Clinical Practice Guideline: **Therapeutic Massage Medical Policy/Guideline**

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Related Policies:
CPG 2: Practice Parameters and Review Criteria
CPG 3: Quality Patient Management
CPG 12: Medical Necessity Decision Assist Guideline for Rehabilitative Care
CPG 14: Clinical Guidelines and Criteria.
CPG 110: Medical Record Maintenance and Documentation Practices
CPG 111: Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations, Re-evaluations and Consultations
CPG 121: Passive Physiotherapy (Therapeutic) Modalities
CPG 135: Physical Therapy Medical Policy/Guidelines
CPG 157: Lymphedema
CR 1: Credentialing Program
UM 1: Clinical Services Program
UM 2: Medical Necessity Review
UM 8: Medical Necessity Definition

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OVERVIEW

American Specialty Health – Specialty (ASH) contracts with licensed/registered/certified massage therapists depending on state-specific board requirements in each jurisdiction.

An important qualification for licensure of massage therapists is graduation from a state licensed massage therapy education program. Some programs also have accreditation from the Commission on Massage Therapy Accreditation, or other programmatic or institutional accreditations recognized by the United States Department of Education. Qualification for licensure, registration, or certification, includes successful completion of the Massage Board Licensing Exam (MBlex), National Certification Board for Therapeutic Massage and Bodywork exam (NCBTMB), or a state-specific exam. Massage therapists are expected to engage in continuing education to ensure they are utilizing the most current, evidence-based therapy approaches and interventions. Continuing education hour requirements are often required by state regulatory boards in order to renew licensure/certification/registration.

ASH also contracts with Physical Therapists, Chiropractors and Acupuncturists who are licensed practitioners able to provide therapeutic massage (See *Physical Therapy Medical Policy/Guidelines [CPG 135 – S], Chiropractic Services Medical Policy/Guidelines [CPG 278 – S], Acupuncture Services Medical Policy/Guidelines [CPG 264 – S]* for more information).

The determination of medically necessary care, as outlined in this guideline, protects against inappropriate care that may be wasteful, unsafe, and harmful to the patient, while assuring approved care is safe, appropriate, curative, and improves the patient's function and quality of life. To protect the health and safety of patients, American Specialty Health (ASH) has implemented medical necessity review strategies to educate practitioners of the

need to implement methods to reduce clinical errors and improve patient safety. These medical necessity review strategies include encouraging practitioners to adopt evidence-based health care approaches to patient care, implement professional standards of care, and follow applicable care management guidelines. Conducting risk management procedures via medical necessity review minimizes potential adverse outcomes and harm to the patient and prevents wasteful, unsafe and inappropriate care.

Care approved through medical necessity review is safe, appropriate, and directed at specific treatment goal resolution to ensure clinical benefit and improvement to the patient's quality of life.

- For risk-reduction and the protection of patients, the review process does not approve treatment when a condition should be referred to a medical physician, the treatment is unsafe, or when treatment is not providing measurable health improvement.
- For the benefit of patients, the review process approves services when the evidence and practitioner treatment plan supports the use of conservative treatment for conditions known to be amenable to the services provided so that patients may recover from conditions without the need for more costly or high-risk treatments such as prescription opioids, injections, or surgery.

GUIDELINES

Medically Necessary

Therapeutic massage is considered medically necessary when **ALL of** the following criteria are met:

1. When therapeutic massage is performed for the purpose of
    - Restoring muscle function
    - Reducing edema
    - Improving joint motion
    - Relieving muscle spasm
    - Restoring or improving physical function
2. Services are delivered by a qualified practitioner of therapeutic massage; and
3. Services require the judgment, knowledge, and skills of a qualified practitioner of massage therapy services due to the complexity and sophistication of the therapy and the clinical condition of the individual; and
4. There is an expectation that the service will result in a clinically significant level of functional improvement within a **reasonable and predictable period of time***; and
5. An individual's function could not reasonably be expected to continue to be sustained or improved without continued care as the individual gradually resumes normal activities; and

6. The documentation objectively verifies progressive functional improvement over specific time frames and clinically justifies the initiation or continuation of massage services; and
7. Treatment is individualized to the member's unique needs, including documentation outlining client-specific quantifiable, attainable treatment goals; and
8. Services are rendered with consideration of benefits and risks to the member; and
9. Treatment is applied utilizing the type, time frame, frequency, and duration consistent with therapeutic goals.

*__Reasonable and predictable period of time__ (generally up to 4 weeks): The specific time frames for which one would expect practical functional improvement is dependent on various factors. A reasonable trial of care is influenced by the diagnosis; assessment findings; stage of the condition (acute, sub-acute, chronic); severity of the condition; and patient-specific elements (age, gender, past and current medical history, family history, and any relevant psychosocial factors).

Not Medically Necessary

1. Duplicative of other modalities/services received.
2. Provided exclusively for the convenience of the member.
3. For conditions related to general wellness (e.g., stress management, sports performance enhancement).
4. Provided as maintenance care.
5. The expectation does **NOT** exist that the service(s) will result in a clinically significant improvement in the level of functioning within a reasonable and predictable period of time (generally up to 4 weeks).
    - If, absent supervised care, function could reasonably be expected to improve at the same/similar rate as the individual gradually resumes normal activities, then the service is considered **not** medically necessary.
    - The individual's condition does not have the potential to improve or is not improving in response to therapy; or would not produce a meaningful improvement relative to the extent and duration of therapy required; and there is an expectation that further improvement is **NOT** attainable.
    - The documentation fails to objectively verify functional progress over a reasonable period of time (up to 4 weeks).
    - The patient has reached maximum therapeutic benefit (MTB).

