

Clinical Practice Guideline: Therapeutic Massage Medical Policy/Guideline

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Product: Specialty

- 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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10 **OVERVIEW**

11 American Specialty Health – Specialty (ASH) contracts with licensed/registered/certified
 12 massage therapists depending on state specific board requirements in each jurisdiction .
 13

14 An important qualification for licensure of massage therapists is graduation from a state
 15 licensed massage therapy education program. Some programs also have accreditation from
 16 the Commission on Massage Therapy Accreditation, or other programmatic or institutional
 17 accreditations recognized by the United States Department of Education. Qualification for
 18 licensure, registration, or certification, includes successful completion of the Massage
 19 Board Licensing Exam (MBlex), National Certification Board for Therapeutic Massage
 20 and Bodywork exam (NCBTMB), or a state-specific exam. Massage therapists are
 21 expected to engage in continuing education to ensure they are utilizing the most current,
 22 evidence-based therapy approaches and interventions. Continuing education hour
 23 requirements are often required by state regulatory boards in order to renew
 24 licensure/certification/registration.
 25

26 ASH also contracts with Physical Therapists, Chiropractors and Acupuncturists who are
 27 licensed practitioners able to provide therapeutic massage (See *Physical Therapy Medical*
 28 *Policy/Guidelines CPG 135 – S*, *Chiropractic Services Medical Policy/Guidelines CPG*
 29 *278 – S*, *Acupuncture Services Medical Policy/Guidelines CPG 264 – S* for more
 30 information).
 31

32 The determination of medically necessary care, as outlined in this guideline, protects
 33 against inappropriate care that may be wasteful, unsafe, and harmful to the patient, while
 34 assuring approved care is safe, appropriate, curative, and improves the patient’s function
 35 and quality of life. To protect the health and safety of patients, American Specialty Health
 36 (ASH) has implemented medical necessity review strategies to educate practitioners of the
 37 need to implement methods to reduce clinical errors and improve patient safety. These
 38 medical necessity review strategies include encouraging practitioners to adopt evidence-
 39 based health care approaches to patient care, implement professional standards of care, and

1 follow applicable care management guidelines. Conducting risk management procedures
 2 via medical necessity review minimizes potential adverse outcomes and harm to the patient
 3 and prevents wasteful, unsafe and inappropriate care.

4
 5 Care approved through medical necessity review is safe, appropriate, and directed at
 6 specific treatment goal resolution to ensure clinical benefit and improvement to the
 7 patient's quality of life.

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

17 **GUIDELINES**

18 **Medically Necessary**

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

- 21 1. When therapeutic massage is performed for the purpose of
 - 22 ○ Restoring muscle function
 - 23 ○ Reducing edema
 - 24 ○ Improving joint motion
 - 25 ○ Relieving muscle spasm
 - 26 ○ Restoring or improving physical function
- 27 2. Services are delivered by a qualified practitioner of therapeutic massage; and
- 28 3. Services require the judgment, knowledge, and skills of a qualified practitioner of
 29 massage therapy services due to the complexity and sophistication of the therapy
 30 and the clinical condition of the individual; and
- 31 4. There is an expectation that the service will result in a clinically significant level of
 32 functional improvement within a **reasonable and predictable period of time***;
 33 and
- 34 5. An individual's function could not reasonably be expected to continue to be
 35 sustained or improved without continued care as the individual gradually resumes
 36 normal activities; and
- 37 6. The documentation objectively verifies progressive functional improvement over
 38 specific time frames and clinically justifies the initiation of continuation of massage
 39 services; and
- 40

- 1 7. Individualized to the member’s unique needs, and there is documentation outlining
- 2 quantifiable, attainable treatment goals; and
- 3 8. Rendered with consideration of benefits and risks to the member; and
- 4 9. Applied utilizing the type, time frame, frequency, and duration consistent with
- 5 therapeutic goals.

