1. **Purpose**

   The purpose of this policy is to define the medical necessity for the use of adjunctive modalities and/or therapeutic procedures.

   There is currently insufficient academic research level evidence to support the use of one or more adjunctive modalities, in addition to the primary treatment procedure, as improving a patient’s recovery or clinical outcome. However, there is reasonable professional consensus level evidence that a modality and/or therapeutic procedure may be a useful adjunct to a Primary Therapeutic Procedure in certain clinical scenarios.

   When an adjunctive modality and/or therapeutic procedure are used to improve the application or the effect of the Primary Therapeutic Procedure, the professional consensus level evidence indicates that they do not exceed one (1) per visit. The use of multiple physical modalities and/or therapeutic procedures, as adjuncts to the Primary Therapeutic Procedure, has not been established in either clinical peer reviewed literature or by professional consensus to improve the application of the Primary Therapeutic Procedure.

2. **Definitions**

2.1. **Primary Therapeutic Procedure** is defined as the principal therapeutic service chosen to treat a defined clinical condition or complaint. The Primary Therapeutic Procedure is considered to be essential to the treatment plan proposed for the individual patient under care in the sense that its clinical value cannot be reproduced by another procedure of equal value to the patient. In this context, it is the center point of the proposed treatment plan for the patient. The Primary Treatment Procedure may change during the course of care consistent with the needs of the patient.

2.2 **Adjunctive Modality and/or Therapeutic Procedure** is/are defined as a service rendered in conjunction with or concurrent to the Primary Therapeutic Procedure for the purpose of facilitating the application or enhancing the effect of the Primary Therapeutic Procedure.

3. **Statement of Policy**
3.1 The determination of medical necessity for the use of adjunctive modalities and/or therapeutic procedures is always made on a case-by-case basis.

3.2 The use of an adjunctive modality and/or therapeutic procedure may be considered medically necessary if the following criteria are met:

- When the application of the Primary Therapeutic Procedure may be impaired by one or more of the following factors: extreme pain or initial patient fear; or

- When the intended effect of the Primary Therapeutic Procedure is enhanced by the adjunctive modality and/or therapeutic procedure based on established academic evidence that the adjunctive modality/procedure provides independent therapeutic value for the diagnosed condition.

3.3 The use of more than one adjunctive modality and/or therapeutic procedure is considered not medically necessary based on lack of evidence to support the use of more than one adjunct to either improve or enhance the application or effect of the Primary Therapeutic Procedure.

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 traction for the treatment of spinal and radicular pain syndromes 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.


  Summary: Adjunctive therapies (heat, cold, electrical stimulation, ultrasound, traction, exercise, etc.) can be used in conjunction with a primary treatment to address pain, inflammation, etc. After the acute phase (48 to 72 hours) of an injury, an active approach is preferable because it allows the patient more control over pain and function and re-educates neuromusculature.

Summary: There is insufficient information available to adequately assess conservative intervention in the treatment of mechanical neck pain.


Summary: This study suggests that exercise; mobilization and manipulation have more benefit than less active treatment. However a larger, better designed study is required in order to determine the value and cost-effectiveness of individual treatments.


Summary: Spinal manipulation and/or mobilization are possible treatments for low back or neck pain. Few trials differentiate between acute and chronic with primarily short term follow-up. The value of spinal manipulation and mobilization should be addressed to determine its effectiveness.


Summary: In the treatment of whiplash associated disorders mobilization is suggested to be successful in treating pain and increasing ROM.


Summary: In the physical therapy treatment of neck disorders, pulsed shortwave and manual therapy did not provide added benefit over advice and exercise.

Summary: Reduction of pain in neck disorders was not achieved through patient education, individual or group.

  
  Summary: There is insufficient information available to adequately support physical medicine modalities in the treatment of mechanical neck pain.

- Michael T. Haneline, D, MPHa: Symptomatic Outcomes and Perceived Satisfaction Levels of Chiropractic Patients with A Primary Diagnosis Involving Acute Neck Pain.
  
  Summary: Patients with acute neck pain appear satisfied with their chiropractic treatments. However, the study’s design is less than optimal for hard conclusions to be made.

  
  Summary: There is insufficient information available to adequately assess selective rehabilitation interventions in the treatment of neck pain.

  
  Summary: There is insufficient information available to adequately assess conservative intervention in the treatment of mechanical neck pain.

  
  Summary: There is weak information available to adequately assess which treatments are most effective for patients with whiplash-associated-disorders.

Summary: Additional research is needed to clarify the efficacy of active treatments (exercise/mobilization). However, current evidence suggests active based treatment is effective for acute whiplash-associated-disorders.


  Summary: There is insufficient information available to adequately assess interventions in the treatment of sub-acute whiplash-associated-disorders.