Definitions of Key Terminology used in Clinical Reviews

Elective/Convenience Services

Examples of elective/convenience services include: (a) preventive services; (b) wellness services; (c) services not necessary to return the patient to pre-illness/pre-injury functional status and level of activity; (d) services provided after the patient has reached MTB.

(Elective/convenience services may not be covered through specific client or ASH benefits.)

Minimal Clinically Important Difference (MCID)
The MCID is the minimal amount of change in a score of a valid outcome assessment tool that indicates an actual improvement in the patient's function or pain. Actual significance of outcome assessment tool findings requires correlation with the overall clinical presentation, including updated subjective and objective assessment findings.

Maximum Therapeutic Benefit (MTB)
MTB is the patient's health status when the application of skilled therapeutic services has achieved its full potential (which may or may not be the complete resolution of the patient's condition.) At the point of MTB, continuation of the same or similar skilled treatment approach will not significantly improve the patient's impairments and function during this episode of care.

If the patient continues to have significant complaints, impairments, and documented functional limitations, one should consider the following:

- Referring the patient for consultation by another health care practitioner for possible co-management or a different therapeutic approach.

Preventive Services
Preventive services are designed to reduce the incidence or prevalence of illness, impairment, and risk factors, and to promote optimal health, wellness, and function. These services are not designed or performed to treat or manage a specific health condition. (Preventive services may or may not be covered under specific clients or through ASH benefits.)

Acute
The stage of an injury, illness, or disease, in which the presence of clinical signs and symptoms is less than six weeks in duration, typically characterized by the presence of one or more signs of inflammation or other adaptive response.

Sub-Acute
The stage of an injury, illness, or disease, in which the presence of clinical signs and symptoms is greater than four weeks, but not greater than twelve weeks in duration.

Chronic
The stage of an injury, illness, or disease, in which the presence of clinical signs and symptoms is greater than twelve weeks in duration.

Red Flag(s)
Signs and symptoms presented through history or assessment that warrant more detailed and immediate medical assessment and/or intervention.

Yellow Flag(s)
Adverse prognostic indicators with a psychosocial predominance associated with chronic pain and disability. Yellow flags signal the potential need for more intensive and complex treatment and/or earlier specialist referral.

Co-Morbid Condition(s)
The presence of a concomitant condition, that may inhibit, lengthen, or otherwise alter the expected response to care.

Health Equity (HE)
The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes (Centers for Medicare & Medicaid Services, 2024).

Social Determinants of Health (SDOH)
The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Five domains: 1) Economic stability; 2) Education access and quality; 3) Health care access and quality; 4) Neighborhood and built environment; 5) Social and community context (Office of Disease Prevention and Health Promotion [ODPHP], n.d.).

DESCRIPTION/ BACKGROUND

Licensed practitioners who provide therapeutic massage assess pain, manage movement dysfunction, and enhance physical and functional abilities for health conditions related primarily to impairments of the musculoskeletal system. Assessment involves a therapeutic massage description of symptoms, not a medical diagnosis. Therapeutic massage is limited to the care and services provided by a licensed practitioner whose scope of practice includes soft tissue manipulation/mobilization. From a healthcare perspective, Fritz (2008) states medical/clinical massage "is an outcome-based treatment specifically targeted to address conditions that have been diagnosed by an appropriate healthcare professional." However, state regulation and benefit policy may allow for direct access without the need for a diagnosis. In this situation, the therapeutic massage practitioner provides a description of symptoms and assessment while screening for indications and contraindications. As such, access to therapeutic massage services is a desirable physical medicine option for health care consumers in order to relieve pain, improve function, and enhance quality of life.

Therapeutic massage services may reduce disability and clinical cost by reducing the need for services of greater expense, greater risk, or both to the patient. Licensed practitioners provide services to patients who have impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury, disease, or other causes.

Practitioners perform the patient management elements of symptoms description, assessment, and therapy planning. Therapeutic massage assessment may include the following:

- Pertinent health history
- Visual assessment of gait
- Integumentary integrity
- Pain levels
- Posture
- Gross ranges of motion
- Palpation
- Ability to perform related self-care and activities of daily living

Therapeutic massage interventions are provided by or under the direction and supervision of licensed healthcare practitioners in accordance with applicable state laws. A *therapeutic massage intervention* is the purposeful interaction of the practitioner with the patient, and, when appropriate, with other individuals involved in patient care, using various therapeutic massage techniques to produce changes in the condition that are consistent with the diagnosis (if provided by clinician with diagnostic authority) and symptom description. Therapeutic massage services include massage technique interventions (subject to state scope and appropriate training), communication with other health care team members, patients and family/caregivers and appropriate documentation of services provided.

