



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all plans administered by CIGNA Companies including plans administered by Great-West Healthcare, which is now a part of CIGNA.

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Subject Massage Therapy

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Hyperlink to Related Coverage Policies

- Chiropractic Care
- Complementary and Alternative Medicine
- Complex Lymphedema Therapy (Complete Decongestive Therapy)
- Dry Hydrotherapy
- Occupational Therapy
- Physical Therapy

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2009 CIGNA

Coverage Policy

Massage therapy is specifically excluded under some benefit plans. If covered, massage therapy is generally subject to the terms, conditions and limitations of the Short-Term Rehabilitation Therapy or Chiropractic Care Services benefits as described in the applicable plan's schedule of copayments. Many benefit plans include a maximum allowable benefit for duration of treatment or number of visits. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage.

If massage therapy is not specifically excluded from coverage in the benefit plan, the following condition of coverage applies.

CIGNA covers massage therapy when provided as one component of a medically necessary and covered comprehensive physical therapy or chiropractic treatment plan.

CIGNA does not cover massage therapy when it is provided in the absence of other therapeutic modalities because it is considered not medically necessary.

Note: Massage therapy may be provided by several types of providers. To qualify for coverage, the provider must meet the definition of provider contained in the benefit plan. Please refer to the applicable plan language to determine benefit coverage for the rendering provider.

General Background

Massage therapy is a therapeutic procedure used in the field of physical medicine and rehabilitation. It is also referred to as therapeutic massage. This treatment is the manipulation of soft tissue using the hands or a mechanical device. There are a number of variables related to this procedure that may impact the effectiveness of the treatment. These include the types of maneuvers used, the therapist rendering the care, the patient position, amount of pressure exerted and the frequency and duration of the treatments. Some of the movement techniques of massage therapy include:

- effleurage (i.e., stroking or gliding)
- petrissage (i.e., kneading or compression)
- tapotement (i.e., striking or percussion)
- vibration (i.e., shaking)

Massage therapy is one of the passive modalities used by physical therapists and occupational therapists, usually in combination with other modalities. It may also be utilized by chiropractors in conjunction with manipulation. Massage that is applied to acupuncture points is known as acupressure. Passive modalities/procedures are most effective during the acute phase of treatment, since they are typically directed at reducing pain and swelling. They may also be utilized during the acute phase of the exacerbation of a chronic condition. The intended goal of massage therapy includes the relief of musculoskeletal pain and improving function. Massage is noted to be a generally safe therapeutic treatment, with low risk for adverse effects. Contraindications may include treating an area over inflammation, skin infection or deep vein thrombosis (Furlan, et al., 2005).

Literature Review

Few clinical trials have been undertaken to assess the effect of this modality when performed alone in the treatment of specific medical conditions. Rehabilitation programs will frequently combine massage therapy with one or more other treatment interventions, which makes it difficult to draw conclusions regarding the efficacy of this treatment when used as the sole modality. Massage therapy has been a mainstay of physiotherapy management for musculoskeletal pain. However, there has been little rigorous research into the effects of massage, and its clinical benefits remain unsubstantiated in the literature (Herbert, et al., 2001).

Preyde (2000) conducted a randomized controlled trial for the purpose of comparing comprehensive massage therapy (i.e., soft-tissue manipulation, remedial exercise, posture education), two components of massage therapy and a placebo in the treatment of subacute low back pain. Ninety-eight subjects were included in the study. Subjects with subacute low back pain were assigned to one of four groups: 25 to a comprehensive massage therapy group, 25 to a soft-tissue manipulation only, 22 to remedial exercise with posture education only, and 26 to a placebo of sham laser therapy. Each subject received six treatments during a one-month time period. Outcome measures were obtained at baseline and after treatment at one month follow-up. Outcome was measured with the Roland Disability questionnaire (RDQ), the McGill Pain Questionnaire, the State Anxiety Index and the Modified Schober test. Ninety-one completed follow-up tests. The comprehensive massage therapy group had improved function, less intense pain and a decrease in the quality of pain compared with the other three groups. Clinical significance was apparent for the comprehensive massage therapy group and soft-tissue manipulation group on the measure of function. At one-month follow-up, 63% of subjects in the comprehensive massage therapy group reported no pain as compared to 27% of the soft-tissue manipulation group, 14% of the remedial exercise group and 0% of the sham laser group. Limitations of this study include the use of a single setting, which precludes generalized conclusions; the use of a specific form of massage therapy provided by only two massage therapists; unmeasured provider effects on the validity of outcome measures; and the confines of the protocol.