6

7 *Reasonable and predictable period of time (generally up to 4 weeks): The specific

8 time frames for which one would expect practical functional improvement is dependent

9 on various factors. A reasonable trial of care is influenced by the diagnosis; assessment

10 findings; stage of the condition (acute, sub-acute, chronic); severity of the condition;

11 and patient-specific elements (age, gender, past and current medical history, family

12 history, and any relevant psychosocial factors).

13

14 **Not Medically Necessary**

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

33

34 **Definitions of Key Terminology used in Clinical Reviews**

35 **Elective/Convenience Services**

36 Examples of elective/convenience services include: (a) preventive services; (b) wellness

37 services; (c) services not necessary to return the patient to pre-illness/pre-injury functional

38 status and level of activity; (d) services provided after the patient has reached MTB.

39 (Elective/convenience services may not be covered through specific client or ASH

40 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 examination/evaluation 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 six 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 examination/assessment that warrant more detailed and immediate medical assessment and/or intervention.

1 Yellow Flag(s)

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

6 Co-Morbid Condition(s)

7 The presence of a concomitant condition, that may inhibit, lengthen, or alter in some way
8 the expected response to care.

10 Health Equity (HE)

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

17 Social Determinants of Health (SDoH)

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

24 DESCRIPTION/ BACKGROUND

25 Licensed practitioners who provide therapeutic massage assess pain, manage movement
26 dysfunction, and enhance physical and functional abilities for health conditions related
27 primarily to impairments of the musculoskeletal system. Assessment involves a therapeutic
28 massage description of symptoms, not a medical diagnosis. Therapeutic massage is limited
29 to the care and services provided by a licensed practitioner whose scope of practice includes
30 soft tissue manipulation. From a healthcare perspective, Fritz (2008) states medical/clinical
31 massage “is an outcome-based treatment specifically targeted to address conditions that
32 have been diagnosed by an appropriate healthcare professional.” State regulation and
33 benefit policy may allow for direct access without the need for a diagnosis. In this situation,
34 the practitioner provides a description of symptoms and assessment while screening for
35 indications and contraindications. As such, access to therapeutic massage services is a
36 desirable physical medicine option for health care consumers in order to relieve pain,
37 improve function, and enhance quality of life. Therapeutic massage services may reduce
38 disability and clinical cost by reducing the need for services of greater expense, greater
39 risk, or both to the patient. Licensed practitioners provide services to patients who have
40 impairments, functional limitations, disabilities, or changes in physical function and health
41 status resulting from injury, disease, or other causes.

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

- 4 • Pertinent health history
- 5 • Visual assessment of gait
- 6 • Integumentary integrity
- 7 • Pain levels
- 8 • Posture
- 9 • Gross range of motion
- 10 • Palpation
- 11 • Ability to perform related self-care and activities of daily living

12
13 Therapeutic massage interventions are provided by or under the direction and supervision
14 of licensed healthcare practitioners in accordance with applicable state laws. A *therapeutic*
15 *massage intervention* is the purposeful interaction of the practitioner with the patient, and,
16 when appropriate, with other individuals involved in patient care, using various therapeutic
17 massage techniques to produce changes in the condition that are consistent with the
18 diagnosis (if provided by clinician with diagnostic authority) and symptom description.
19 Therapeutic massage services include massage technique interventions (subject to state
20 scope and appropriate training), communication with other health care team members,
21 patients and family/caregivers and appropriate documentation of services provided.
22

23 Licensed practitioners who are contracted with ASH to provide therapeutic massage are
24 expected to provide evidence-based services to decrease disability, improve function and
25 independence, improve quality of life, and promote the attainment and maintenance of
26 health in all patient populations. Practitioners may identify general health risk factors and
27 behaviors that may impede optimal functioning and refer patients to their appropriate
28 health care providers for further evaluation as part of continuity of care plan. The frequency
29 and duration of treatment depends on several factors including: 1) patient response to
30 treatment (influenced by age, nature and severity of injury, and previous history); 2) patient
31 compliance with a self-management program; 3) the occurrence of any exacerbations
32 during the course of treatment; and 4) the presence of pre-existing or complicating factors
33 (e.g., underlying disease, yellow flags).
34

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

1 **THERAPEUTIC PROCEDURES AND MODALITIES**

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

7
8 The American Medical Association (AMA) Current Procedural Terminology (CPT)
9 manual defines a therapeutic procedure as "A manner of effecting change through the
10 application of clinical skills and/or services that attempt to improve function."

