan and did not receive massage therapy. The primary outcome measure was a change in the Western Ontario and McMaster Universities Arthritis Index (WOMAC-Global). Three researchers assessed the 125 enrolled participants' pain, function, and joint flexibility. One hundred and nineteen participants completed the 8-week trial and 115 completed the entire 24-week trial. Conclusion by the authors: Based on the convenience of a once-weekly protocol, cost savings, and consistency with a typical real world massage protocol, the 60-minute once weekly dose was determined to be optimal, potentially establishing a standard for future clinical trials.

In 2016, Nelson and Churilla published the results of a systematic review of randomized controlled trials of massage therapy for individuals with arthritis. Their goal was to critically appraise and synthesize the current evidence regarding the effects of massage therapy as a stand-alone treatment on pain and functional outcomes among those with osteoarthritis or rheumatoid arthritis. Their review found seven randomized controlled trials representing 352 participants who satisfied the inclusion criteria. Their results found low-to moderate-quality evidence that massage therapy is superior to nonactive therapies in reducing pain and improving certain functional outcomes. They concluded that it is unclear whether massage therapy is more effective than other forms of treatment as an intervention for individuals with arthritis.¹⁴



Practice Guidelines and Position Statements

American Physical Therapy Association (APTA)

The APTA publishes positions and policies, the most recent revisions are available at www.apta.org.⁷ 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.”

Medicare National Coverage

“Part A covers medically necessary physical therapy services that are ordered by a physician under home health services if the individual is homebound. Part B helps pay for medically necessary outpatient physical therapy services that are ordered by a physician. 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”. “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”^{6,9}

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History



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



Date	Comments
	revised with Chiropractic Services policy added. Revised wording of policy guidelines 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 <i>are required</i> to be licensed in most states instead of <i>must be</i> 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.



Date	Comments
06/07/18	Minor update. Clarified language in the Benefit Application section.
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.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply. CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). ©2024 Premera All Rights Reserved.

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.

