1. **Purpose**

The purpose of this policy is to establish criteria for the medical necessity of the use of manual therapy.

2. **Definition**

Manual therapy is defined as direct one-on-one patient contact in the performance of skilled hands-on therapeutic techniques including but not limited to manipulation, joint mobilization, soft tissue mobilization, myofascial release, connective tissue techniques, manual lymphatic drainage, and manual traction. These procedures are timed services performed on one or more regions and should be reported for each 15 minute time period performed.

3. **Statement of Policy**

3.1. The determination of medical necessity for the use of manual therapy is always made on a case-by-case basis.

3.2. Manual therapy may be considered **medically necessary** for the treatment of conditions involving pain, edema and/or loss of function.

3.3. The use of multiple manual therapy procedures on the same date of service (e.g. chiropractic manipulative therapy, osteopathic manipulative therapy, massage therapy) may be considered redundant or otherwise incorporated within the primary therapeutic approach if performed on the same region.

3.4. Any treatment plan involving the use of manual therapy should ultimately result in a reduction in the patient's pain and/or an improved ability to carry out activities of daily living. The use of manual therapy beyond two to three (2-3) weeks without a clinically meaningful reduction in pain levels and/or clinical signs of functional improvement may be considered **not medically necessary**.

4. **References**

4.1. Scientific:

The following scientific references were utilized in the formulation of this medical policy. Triad Healthcare, Inc. will continue to review clinical evidence surrounding manual therapy and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to Triad Healthcare, Inc. so the information can be reviewed by the Academic Advisory Committee (AAC)
and the Medical Quality Improvement Committee (MQIC) to determine if a modification of the policy is in order.


• Vernon H, Humphreys K, Hagino C. Chronic mechanical neck pain in adults treated by manual therapy: a systematic review of change scores in randomized

- Werners R, Pynsent PB, Bulstrode CJ. Randomized trial comparing interferential therapy with motorized lumbar traction and massage in the management of low back pain in a primary care setting, Spine 1999 Aug 1;24(15):1579-84.

4.2. Related Triad Medical Policies:

- TMMP 18 - Medical Necessity Policy
- TMMP 10 - Use of Physical Medical Modalities and Therapeutic Procedures
- TMMP 11 - Use of Spinal Mobilization/Manipulation
- TMMP 12 - Use of Non-Spinal/Extremity Mobilization/Manipulation

5. Attachments

5.1. Provider Manual
**Policy Library: Medical**

**Effective Date:** 09/25/2008  
**Approval Date:** 09/25/2008  
**Approved By:** MQIC/SLT

**Doc. Control #:** PRV.MQ.MP.036.001

**Title/Subject:** TMMP 122 - MANUAL THERAPY (97140)

### Table of Revisions

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>09/25/2008</td>
<td>Level 1, 2, 3</td>
<td>New medical policy</td>
</tr>
</tbody>
</table>

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