11
12 Therapeutic massage and soft tissue mobilization a type of manual therapy are skilled
13 passive therapeutic procedures and represent the primary forms of Passive Care performed
14 by licensed practitioners who provide therapeutic massage and are defined as follows.

15
16 **Therapeutic Massage (CPT® 97124)**

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

26
27 **Soft Tissue Mobilization (CPT® 97140)**

28 Soft tissue mobilization techniques are more specific in nature and include, but are not
29 limited to myofascial release techniques, friction massage, and trigger point techniques.
30 Specifically, myofascial release is a soft tissue manual technique that involves
31 manipulation or mobilization of the muscles, fascia, and skin. Skilled manual techniques
32 (active and/or passive) are applied to soft tissue to effect changes in the soft tissues,
33 articular structures, neural or vascular systems. Examples are facilitation of fluid exchange,
34 restoration of movement in acutely edematous muscles, or stretching of shortened
35 connective tissue. This procedure is considered medically necessary for treatment of
36 restricted motion of soft tissues in involved extremities, neck, and trunk.

37
38 Where applicable, some therapeutic massage scope of practice laws may allow the licensed
39 massage therapist to perform other various modalities and procedures. These should only
40 be performed by licensed massage therapists who have the knowledge, training, and

1 expertise to perform such modalities and procedures, and within the licensed massage
2 therapist's scope of practice.

4 **DOCUMENTATION GUIDELINES**

5 **Initial Assessment**

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

8
9 The assessment:

- 10 • Is documented contemporaneously, dated, and signed by the practitioner
- 11 • Incorporates appropriate assessment findings to facilitate outcome measurement
- 12 • Produces data that are sufficient to allow assessment, symptoms description, and
13 the establishment of a plan of care
- 14 • Is sufficient to determine the medical necessity of treatment, including:
 - 15 ○ Description of symptoms
 - 16 ○ Date of onset or exacerbation
 - 17 ○ Evaluation findings
 - 18 ○ Therapeutic massage assessment and care plan consistent with current
19 therapeutic massage practice and updated based on the patient's progress
 - 20 ○ Recommendations and/or referral for exercise and/or self-care
 - 21 ○ Interdisciplinary referrals for health care issues outside of therapeutic massage
22 practitioner's scope or benefit coverage
 - 23 ○ Documented measurable objective improvement/response to care
 - 24 ○ Estimate of release from care

25 26 **Re-assessment**

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

30
31 The re-assessment:

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

35 36 **Discharge/Discontinuation of Intervention**

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

1 The therapeutic massage discharge documentation includes:

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

8

9 **Patient Reported Outcome Measures (PROMs)**

10 Measuring outcomes is an important component of the practices of licensed practitioners
 11 who provide therapeutic massage. The most common PROM used by licensed massage
 12 therapists is the Numeric Pain Rating Scale. Other PROMs are available to the licensed
 13 massage therapist that are specific for anatomical area, health condition or functional
 14 component (e.g., Neck Disability Index, Oswestry Low Back Disability Index, Disability
 15 of Arm, Shoulder, and Hand - DASH). PROMs are important in direct management of
 16 individual patient care and for the opportunity they provide the profession in collectively
 17 comparing care and determining effectiveness.