Licensed practitioners who are contracted with ASH to provide therapeutic massage are expected to provide evidence-based services to decrease disability, improve function and independence, and improve quality of life in all patient populations. Practitioners may identify general health risk factors and behaviors that may impede optimal functioning and refer patients to their appropriate health care providers for further evaluation as part of continuity of care plan. The frequency and duration of treatment depends on several factors including: 1) patient response to treatment (influenced by age, nature and severity of injury, and previous history); 2) patient compliance with a self-management program; 3) the occurrence of any exacerbations during the course of treatment; and 4) the presence of pre-existing or complicating factors (e.g., underlying disease, yellow flags).

Practitioners who provide therapeutic massage may engage in consultation, education, and research. Educating patients is an important aspect of therapeutic massage services, especially regarding treatment goals, expectations regarding response to care, and self-care recommendations.

THERAPEUTIC PROCEDURES AND MODALITIES

The American Medical Association (AMA) Current Procedural Terminology (CPT) manual defines a modality as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electric energy." For more information, see the *Passive Physiotherapy (Therapeutic) Modalities (CPG 121 – S)* clinical practice guideline.

The American Medical Association (AMA) Current Procedural Terminology (CPT) manual defines a therapeutic procedure as "A manner of effecting change through the application of clinical skills and/or services that attempt to improve function."

Therapeutic massage and soft tissue mobilization, a type of manual therapy, are skilled passive therapeutic procedures and represent the primary forms of Passive Care performed by licensed practitioners who provide therapeutic massage and are defined as follows.

Therapeutic Massage (CPT® 97124)

Therapeutic massage involves manual techniques that include applying fixed or movable pressure, holding and/or causing movement of or to the body, using primarily the hands. These techniques affect the musculoskeletal, circulatory-lymphatic, nervous, and other systems of the body with the intent of improving the patient's health. The most widely used forms of basic therapeutic massage include Swedish massage, deep-tissue massage, sports massage, and neuromuscular massage. Therapeutic massage may be considered medically necessary in combination with another therapeutic procedure or activity on the same day, when prescribed or performed by another healthcare practitioner if the therapy meets the medical necessity criteria listed above.

Soft Tissue Mobilization (Inclusive of Manual Therapy CPT® 97140)

Soft tissue mobilization techniques are more specific in nature and include, but are not limited to myofascial release techniques, manual lymph drainage, deep transverse friction, and trigger point techniques. Specifically, myofascial release is a soft tissue manual technique that involves manipulation or mobilization of the muscles, fascia, and skin. Skilled manual techniques (active and/or passive) are applied to soft tissue to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples are facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened connective tissue. This procedure is considered medically

necessary for treatment of restricted motion of soft tissues in involved extremities, neck, and trunk.

Where applicable, some therapeutic massage scope of practice laws may allow the licensed massage therapist to perform other various modalities and procedures. These should only be performed by licensed massage therapists who have the knowledge, training, and expertise to perform such modalities and procedures, and within the licensed massage therapist's scope of practice.

Relative and Absolute Contraindications

The following are some relative and absolute local and general contraindications that should be considered when performing therapeutic massage. This list is not intended to be all inclusive and other contraindications may occur. Relative contraindications require caution with the delivery of massage and may include alteration of technique, duration of office visit, pressure modifications, pacing, considerations for referral/medical co-management, and a heightened awareness of patient feedback.

Local absolute contraindications include the following:

- Acute flare-up of inflammatory arthritis
- Aneurysms
- Cysts
- Contagious skin conditions
- Infections
- Cancer
- Phlebitis, thrombophlebitis, arteritis

General Absolute Contraindications

- Acute conditions requiring medical attention (e.g., coma, anaphylaxis, seizure)
- Advanced kidney failure
- Highly metastatic cancers
- Sepsis
- Significant fever (>101.5 degrees F)
- Unstable cerebrovascular accident
- Unstable hypertension or myocardial infarction

Local Relative Contraindications

- Acute disk herniation
- Acute inflammation
- Anti-inflammatory injection site
- Chronic arthritic conditions

- Chronic or longstanding superficial thrombosis
- Contusion
- Flaccid paralysis
- Joint instability or hypermobility
- Pitting edema

General Relative Contraindications

- Asthma
- Atherosclerosis
- Cancer
- Chronic congestive heart failure
- Chronic kidney disease
- Patient taking medications that alter neurological, cardiovascular, psychological, or kidney function
- Epilepsy
- Immunosuppression
- Multiple sclerosis
- Osteoporosis
- Pregnancy
- Psychiatric conditions
- Recent surgical procedures
- Spasticity or rigidity

Precautions and Contraindications to Therapeutic Modalities and Procedures

Thermotherapy

The use of thermotherapy is contraindicated for the following:

- Recent or potential hemorrhage
- Thrombophlebitis
- Impaired sensation
- Impaired mentation
- Local malignant tumor
- IR irradiation of the eyes
- Infected areas

Precautions for use of thermotherapy include:

- Acute injury or inflammation
- Pregnancy
- Impaired circulation
- Poor thermal regulation

- Edema
- Cardiac insufficiency
- Metal in the area
- Over an open wound
- Large scars
- Over areas where topical counterirritants have recently been applied
- Demyelinated nerve

Cryotherapy

The use of cryotherapy is contraindicated for the following:

- Cold hypersensitivity
- Cold intolerance
- Cryoglobulinemia
- Paroxysmal cold hemoglobinuria
- Raynaud disease or phenomenon
- Over regenerating peripheral nerves
- Over an area with circulatory compromise or peripheral vascular disease

Precautions for cryotherapy include:

- Over the superficial branch of a nerve
- Neuropathy
- Over an open wound
- Hypertension
- Poor sensation or mentation

DOCUMENTATION GUIDELINES

Initial Assessment

The practitioner performs an initial assessment to establish a therapeutic massage plan of care prior to any intervention.