  Summary: The most effective noninvasive treatment for chronic whiplash-associated-disorders was determined to be exercise programs. However, additional research is required to determine the effectiveness of various exercise programs.


  Summary: Additional research is required to determine the effectiveness of invasive interventions in the treatment of chronic whiplash-associated-disorders.


  Summary: There is insufficient information available to adequately assess the effectiveness of traction for back and neck pain.


  Summary: There is insufficient information available to adequately assess the effectiveness of massage as an adjunct to manual therapy; and manual therapy as an adjunct to exercise.

Summary: Spinal manipulation and electrical nerve stimulation in the treatment of acute neck pain (non-whiplash) has limited evidence of its benefit.


Summary: In control groups of patients with neck/shoulder pain, exercise resulted in a decrease in pain in all groups. The type of exercises performed was of little significance.

Although there is a well documented hierarchy of evidence, the ‘best evidence’ available is one which can be applied to an individual patient and can be adopted into the clinical decision making process. The absence of ‘higher’ forms of evidence (e.g., meta-analysis; randomized control trials) does not equate to a lack of evidence, nor should it be extrapolated to conclude that care is not ‘evidence based’. This medical policy was established with input from practicing health care providers by a consensus process based on the clinical experience and expert opinion of the members of the Triad Healthcare, Inc.’s, Medical Operations Committee (MOC), Academic Advisory Committee (AAC) & Medical Quality Improvement Committee (MQIC). Should scientific studies or any relevant material become available, please forward the information to Triad Healthcare, Inc. so that the information can be reviewed by the MOC, AAC and the MQIC to determine if a modification of the policy is in order.

4.2 Related Triad Medical Policies:

- **TMMP 9 – Episodic Management of Chronic Musculoskeletal Pain - Physical Medicine**
- **TMMP 10 – Use of Passive and Active Care**
- **TMMP 11 – Use of Spinal Mobilization / Manipulation**
- **TMMP 12 – Use of Non-Spinal / Extremity Mobilization / Manipulation**
- **TMMP 15 – Minimal Clinical Progress / Improvement**
- **TMMP 17 – Contraindications to Care**
<table>
<thead>
<tr>
<th>Title/Subject:</th>
<th>TMMP 13 - USE OF ADJUNCTIVE MODALITIES AND/OR THERAPEUTIC PROCEDURES</th>
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- TMMP 18 – Medical Necessity
- TMMP 100 – Application of Hot or Cold Packs
- TMMP 101 – Traction – Mechanical
- TMMP 102 – Electrical Stimulation Therapy – Unattended
- TMMP 103 – Vasopneumatic Devices
- TMMP 104 – Paraffin Bath Therapy
- TMMP 105 – Whirlpool Therapy
- TMMP 106 – Diathermy
- TMMP 107 – Infrared Light / Low Level Laser Therapy
- TMMP 108 – Ultraviolet Light Therapy
- TMMP 109 – Iontophoresis Therapy
- TMMP 110 – Contrast Baths
- TMMP 111 – Ultrasound / Phonophoresis
- TMMP 112 – Therapeutic Exercises
- TMMP 113 – Neuromuscular Re-Education
- TMMP 114 – Aquatic Therapy
- TMMP 115 – Massage Therapy
- TMMP 116 – Therapeutic Activities
- TMMP 117 – Casting / Splinting / Strapping Procedures
- TMMP 118 – Activities of Daily Living / Self-Care Management Training
- TMMP 119 – Cognitive Skills Development
- TMMP 120 – Gait Training
- TMMP 121 - Group Therapeutic Procedures
- TMMP 122 – Manual Therapy
- TMMP 123 – Wheelchair Management
Table of Revisions

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<tr>
<td>10/27/2014</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
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<tr>
<td>10/11/2013</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. Correction in §4.2. to TMMP 11 medical policy title.</td>
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<tr>
<td>11/16/2012</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. After discussion, a CPT code table was not added to this policy as the volume of potential codes to be included is too large.</td>
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<tr>
<td>05/20/2011</td>
<td>Level 1, 2, 3</td>
<td>New medical policy.</td>
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Triad’s Medical Policies are not recommendations for treatment and providers are expected to exercise their clinical judgment in providing the most appropriate care. Health care providers and patients should not rely on these Medical Policies in making health care decisions. These Medical Policies are guidelines and do not constitute an authorization, certification, explanation of benefits or guarantee of payment. Applications of Triad’s Medical Policies are determined by the enrollee’s benefit documents and contracts and as such individual benefits must be verified. Determinations of medical necessity apply only if the benefit exists and no contract exclusions are applicable. In the event of a conflict, a participant’s benefit plan document shall supersede the information contained in Triad’s Medical Policies.