18

19 **CLINICAL REVIEW PROCESS**

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

29

30 **Clinical Review for Medical Necessity**

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

37

38 **Approval**

39 ASH CQEs have the responsibility to approve appropriate care for all services that are
 40 medically necessary. The CQEs assess the clinical data supplied by the practitioner in order
 41 to determine whether submitted services and/or the initiation or continuation of care has

1 been documented as medically necessary. The practitioner is accountable to document the
 2 medical necessity of all services submitted/provided. It is the responsibility of the peer
 3 CQE to evaluate the documentation in accordance with their training, understanding of
 4 practice parameters, and review criteria adopted by ASH through its clinical committees.

5
 6 The following items influence clinical service approvals:

- 7 • No evidence of contraindication(s) to services submitted for review
- 8 • Complaints, exam findings, and diagnoses correlate with each other
- 9 • Treatment plan is supported by the nature and severity of complaints
- 10 • Treatment plan is supported by exam findings
- 11 • Treatment plan is expected to improve symptoms (e.g., pain, function) within a
 12 reasonable period of time
- 13 • Maximum therapeutic benefit has not been reached
- 14 • Treatment plan requires the skills of the practitioner
- 15 • Demonstration of progression toward active home/self-care and discharge

16 17 **Partial Approval**

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

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

28
 29 Additional services may be submitted and reviewed for evaluation of the patient's response
 30 to the initial trial of care. If the practitioner or patient disagrees with the partial approval of
 31 services, they contact the CQE listed on their response form to discuss the case, submit
 32 additional documentation through the Reopen process, or submit additional documentation
 33 to appeal the decision through the Provider Appeals and Member Grievances process.

34 35 **Non-approval / Denial**

36 Occurs when none of the services submitted for review are determined to be medically
 37 necessary services. The most common causes for a non-approval/denial of all services are
 38 administrative or contractual in nature (e.g., ineligibility, reached plan benefit limits, non-
 39 coverage). Clinically, it is appropriate to deny continued/ongoing care if the patient's

1 condition(s) have not, or are no longer, responding favorably to the services being rendered
 2 by the treating practitioner, or the patient has reached maximum therapeutic benefit.

3
 4 **Additional / Continued Care**

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

- 9 • The patient has made clinically significant progress under the initial treatment
 10 plan/program based on a reliable and valid outcome tool or updated subjective,
 11 functional, and objective examination findings.
- 12 • Additional clinically significant progress can be reasonably expected by continued
 13 treatment. (The patient has not reached MTB or maximum medical improvement.)
- 14 • There is no indication that immediate care/evaluation is required by other health
 15 care professionals.

16
 17 Any exacerbation or flare-up of the condition that contributes to the need for additional
 18 treatment/services must be clearly documented.

19
 20 The clinical information that the CQE expects to see when evaluating the documentation
 21 in support of the medical necessity of submitted treatment/services should be
 22 commensurate with the nature and severity of the presenting complaint(s) and scope of the
 23 practitioner of services and may include but is not limited to:

- 24 • History
- 25 • Physical examination/evaluation
- 26 • Documented treatment plan and goals
- 27 • Estimated time of discharge

28
 29 In general, the initiation of care is warranted if there are no contraindications to prescribed
 30 care, there is reasonable evidence to suggest the efficacy of the prescribed intervention,
 31 and the intervention is within the scope of services permitted by state or federal law. The
 32 treatment submission for a disorder is typically structured in time-limited increments
 33 depending on clinical presentation. Dosage (frequency and duration of service) should be
 34 appropriately correlated with clinical findings, potential complications/barriers to recovery
 35 and clinical evidence. When the practitioner discovers that a patient is nonresponsive to
 36 the applied interventions within a reasonable time frame, re-assessment and treatment
 37 modification should be implemented and documented. If the patient's condition(s) worsen,
 38 the practitioner should take immediate and appropriate action to discontinue or modify care
 39 and/or make an appropriate healthcare referral.

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

6 **Critical Factors during Clinical Reviews**

7 The complexity and/or severity of historical factors, symptoms, examination findings, and
 8 functional deficits play an essential role to help quantify the patient's clinical status and
 9 assess the effectiveness of planned interventions over time. CQEs consider patient-specific
 10 variables as part of the medical necessity verification process. The entire clinical picture
 11 must be taken into consideration with each case evaluated based upon unique patient and
 12 condition characteristics.