The assessment:

- Is documented contemporaneously, dated, and signed by the practitioner
- Incorporates appropriate assessment findings to facilitate outcome measurement
- Produces data that are sufficient to allow assessment, symptoms description, and the establishment of a plan of care
- Is sufficient to determine the medical necessity of treatment, including:
    - Description of symptoms
    - Date of onset or exacerbation
    - Evaluation findings

- Therapeutic massage assessment and care plan consistent with current therapeutic massage practice and updated based on the patient's progress
- Recommendations and/or referral for exercise and/or self-care
- Interdisciplinary referrals for health care issues outside of therapeutic massage practitioner's scope or benefit coverage
- Documented measurable objective improvement/response to care
- Screening for yellow and red flags or absolute and regional contraindications to therapeutic massage
- Estimate of release from care

Re-assessment

The practitioner re-assesses the patient as necessary during an episode of care to monitor progress or change in patient status and modifies the plan of care accordingly including discontinuation of therapeutic massage services if indicated.

The re-assessment:

- Is documented contemporaneously, dated, and signed by the practitioner
- Documented measurable objective improvement/response to care
- Includes modifications to the plan of care, as appropriate

Discharge/Discontinuation of Intervention

The practitioner discharges the patient from therapeutic massage services when therapeutic massage is contraindicated, the anticipated goals or expected outcomes for the patient have been achieved, or the patient is not progressing toward goals or significantly benefiting from therapeutic massage.

The therapeutic massage discharge documentation includes:

- Documentation contemporaneously dated and signed by the practitioner
- Status of the patient at discharge and outcomes attained (e.g., initial, subsequent, and final outcome measure scores)
- Rationale for discontinuation of therapeutic massage
- Proposed self-care recommendations, if applicable
- Referrals to other health care practitioners/referring physicians, as appropriate

Patient Reported Outcome Measures (PROMs)

Measuring outcomes is an important component of the practices of licensed practitioners who provide therapeutic massage. The most common PROM used by licensed massage therapists is the Numeric Pain Rating Scale. Other PROMs are available to the licensed massage therapist that are specific to anatomical area, health condition or functional component (e.g., Neck Disability Index, Oswestry Low Back Disability Index, Disability of Arm, Shoulder, and Hand - DASH). PROMs are important in direct management of

individual patient care and for the opportunity they provide the profession in collectively comparing care and determining effectiveness.

CLINICAL REVIEW PROCESS

Medical necessity evaluations require approaching clinical data and scientific evidence from a global perspective and synthesizing the various elements into a congruent picture of the patient's condition and need for skilled treatment intervention. Clinical review decisions made by the clinical quality evaluators (CQEs) are based upon the information provided by the treating practitioner in the submitted documentation and other related findings and information. Failure to appropriately document pertinent clinical information may result in adverse determinations (partial approval or denial) of those services. Therefore, thorough documentation of all clinical information that established the diagnosis/diagnoses and supports the intended treatment is essential.

Clinical Review for Medical Necessity

The goal of the CQEs during the review and decision-making process is to approve, as appropriate, those clinical services necessary to return the patient to pre-clinical/pre-morbid health status, stabilize, or functionally improve a chronic condition, as supported by the documentation presented. The CQE is to evaluate if the documentation and other clinical information presented by the practitioner appropriately represents the patient's condition and justifies the treatment plan that is presented.

Approval

ASH CQEs have the responsibility to approve appropriate care for all services that are medically necessary. The CQEs assess the clinical data supplied by the practitioner in order to determine whether submitted services and/or the initiation or continuation of care has been documented as medically necessary. The practitioner is accountable to document the medical necessity of all services submitted/provided. It is the responsibility of the peer CQE to evaluate the documentation in accordance with their training, understanding of practice parameters, and review criteria adopted by ASH through its clinical committees.

The following items influence clinical service approvals:

- No evidence of contraindication(s) to services submitted for review
- Complaints, exam findings, and diagnoses correlate with each other
- Treatment plan is supported by the nature and severity of complaints
- Treatment plan is supported by assessment findings
- Treatment plan is expected to improve symptoms (e.g., pain, functional limitations) within a reasonable period of time
- Maximum therapeutic benefit has not been reached
- Treatment plan requires the skills of the practitioner

- Demonstration of progression toward active home/self-care and discharge is provided

Partial Approval

Occurs when only a portion of the submitted services are determined to be medically necessary services. The partial approval may refer to a decrease in treatment frequency and/or treatment time frame from the original amount/length submitted for review. This decision may be due to any number of reasons, such as:

- the practitioner's documentation of the history and exam findings are inconsistent with the clinical conclusion(s)
- the treatment dosage (frequency/time frame) submitted for review is not supported by the underlying diagnostic or clinical features
- the need to initiate only a limited episode of care in order to monitor the patient's response to care

Additional services may be submitted and reviewed for evaluation of the patient's response to the initial trial of care. If the practitioner or patient disagrees with the partial approval of services, they may contact the CQE listed on their response form to discuss the case, submit additional documentation through the Reopen process, or submit additional documentation to appeal the decision through the Provider Appeals and Member Grievances process.