The Philadelphia Panel (2001), an expert panel, developed evidence-based clinical practice guidelines on selected rehabilitation interventions for neck pain, knee pain, shoulder pain and low back pain. It was noted that certain rehabilitation interventions, such as massage, are used for pain relief in the acute stage but also as a preparation before main intervention. The approach is generally chosen on the basis of empirical experience. The panel concluded that there was insufficient evidence to include or exclude therapeutic massage alone as an intervention for these conditions.

A Cochrane review was performed with the objective of assessing the efficacy of deep transverse friction massage for the treatment of tendinitis (Brosseau, et al., 2002). Deep transverse friction massage is a technique that is used in treating musculoskeletal conditions. This type of massage attempts to reduce abnormal fibrous adhesions and make scar tissue more mobile by realigning the normal soft tissue fibers. Two trials met inclusion criteria for the review. One study compared two groups: one group received deep friction massage with physiotherapy, and one received physiotherapy alone. The second study had several comparison groups that combined deep transverse friction massage with another treatment and then compared this with yet another treatment. Deep transverse friction massage combined with additional physiotherapy did not demonstrate a consistent, clinically important benefit when compared to a control. Based on these studies, the authors concluded that deep transverse friction massage combined with other physiotherapy modalities did not significantly reduce tendinitis symptoms compared to a control group. Additional well-designed studies are necessary before conclusions can be drawn regarding the efficacy or lack of efficacy of deep transverse friction massage for treatment of symptomatic tendinitis.

Perlman et al. (2006) conducted a randomized controlled trial to study massage therapy for osteoarthritis of the knee. The study involved 68 patients with radiographically confirmed osteoarthritis of the knee. The study participants were assigned to either treatment of twice-weekly sessions of massage in weeks one through four and once-weekly sessions in weeks five through eight or to the control group. The therapists administered a standard Swedish full-body therapeutic massage technique and a standard protocol for the study intervention, which included petrissage, effleurage and tapotement techniques used at the therapist's discretion. The usual care included pain medication, exercises or hot and cold therapy. The control group continued to receive conventional medical care during the initial period, then crossed over to receive massage (weeks 9–16) after an initial eight-week delay. Outcome measurements were collected at baseline and after completion of interventions (weeks 8 and 16) in both groups. The Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) pain and functional scores and visual analog scale of pain were used the outcome assessment. The group receiving massage therapy demonstrated significant improvements in the mean WOMAC global scores in areas of pain, stiffness, and physical function domains and in the visual analog of pain scale. The authors noted that study limitations were that the study involved a single intervention and duration of only 16 weeks. It was noted that osteoarthritis is a chronic condition, and longer studies will be needed. The authors concluded that this pilot study suggests that massage therapy is efficacious in treatment of osteoarthritis of the knee with beneficial effects persisting for weeks following treatment. Further clinical trials are warranted to determine optimal treatment protocols, absolute efficacy, cost-effectiveness, and generalization to other patient groups.

Karels et al. (2006) conducted a prospective cohort study to describe the interventions applied by physical therapists in treating patients with complaints of arm, neck and/or shoulder. Seventy-seven physical therapists provided treatment data for 619 patients. Self-reported questionnaires were used to collect data from the physical therapists. The participating physical therapists recorded an average of 11 visits per patient. The average treatment duration was ten weeks. It was noted that almost all of the physical therapists applied two interventions at one visit, with most of the interventions being a combination of massages and exercise therapy. The results indicated that exercise therapy (93%) and massage (87%) are the primary treatments in patients with complaints of the arm, neck and/or shoulder, with most patients being treated with a combination of these two interventions. The authors concluded that the observational study has provided a large inventory of treatment provided for these diagnoses; however, little is known regarding the effectiveness of frequently applied intervention techniques. The authors recommend additional studies that focus on the effectiveness of exercise therapies alone and in combination with massage therapy for patients with complaints of the arm, neck, and/or shoulder.