13
 14 Such variables may include, but not be limited to co-morbid conditions and other barriers
 15 to recovery, the stage(s) of the condition(s), mechanism of injury, severity of the
 16 symptoms, functional deficits, and exam findings, as well as social and psychological status
 17 of the patient and the available support systems for self-care. In addition, the patient's age,
 18 symptom severity, and the extent of positive clinical findings may influence duration,
 19 intensity, and frequency of services approved as medically necessary. For example:

- 20 • Severe symptomatology, exam findings, and/or functional deficits may require
 21 more care overall (e.g., longer duration, more services per encounter, and frequency
 22 of encounters that the average); these patients require a higher frequency; but may
 23 require short-term trials of care initially to assess patient response to care.
- 24 • Less severe symptomatology, exam findings and/or functional deficits usually
 25 require less care (e.g., shorter duration, fewer services per encounter, and frequency
 26 of encounters that the average); overall but may allow for less oversight and a
 27 longer initial trial of care.
- 28 • As patients age, they may have a slower response to care, and this may affect the
 29 approval of a trial of care.
- 30 • Complicating and/or co-morbid condition factors vary depending upon individual
 31 patient characteristics, the nature of the condition/complaints, historical and
 32 examination elements, and may require appropriate coordination of care and/or
 33 more timely re-evaluation.

34
 35 Health equity is the attainment of the highest level of health for all people, where everyone
 36 has a fair and just opportunity to attain their optimal health. Factors that can impede health
 37 equity include, but are not limited to, race, ethnicity, disability, sexual orientation, gender
 38 identity, socioeconomic status, geography, and preferred language. Social Determinants of
 39 Health (SDoH) are important influences on health equity status. SDoH are the conditions
 40 in the environments where people are born, live, learn, work, play, worship, and age that

1 affect a wide range of health, functioning, and quality-of-life outcomes and risks. There
 2 are typically five domains of SDoH: 1) Economic stability; 2) Education access and
 3 quality; 3) Health care access and quality; 4) Neighborhood and built environment; 5)
 4 Social and community context. These barriers to health equity may impact health care
 5 access, the patient presentation, clinical evaluations, treatment planning, and patient
 6 outcomes which may in turn influence medical necessity considerations.

7
 8 The following are examples of the factors CQEs consider when verifying the medical
 9 necessity of therapeutic massage for musculoskeletal conditions and pain disorders.

10 **General Factors**

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

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

23 Nature of Complaint(s)

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

27 History

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

1 Examination

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

5

6 **Assessment of Red Flags**

7 At any time the patient is under care, the practitioner is responsible for seeking and

8 recognizing signs and symptoms that require additional diagnostics, treatment/service,

9 and/or referral. A careful and adequately comprehensive history and evaluation in addition

10 to ongoing monitoring during the course of treatment is necessary to discover potential

11 serious underlying conditions that may need urgent attention. Red flags can present

12 themselves at several points during the patient encounter and can appear in many different

13 forms. If a red flag is identified during a medical necessity review, the CQE should

14 communicate with the practitioner of services as soon as possible by telephone and/or

15 through standardized communication methods. When red flag is identified, the CQE may

16 inquire whether such red flag was identified and addressed by the practitioner, not approve

17 services and recommend returning the patient back to the referring healthcare practitioner

18 or referring the patient to other appropriate health care practitioner/specialist with the

19 measure of urgency as warranted by the history and clinical findings.