Non-approval / Denial

Occurs when none of the services submitted for review are determined to be medically necessary services. The most common causes for a non-approval/denial of all services are administrative or contractual in nature (e.g., ineligibility, reached plan benefit limits, non-coverage). Clinically, it is appropriate to deny continued/ongoing care if the patient's condition(s) have not, or are no longer, responding favorably to the services being rendered by the treating practitioner, or the patient has reached maximum therapeutic benefit. Care may also be denied due to health and safety risks or contraindications that have not been agreed upon between the treating practitioner and CQE.

Additional / Continued Care

Approval of additional treatment/services requires submission of additional information, including the patient's response to care and updated clinical findings. In cases where an additional course of care is submitted, the decision to approve additional services will be based upon the following criteria:

- The patient has made clinically significant progress under the initial treatment plan/program based on a reliable and valid outcome tool or updated subjective, functional, and objective assessment findings.

- Additional clinically significant progress can be reasonably expected by continued treatment (patient has not reached MTB).
- There is no indication that immediate care/evaluation is required by other health care professionals.

Any exacerbation or flare-up of the condition that contributes to the need for additional treatment/services must be clearly documented.

The clinical information that the CQE expects to see when evaluating the documentation in support of the medical necessity of submitted treatment/services should be commensurate with the nature and severity of the presenting complaint(s) and scope of the practitioner of services and may include but is not limited to:

- History
- Physical assessment
- Documented treatment plan and goals
- Estimated time of discharge

In general, the initiation of care is warranted if there are no contraindications to prescribed care, there is reasonable evidence to suggest the efficacy of the prescribed intervention, and the intervention is within the scope of services permitted by state or federal law. The treatment submission for medical necessity review is typically structured in time-limited increments depending on clinical presentation. Dosage (frequency and time frame of service) should be appropriately correlated with clinical findings, potential complications/barriers to recovery and clinical evidence. When the practitioner discovers that a patient is nonresponsive to the applied interventions within a reasonable time frame, re-assessment and treatment modification should be implemented and documented. If the patient's condition(s) worsens, the practitioner should take immediate and appropriate action to discontinue or modify care and/or make an appropriate healthcare referral.

Services that do not require the professional skills of a practitioner to perform or supervise are not medically necessary. If a patient's recovery can proceed safely and effectively through a home exercise program or self-management program, services are not indicated or medically necessary.

Critical Factors during Clinical Reviews

The complexity and/or severity of historical factors, symptoms, assessment findings, and functional deficits play an essential role in helping quantify the patient's clinical status and assess the effectiveness of planned interventions over time. CQEs consider patient-specific variables as part of the medical necessity verification process. The entire clinical picture

must be taken into consideration with each case evaluated based upon unique patient and condition characteristics.

Such variables may include but not be limited to co-morbid conditions and other barriers to recovery, the stage(s) of the condition(s), mechanism of injury, severity of the symptoms, functional deficits, and assessment findings, as well as social and psychological status of the patient and the available support systems for self-care. In addition, the patient's age, symptom severity, and the extent of positive clinical findings may influence duration, intensity, and frequency of services approved as medically necessary. For example:

- Severe symptomatology, assessment findings, and/or functional deficits may require more care overall (e.g., longer time frame, more services per encounter, and higher frequency of encounters than average); these patients require a higher frequency; but may require short-term trials of care initially to assess patient response to care.
- Less severe symptomatology, assessment findings and/or functional deficits usually require less care (e.g., shorter time frame, fewer services per encounter, and frequency of encounters than the average) overall but may allow for less oversight and a longer initial trial of care.
- As patients age, they may have a slower response to care, and this may affect the approval of care.
- Complicating and/or co-morbid condition factors vary depending upon individual patient characteristics, the nature of the condition/complaints, historical and assessment elements, and may require appropriate coordination of care and/or more timely re-assessment.

Health equity is the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health. Factors that can impede health equity include, but are not limited to, race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, and preferred language. Social Determinants of Health (SDOH) are important influences on health equity status. SDOH are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. There are typically five domains of SDOH: 1) Economic stability; 2) Education access and quality; 3) Health care access and quality; 4) Neighborhood and built environment; 5) Social and community context. These barriers to health equity may impact health care access, the patient presentation, clinical evaluations, treatment planning, and patient outcomes which may in turn influence medical necessity considerations.

The following are examples of the factors CQEs consider when verifying the medical necessity of therapeutic massage for musculoskeletal conditions and pain disorders.

General Factors

Multiple patient-specific historical and clinical findings may influence clinical decisions, such as but not limited to:

- Red Flags
- Yellow Flags (psychosocial factors)
- Co-morbid conditions (e.g., diabetes, inflammatory conditions, joint instability)
- Age (older or younger)
- Non-compliance with treatment and/or self-care recommendations
- Lack of response to appropriate care
- Lifestyle factors (e.g., smoking, diet, stress, deconditioning)
- Work and recreational activities
- Pre-operative/post-operative care
- Medication use (type and compliance)

Nature of Complaint(s)

- Acute and severe symptoms
- Functional testing results that display severe disability/dysfunction
- Pain that radiates below the knee or elbow (for spinal conditions)