Haraldsson et al. (2006) conducted a Cochrane review to assess the effects of massage on pain, function, patient satisfaction and cost of care in adults with neck pain. Nineteen trials met the inclusion criteria. Overall, the methodological quality was noted to be low, with 12 of the 19 trials judged to be low-quality studies. The trials could not be statistically pooled due to the heterogeneity of the treatment and control groups. It was also noted that the participant characteristics, descriptions of massage intervention and credentials or experience of the massage professional were not well reported. Six of the trials reported on massage as a stand-alone treatment, with the results noted to be inconsistent. Of the 14 trials that used massage as part of a multimodal intervention, none was designed such that the relative contribution of massage could be determined. The authors concluded that "no recommendations for practice can be made at this time because the effectiveness of

massage for neck pain remains uncertain.” The authors noted that pilot studies are needed to characterize massage treatment and establish the optimal treatment to be used in subsequent larger trials.

A review of the evidence was conducted by American Pain Society and the American College of Physicians in the development of clinical practice guidelines for acute and chronic low back pain (Chou, et al., 2007a). The review included evidence from systematic reviews and randomized controlled trials. In regards to massage, the review found eight unique trials of massage that were included in two systematic reviews. For acute low back pain there was insufficient evidence found to determine the efficacy of massage. The review found fair evidence that massage is similar in efficacy to other noninvasive interventions for chronic low back pain. The evidence was insufficient to determine the effect of the number or duration of massage sessions on efficacy of the treatment.

A Cochrane review was conducted for the purpose of assessing the effects of massage therapy for non-specific low back pain (Furlan, et al., 2002). Nine publications reporting on eight randomized trials were included. In one trial, massage was compared to an inert treatment (i.e., sham laser), while in the other seven, massage was compared to different active treatments. The evaluation concluded that massage might be beneficial for patients with subacute and chronic nonspecific low back pain, especially when combined with exercise and education, in terms of improving symptoms and function. Additional studies are needed to confirm the conclusion and to assess other impacts of massage therapy. In 2008, Furlan et al. updated this Cochrane review. Thirteen randomized trials were included in the review. In this review, four of the trials from the previous review were excluded and nine additional randomized controlled trials were included. In two studies, massage therapy was compared to an inert therapy. In eight studies, massage was compared to other active treatments. These studies demonstrated that massage was similar to exercises, and massage was superior to joint mobilization, relaxation therapy, physical therapy, acupuncture, and self-care education. The beneficial effects of massage in patients with chronic low-back-pain lasted at least one year after the end of treatment. Two studies compared two different techniques of massage. The authors concluded that massage may be beneficial for patients with subacute and chronic non-specific back pain, in particular when combined with exercises and education. The authors noted that additional studies are needed to confirm these conclusions.

Summary

Massage therapy, or therapeutic massage, is a therapeutic procedure used in the field of physical medicine and rehabilitation. Few clinical trials have been undertaken to assess the effect of this modality alone in the treatment of specific medical conditions. Rehabilitation programs have frequently combined massage therapy with one or more other treatment interventions. While there is scant literature regarding the efficacy of this treatment when used as the sole modality, massage therapy has been a mainstay of physical therapy or chiropractic treatment plans for the management of musculoskeletal pain.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT®*	Description
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

ICD-9-CM Diagnosis Codes	Description
	Multiple/Varied

*Current Procedural Terminology (CPT®) © 2008 American Medical Association: Chicago, IL.

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Policy History

<u>Pre-Merger Organizations</u>	<u>Last Review Date</u>	<u>Policy Number</u>	<u>Title</u>
CIGNA HealthCare	3/15/2007	0310	Massage Therapy

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Connecticut General Life Insurance Company has acquired the business of Great-West Healthcare from Great-West Life & Annuity Insurance Company (GWLA). Certain products continue to be provided by GWLA (Life, Accident and Disability, and Excess Loss). GWLA is not licensed to do business in New York. In New York, these products are sold by GWLA's subsidiary, First Great-West Life & Annuity Insurance Company, White Plains, N.Y.