20

21 Important red flags and events as well as the points during the clinical encounter at which

22 they are likely to appear include but may not be limited to:

23

24 **Past or Current History**

- 25 • Personal or family history of cancer
- 26 • Current or recent urinary tract, respiratory tract, or other infection
- 27 • Anticoagulant therapy or blood clotting disorder
- 28 • Metabolic bone disorder (osteopenia and osteoporosis)
- 29 • Unintended weight loss
- 30 • Significant trauma sufficient to cause fracture or internal injury
- 31 • Unexplained dizziness or hearing loss
- 32 • Trauma with skin penetration
- 33 • Immunosuppression (AIDS/HIV/ARC)
- 34 • Intravenous drug abuse, alcoholism
- 35 • Prolonged corticosteroid use
- 36 • Previous adverse reaction to substances or other treatment modalities
- 37 • Use of substances or treatment which may contraindicate proposed services
- 38 • Uncontrolled health condition (e.g., diabetes, hypertension, asthma)

1 Present Complaint

- 2 • Writhing or cramping pain
- 3 • Precipitation by significant trauma
- 4 • Pain that is worse at night or not relieved by any position
- 5 • Suspicion of vascular/cerebrovascular compromise
- 6 • Symptom's indicative of progressive neurological disorder
- 7 • Unexplained dizziness or hearing loss
- 8 • Complaint inconsistent with reported mechanism of injury and/or evaluation
- 9 findings
- 10 • Signs of psychological distress

11
12 Physical Examination/Assessment

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

27
28 Pattern of Symptoms Not Consistent with Benign Disorder

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

1 Lack of Response to Appropriate Care

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

8 **Assessment of Yellow Flags**

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

13
14 If a yellow flag is identified during a medical necessity review, the reviewer should
15 communicate with the practitioner of services as soon as possible by telephone and/or
16 through standardized communication methods. The CQE may inquire if the yellow flag
17 was identified, and, if so, how it was addressed. They may recommend returning the patient
18 back to the referring healthcare practitioner or referring the patient to other health care
19 practitioner/specialist as appropriate.

21 **Health Equity Factors**

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

30 **Assessment of Historical Information**

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

- 33 • The mechanism of onset and date of onset are congruent with the stated condition’s
- 34 etiology.
- 35 • The patient’s past medical history and response to care do not pose
- 36 contraindication(s) for the services submitted for review.
- 37 • The patient’s past medical history of pertinent related and unrelated conditions does
- 38 not pose contraindication(s) for the services submitted for review.
- 39 • The patient’s complaint(s) have component(s) that are likely to respond favorably
- 40 to services submitted for review.

- 1 • Provocative and palliative factors identified on examination indicate the presence
- 2 of a musculoskeletal condition as expected per diagnosis(es) or complaints, or as
- 3 consistent with other type of diagnosis(es).
- 4 • The patient's severity of limitations to activities of daily living (ADLs) are
- 5 appropriate and commensurate for the presence of the condition(s) or disorder(s).
- 6 • The quality, radiation, severity, and timing of pain are congruent with the
- 7 documented condition(s) or disorder(s).
- 8 • The patient's past medical history of having the same or similar condition(s)
- 9 indicates a favorable response to care.
- 10 • The absence or presence of co-morbid condition(s) may or may not present absolute
- 11 or relative contraindications to care.

13 **Assessment of Examination Findings**

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

29 **Assessment of Treatment / Treatment Planning**

- 30 • Treatment dosage (frequency and duration of service) is appropriately correlated
- 31 with the nature and severity of the subjective complaints, potential
- 32 complications/barriers to recovery, and objective clinical evidence.
- 33 • Services that do not require the professional skills of a practitioner to perform or
- 34 supervise are not medically necessary, even if they are performed by a massage
- 35 therapy practitioner. Therefore, if the continuation of a patient's care can proceed
- 36 safely and effectively through a home exercise program or self-management
- 37 program, services are not indicated or medically necessary.
- 38 • The set therapeutic goals are functionally oriented, realistic, measurable, and
- 39 evidence based.
- 40 • The proposed/estimated date of release/discharge from treatment is noted.