History

- Trauma resulting in significant injury or functional deficits.
- Pre-existing pathologies/surgery(ies)
- Congenital anomalies (e.g., severe scoliosis)
- Recurring exacerbations
- Prior episodes (e.g., >3 for spinal conditions)
- Multiple new conditions which introduce concerns regarding the cause of these conditions

Assessment

- Severe signs/findings
- Results from diagnostic testing that are likely to impact coordination of care and response to care (e.g., fracture, joint instability, neurological deficits)

Assessment of Red Flags

At any time the patient is under care, the practitioner is responsible for seeking and recognizing signs and symptoms that require additional diagnostics, treatment/service,

and/or referral. A careful and adequately comprehensive history and evaluation in addition to ongoing monitoring during the course of treatment is necessary to discover potential serious underlying conditions that may need urgent attention. Red flags can present themselves at several points during the patient encounter and can appear in many different forms. If a red flag is identified during a medical necessity review, the CQE should communicate with the practitioner of services as soon as possible by telephone and/or through standardized communication methods. When red flag is identified, the CQE may inquire whether such red flag was identified and addressed by the practitioner, not approve services and recommend returning the patient back to the referring healthcare practitioner or referring the patient to other appropriate health care practitioner/specialist with the measure of urgency as warranted by the history and clinical findings.

Important red flags and events as well as the points during the clinical encounter at which they are likely to appear include but may not be limited to:

Past or Current History

- Personal or family history of cancer
- Current or recent urinary tract, respiratory tract, or other infection
- Anticoagulant therapy or blood clotting disorder
- Metabolic bone disorder (osteopenia and osteoporosis)
- Unintended weight loss
- Significant trauma sufficient to cause fracture or internal injury
- Unexplained dizziness or hearing loss
- Trauma with skin penetration
- Immunosuppression (e.g., AIDS/HIV/ARC)
- Intravenous drug abuse, alcoholism
- Prolonged corticosteroid use
- Previous adverse reaction to substances or other treatment modalities
- Use of substances or treatment which may contraindicate proposed services
- Uncontrolled health condition (e.g., diabetes, hypertension, asthma)
- Fever, chills, or sweats without other obvious source

Present Complaint

- Writhing or cramping pain
- Precipitation by significant trauma
- Pain that is worse at night or not relieved by any position
- Suspicion of vascular/cerebrovascular compromise
- Symptoms indicative of a progressive neurological disorder
- Unexplained dizziness or hearing loss

- Complaint inconsistent with reported mechanism of injury and/or evaluation findings
- Signs of psychological distress

Physical Assessment

- Inability to reproduce symptoms of musculoskeletal diagnosis or complaints
- Fever, chills, or sweats without other obvious source
- New or recent neurologic deficit (e.g., special senses, peripheral sensory, motor, language, and cognitive)
- Positive vascular screening tests (e.g., carotid stenosis, vertebrobasilar insufficiency, abdominal aortic aneurysm)
- Uncontrolled hypertension
- Signs of nutritional deficiency
- Signs of allergic reaction requiring immediate attention
- Surface lesions or infections in area to be treated
- Widespread or multiple contusions
- Unexplained severe tenderness or pain
- Signs of abuse/neglect
- Signs of psychological distress

Pattern of Symptoms Not Consistent with Benign Disorder

- Chest tightness, difficulty breathing, chest pain
- Headache of morbid proportion
- Rapidly progressive neurological deficit
- Significant, unexplained extremity weakness or clumsiness
- Change in bladder or bowel function
- New or worsening numbness or paresthesia
- Saddle anesthesia
- New or recent bilateral radiculopathy

Lack of Response to Appropriate Care

- History of consultation/care from a series of practitioners or a variety of health care approaches without resolving the patient's complaint
- Unsatisfactory clinical progress, especially when compared to apparently similar cases or natural progression of the condition
- Signs and symptoms that do not fit the normal pattern and are not resolving

Assessment of Yellow Flags

When yellow flags are present, clinicians need to be vigilant for deviations from the normal course of illness and recovery. Examples of yellow flags include depressive symptoms, injuries still in litigation, signs and symptoms not consistent with pain severity, and behaviors incongruent with underlying anatomic and physiological principles.

If a yellow flag is identified during a medical necessity review, the reviewer should communicate with the practitioner of services as soon as possible by telephone and/or through standardized communication methods. The CQE may inquire if the yellow flag was identified, and, if so, how it was addressed. They may recommend returning the patient back to the referring healthcare practitioner or referring the patient to other health care practitioner as appropriate.

Health Equity Factors

Health Equity factors may be barriers to clinical progress when reviewing practitioner submissions for medical necessity. If the CQE notes a related health equity factor, they may communicate with the specialty practitioner regarding the patient's situation and any possible relationship to medical necessity. Standardized referral recommendations or resources for assisting with the patient's health-related needs may also be provided. If the CQE notes a related health and safety issue, they will utilize the current HSIT guidelines.

Assessment of Historical Information

The following factors are assessed in review and determination if the services are medically necessary:

- The mechanism and date of onset are congruent with the stated condition's etiology.
- The patient's past medical history and response to care do not pose contraindication(s) for the services submitted for review.
- The patient's past medical history of pertinent related and unrelated conditions does not pose contraindication(s) for the services submitted for review.
- The patient's complaint(s) have component(s) that are likely to respond favorably to services submitted for review.
- Provocative and palliative factors identified on examination indicate the presence of a musculoskeletal condition as expected per diagnosis(es) or complaints, or as consistent with other type of diagnosis(es).
- The patient's severity of limitations to activities of daily living (ADLs) are appropriate and commensurate for the presence of the condition(s) or disorder(s).
- The quality, radiation, severity, and timing of pain are congruent with the documented condition(s) or disorder(s).
- The patient's past medical history of having the same or similar condition(s) indicates a favorable response to care.