- 1 • The treatment/therapies are appropriately correlated with the nature and severity of
- 2 the patient's condition(s) and set treatment goals.
- 3 • Functional testing and/or patient-reported outcomes demonstrate improvement that
- 4 is relevant to the patient. This is important in order to determine the need for
- 5 continued care, the appropriate frequency of visits, estimated date of release from
- 6 care, and if a referral to an appropriate health care practitioners/specialist is
- 7 indicated.
- 8 • Home care, self-care, and active-care instructions are documented.

9

10 **Factors that Influence Adverse Determinations of Clinical Services (Partial**

11 **Approvals/Denials)**

12 Factors that influence adverse determinations of clinical services may include but are not

13 limited to these specific considerations and other guidelines and factors identified

14 elsewhere in this policy. Topics/factors covered elsewhere in this guideline are also

15 applicable in this section and may result in an adverse determination on medical necessity

16 review. To avoid redundancy, many of those factors have not been listed below.

17

18 **Additional Factors Considered in Determination of Medical Necessity**

19

20 **History / Complaints / Patient Reported Outcome Measures**

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

32

33 **Evaluation Findings**

- 34 • There is poor correlation and/or a significant discrepancy in any of the following:
- 35 ○ patient's history
- 36 ○ subjective complaints
- 37 ○ objective findings
- 38 ○ diagnosis
- 39 ○ treatment plan

- 1 • The patient’s objective findings have not demonstrated clinically significant
- 2 improvement
- 3 • The objective findings are essentially normal or are insufficient to support the
- 4 medical necessity of any/all submitted services
- 5 • The submitted objective findings are insufficient due to any of, but not limited to,
- 6 the following reasons:
- 7 ○ old or outdated relative to the requested dates of service
- 8 ○ do not properly describe the patient’s current status
- 9 ○ do not substantiate the medical necessity of the current treatment plan do
- 10 not support the patient’s diagnosis/diagnoses do not correlate with the
- 11 patient’s subjective complaint(s) and/or symptom(s)
- 12 • Not all of the patient’s presenting complaints were properly examined
- 13 • The patient does not have any demonstrable functional deficits or impairments
- 14 • The patient has not made reasonable progress toward pre-clinical status or
- 15 functional outcomes under the initial treatment/services
- 16 • Clinically significant therapeutic progress is not evident through a review of the
- 17 submitted records; this may indicate that the patient has reached maximum
- 18 therapeutic benefit
- 19 • The patient is approaching or has reached maximum therapeutic benefit
- 20 • The patient’s exam findings have returned to pre-injury status or prior level of
- 21 function
- 22 • There is inaccurate reporting of clinical findings
- 23 • The exam performed is for any of the following:
- 24 ○ wellness
- 25 ○ pre-employment
- 26 ○ sports pre-participation

28 **Diagnosis**

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

35 **Submitted Medical Records**

- 36 • The submitted records are insufficient to reliably verify pertinent clinical
- 37 information, such as (but not limited to):
- 38 ○ patient’s clinical health status
- 39 ○ the nature and severity of the patient’s complaint(s) and/or symptom(s)
- 40 ○ date/mechanism of onset

- 1 ○ objective findings
- 2 ○ diagnosis/diagnoses
- 3 ○ response to care
- 4 ○ functional deficits/limitations
- 5 • There are daily notes submitted for the same dates of service with different/altered
- 6 findings without an explanation
- 7 • There is evidence of duplicated or nearly duplicated records for the same patient
- 8 for different dates of service, or for different patients
- 9 • There is poor correlation and/or a significant discrepancy between the information
- 10 presented in the submitted records with the information presented during a verbal
- 11 communication between the reviewing CQE and treating practitioner
- 12 • The treatment time (in minutes) and/or the number of units used in the performance
- 13 of a timed service (e.g., procedure) during each encounter/office visit was not
- 14 documented
- 15 • Some or all of the service(s) submitted for review are not documented as having
- 16 been performed in the daily treatment notes