- The absence or presence of co-morbid condition(s) may or may not present absolute or relative contraindications to care.

Assessment Findings

- The assessment is appropriate for the patient's complaint(s) and historical findings.
- Objective palpatory, orthopedic, neurologic, and/or other physical assessment findings are current, clearly defined, qualified, and quantified, including the nature, extent, severity, character, professional interpretation, and significance of the finding(s) in relation to the patient's complaint(s) and differential diagnosis(es).
- Assessment findings provide evidence justifying the condition(s) is/are likely to respond favorably to services submitted for review.
- Assessment findings provide a reasonable and reliable basis for the stated diagnosis(es).
- Assessment findings provide a reasonable and reliable basis for treatment planning; accounting for variables such as age, sex, physical condition, occupational and recreational activities, co-morbid conditions, etc.
- The patient's progress is being appropriately monitored each visit (as noted within daily chart notes and during periodic re-exams) to ensure that acceptable clinical progress is realized.

Assessment of Treatment / Treatment Planning

- Treatment dosage (frequency and time frame of service) is appropriately correlated with the nature and severity of the subjective complaints, potential complications/barriers to recovery, and objective clinical evidence.
- Services that do not require the professional skills of a practitioner to perform or supervise are not medically necessary, even if they are performed by a massage therapy practitioner. Therefore, if the continuation of a patient's care can proceed safely and effectively through a home exercise program or self-management program, services are not indicated or medically necessary.
- The set therapeutic goals are functionally oriented, realistic, measurable, and evidence based.
- The proposed/estimated date of release/discharge from treatment is noted.
- The treatment/therapies are appropriately correlated with the nature and severity of the patient's condition(s) and set treatment goals.
- Functional testing and/or patient-reported outcomes demonstrate improvement that is relevant to the patient. This is important in order to determine the need for continued care, the appropriate frequency of visits, estimated date of release from care, and if a referral to an appropriate health care practitioner is indicated.
- Home care, self-care, and active-care instructions are documented.

Factors that Influence Adverse Determinations of Clinical Services (Partial Approvals/Denials)

Factors that influence adverse determinations of clinical services may include but are not limited to these specific considerations and other guidelines and factors identified elsewhere in this policy. Topics/factors covered elsewhere in this guideline are also applicable in this section and may result in an adverse determination on medical necessity review. To avoid redundancy, many of those factors have not been listed below.

Additional Factors Considered in Determination of Medical Necessity

History / Complaints / Patient Reported Outcome Measures

- The patient's complaint(s) and/or symptom(s) are not clearly described
- There is poor correlation and/or a significant discrepancy between the complaint(s) and/or symptom(s) as documented by the treating practitioner and described by the patient
- The patient's complaint(s) and/or symptom(s) have not demonstrated clinically significant improvement
- The nature and severity of the patient's complaint(s) and/or symptom(s) are insufficient to substantiate the medical necessity of any/all submitted services
- The patient has little, or no pain as measured on a valid pain scale
- The patient has little, or no functional deficits using a valid functional outcome measure or as otherwise documented by the practitioner

Assessment Findings

- There is poor correlation and/or a significant discrepancy in any of the following:
  - patient's history
  - subjective complaints
  - objective findings
  - diagnosis
  - treatment plan
- The patient's objective findings have not demonstrated clinically significant improvement
- The objective findings are essentially normal or are insufficient to support the medical necessity of any/all submitted services
- The submitted objective findings are insufficient due to any of, but not limited to, the following reasons:
  - old or outdated relative to the requested dates of service
  - do not properly describe the patient's current status
  - do not substantiate the medical necessity of the current treatment plan do not support the patient's diagnosis/diagnoses do not correlate with the patient's subjective complaint(s) and/or symptom(s)

- Not all of the patient's presenting complaints were properly examined
- The patient does not have any demonstrable functional deficits or impairments
- The patient has not made reasonable progress toward pre-clinical status or functional outcomes under the initial treatment/services
- Clinically significant therapeutic progress is not evident through a review of the submitted records; this may indicate that the patient has reached maximum therapeutic benefit
- The patient is approaching or has reached maximum therapeutic benefit
- The patient's assessment findings have returned to pre-injury status or prior level of function
- There is inaccurate reporting of clinical findings
- The exam performed is for any of the following:
    - wellness
    - pre-employment
    - sports pre-participation

Diagnosis

- The diagnosis is not supported by one or more of the following:
    - patient's history (e.g., date/mechanism of onset)
    - subjective complaints (e.g., nature and severity, location)
    - objective findings (e.g., not clearly defined and/or quantified, significance not noted)

Submitted Medical Records

- The submitted records are insufficient to reliably verify pertinent clinical information, such as (but not limited to):
    - patient's clinical health status
    - the nature and severity of the patient's complaint(s) and/or symptom(s)
    - date/mechanism of onset
    - objective findings
    - diagnosis/diagnoses
    - response to care
    - functional deficits/limitations
- There are daily notes submitted for the same dates of service with different/altered findings without an explanation
- There is evidence of duplicated or nearly duplicated records for the same patient for different dates of service, or for different patients
- There is poor correlation and/or a significant discrepancy between the information presented in the submitted records with the information presented during a verbal communication between the reviewing CQE and treating practitioner