Treatment / Treatment Planning

- 19 • The submitted records show that the nature and severity of the patient’s
- 20 complaint(s) and/or symptom(s) require a limited, short trial of care in order to
- 21 monitor the patient’s response to care and determine the efficacy of the current
- 22 treatment plan. This may include, but not limited to, any of the following:
- 23 ○ significant trauma affecting function
- 24 ○ acute/sub-acute stage of condition
- 25 ○ moderate-to-severe or severe subjective and objective findings
- 26 ○ possible neurological involvement
- 27 ○ presence of co-morbidities that may significantly affect the treatment plan
- 28 and/or the patient’s response to care
- 29 ○ There is poor correlation of the treatment plan with the nature and severity
- 30 of the patient’s complaint(s) and/or symptom(s), such as prolonged reliance
- 31 on passive care
- 32 • There is evidence from the submitted records that the patient’s treatment can
- 33 proceed safely and effectively through a home exercise program or self-
- 34 management program
- 35 • The patient’s function has improved, complaints and symptoms have decreased,
- 36 and patient requires less treatment (e.g., lesser units of services per office visit,
- 37 lesser frequency, and/or shorter total duration to discharge)
- 38 • The patient’s symptoms and/or exam findings are mild and the patient’s treatment
- 39 plan requires a lesser frequency (e.g., units of services, office visits per week)
- 40 and/or total duration

- 1 • Therapeutic goals have not been documented. Goals should be measurable and
- 2 written in terms of function and include specific parameters
- 3 • Therapeutic goals have not been reassessed in a timely manner to determine if the
- 4 patient is making expected progress
- 5 • Failure to make progress or respond to care as documented within subjective
- 6 complaints, objective findings and/or functional outcome measures
- 7 • The patient's condition(s) is/are not amenable to the proposed treatment plan
- 8 • Additional significant improvement cannot be reasonably expected by continued
- 9 treatment and treatment must be changed or discontinued
- 10 • The patient has had ongoing care without any documented lasting therapeutic
- 11 benefits
- 12 • The condition requires an appropriate referral and/or coordination with other
- 13 appropriate health care services
- 14 • The patient is not complying with the treatment plan that includes lifestyle changes
- 15 to help reduce frequency and intensity of symptoms
- 16 • The patient is not adhering to treatment plan that includes medically necessary
- 17 frequency and intensity of services without documented extenuating circumstances
- 18 • Home care, self-care, and active-care instructions are not implemented or
- 19 documented in the submitted records
- 20 • As symptoms and clinical findings improve the frequency of services (e.g., visits
- 21 per week/month) did not decrease. The submitted services do not or no longer
- 22 require the professional skills of the treating practitioner. The treatment plan is for
- 23 any of the following:
 - 24 ○ preventive care
 - 25 ○ elective/convenience/wellness care
 - 26 ○ back school
 - 27 ○ vocational rehabilitation or return to work programs
 - 28 ○ work hardening programs
 - 29 ○ routine educational, training, conditioning, return to sport, or fitness.
 - 30 ○ non-covered condition
- 31 • There is duplication of services with other healthcare practitioners/specialties
- 32 • The treatment plan is not supported due to, but not limited to, any of the following
- 33 reasons:
 - 34 ○ technique-/protocol-based instead of individualized and evidence based
 - 35 ○ generic and not individualized for the patient's specific needs
 - 36 ○ does not correlate with the set therapeutic goals
 - 37 ○ not supported in the clinical literature (e.g., proprietary, unproven)
 - 38 ○ not considered evidence-based and/or professionally accepted

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

7 **Health and Safety**

- 8 • There are signs, symptoms and/or other pertinent information presented through the
 9 patient's history, exam findings, and/or response to care that require urgent
 10 attention, further testing, and/or referral to and/or coordination with other
 11 healthcare practitioners/specialists
- 12 • There is evidence of the presence of Yellow and/or Red Flags (See section on Red
 13 and Yellow Flags above)
- 14 • There are historical, subjective, and/or objective findings which present as
 15 contraindications for the plan of care

17 **Referral / Coordination of Services**

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

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

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

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

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