- The treatment time (in minutes) and/or the number of units used in the performance of a timed service (e.g., procedure) during each encounter/office visit was not documented
- Some or all of the service(s) submitted for review are not documented as having been performed in the daily treatment notes

Treatment / Treatment Planning

- The submitted records show that the nature and severity of the patient's complaint(s) and/or symptom(s) require a limited, short trial of care in order to monitor the patient's response to care and determine the efficacy of the current treatment plan. This may include, but not limited to, any of the following:
    - significant trauma affecting function
    - acute/sub-acute stage of condition
    - moderate-to-severe or severe subjective and objective findings
    - possible neurological involvement
    - presence of co-morbidities that may significantly affect the treatment plan and/or the patient's response to care
    - There is poor correlation of the treatment plan with the nature and severity of the patient's complaint(s) and/or symptom(s), such as prolonged reliance on passive care
- There is evidence from the submitted records that the patient's treatment can proceed safely and effectively through a home exercise program or self-management program
- The patient's function has improved, complaints and symptoms have decreased, and patient requires less treatment (e.g., lesser units of services per office visit, lesser frequency, and/or shorter total duration to discharge)
- The patient's symptoms and/or exam findings are mild, and the patient's treatment plan requires a lesser frequency (e.g., units of services, office visits per week) and/or total duration
- Therapeutic goals have not been documented. Goals should be measurable and written in terms of function and include specific parameters
- Therapeutic goals have not been reassessed in a timely manner to determine if the patient is making expected progress
- Failure to make progress or respond to care as documented within subjective complaints, objective findings and/or functional outcome measures
- The patient's condition(s) is/are not amenable to the proposed treatment plan
- Additional significant improvement cannot be reasonably expected by continued treatment and treatment must be changed or discontinued
- The patient has had ongoing care without any documented lasting therapeutic benefits

- The condition requires an appropriate referral and/or coordination with other appropriate health care services
- The patient is not complying with the treatment plan that includes lifestyle changes to help reduce frequency and intensity of symptoms
- The patient is not adhering to treatment plan that includes medically necessary frequency and intensity of services without documented extenuating circumstances
- Home care, self-care, and active-care instructions are not implemented or documented in the submitted records
- As symptoms and clinical findings improve, the frequency of services (e.g., visits per week/month) did not decrease. The submitted services do not or no longer require the professional skills of the treating practitioner. The treatment plan is for any of the following:
    - preventive care
    - elective/convenience/wellness care
    - back school
    - vocational rehabilitation or return to work programs
    - work hardening programs
    - routine education, training, conditioning, return to sport, or fitness
- There is duplication of services with other healthcare practitioners/specialties
- The treatment plan is not supported due to, but not limited to, any of the following reasons:
    - technique-/protocol-based instead of individualized and evidence based
    - generic and not individualized for the patient's specific needs
    - does not correlate with the set therapeutic goals
    - not supported in the clinical literature (e.g., proprietary, unproven)
    - not considered evidence-based and/or professionally accepted

The treatment plan includes services that are considered not evidence-based, not widely accepted, unproven and/or not medically necessary, inappropriate or unrelated to the patient's complaint(s) and/or diagnosis/diagnoses. Also see the *Techniques and Procedures Not Widely Supported as Evidence-Based (CPG 133 – S)* clinical practice guideline for complete list).

Health and Safety

- There are signs, symptoms and/or other pertinent information presented through the patient's history, assessment findings, and/or response to care that require urgent attention, further testing, and/or referral to and/or coordination with other healthcare practitioners/specialists
- There is evidence of the presence of Yellow and/or Red Flags (See section on Red and Yellow Flags above)

- There are historical, subjective, and/or objective findings which present as contraindications for the plan of care

Referral / Coordination of Services

When a potential health and safety issue is identified, the CQE must communicate with the practitioner of services as soon as possible by telephone and/or through standardized communication methods to recommend returning the patient back to the referring health care practitioner or referring the patient to other appropriate health care practitioner/specialist with the measure of urgency as warranted by the history and clinical findings. Such referral does not preclude coordinated cotreatment if / when applicable and documented as such.

Clinical factors that may require referral or coordination of services include, but not limited to:

- Symptoms worsening following treatment
- Deteriorating condition (e.g., orthopedic or neurologic findings, function)
- Reoccurring exacerbations despite continued treatment
- No progress despite treatment
- Identification of Red and Yellow Flags
- Identification of co-morbid conditions that don't appear to have been addressed previously that represent contraindications to services
- Constitutional signs and symptoms indicative of systemic condition (e.g., unintended weight loss of greater than 4.5 kg/10 lbs. over 6-month period)
- Inability to provoke symptoms with standard exam
- Treatment needed outside of scope of practice

The Clinical Policy is reviewed and approved by the ASH Clinical Quality committees that are comprised of contracted network practitioners including practitioners of the same clinical discipline as the practitioner for whom compliance with the practices articulated in this document is required. Guidelines are updated at least annually, or as new information is identified that result in material changes to one or more of these policies.

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