



Manual Therapy

LOB(s): <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicare <input checked="" type="checkbox"/> Medicaid	State(s): <input checked="" type="checkbox"/> Idaho <input checked="" type="checkbox"/> Montana <input checked="" type="checkbox"/> Oregon <input checked="" type="checkbox"/> Washington <input type="checkbox"/> Other: <input checked="" type="checkbox"/> Oregon
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Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Manual therapy is a clinical approach utilizing skilled, specific active and/or passive hands-on techniques to diagnose and treat soft tissues and joint structures in the trunk, neck, and extremities. The goals of manual therapy include; increasing range of motion (ROM), reducing or eliminating pain or soft tissue inflammation, improving contractile and non-contractile tissue repair, facilitating movement, and improving function.

Manual Therapy Techniques are commonly performed by chiropractors, physical therapists, or other health care professionals can be classified by area of treatment (e.g., joints and soft tissues) and include, but are not limited to the following:

- Soft-tissue manual therapy techniques include, but are not limited to the following:
 - Active Release Therapy
 - Augmented soft-tissue mobilization (e.g., Graston)
 - Functional mobilization
 - Manual trigger point therapy
 - Manual lymph drainage
 - Myofascial release
 - Proprioceptive neuromuscular facilitation

- Scar mobilization
- Soft tissue mobilization
- Strain-counter-strain (positional release)
- Transverse frictional massage
- Joint manual therapy techniques include, but are not limited to the following:
 - Joint manipulation/thrust
 - Joint mobilization
 - Manual Traction
 - Mobilizations with movement (Mulligan techniques)
 - Muscle energy technique
 - Post-isometric relaxation

Physical Therapy Time Requirements for Manual Therapy Techniques

PacificSource follows the midpoint (halfway) billing rule of reimbursement units for time-based therapy codes. For example, reimbursement for 1 unit of CPT code 97140 requires services to be provided for at least 8 minutes of 15 minutes. Accordingly, multiple units of CPT code 97140 would follow the same requirements, such as:

- Services for 23 to 30 minutes = 2 units
- Services for 38 to 45 minutes = 3 units

Criteria

Commercial

PacificSource considers Manual Therapy Techniques medically necessary when **ALL** of the following criteria is met:

1. Patient has a diagnosis/disorder for which manual therapy techniques (e.g., musculoskeletal pain or lymphatic drainage) is clinically appropriate
2. Clinical documentation requirements from provider to include **ALL** the following:
 - a. Therapist's skill are medically necessary to improve or restore of the member's functional status
 - b. Services cannot be conducted for or by the member without the assistance of the therapist
 - c. Personalized treatment plan/goals associated with Manual Therapy Techniques
 - d. Location of Manual Therapy Techniques application (e.g., spinal region(s), shoulder, thigh)
 - e. Description of the Manual Therapy Techniques used (e.g., joint manipulation, myofascial release, mobilization)
 - f. Objective measurement including, but not limited to: Range of Motion (ROM) and strength of affected area by pre- and post-assessment
3. Billed as a stand-alone procedure: (CPT codes 97140 and 97124 are timed-therapy services)
 - a. **CPT code 97140**

- A maximum of **three (3)** units per date of service is allowed for CPT 97140 (applies to all PS plans, including ASO groups).
- CPT code 97140 is ineligible for modifier 51 (multiple procedures)

4. Exclusions:

- Cupping, rolfing, moxibustion, tui na, gua-sha and qigong therapy
- Post-acute phase of the condition(s) indicated for manual therapy
- Services for preventative, maintenance, or wellness care
- As part of vocational, stroke or long-term rehabilitation programs
- Hypnotherapy, behavior training, sleep therapy, or biofeedback
- Treatment of menstrual cramps, infertility, addiction disorders (including smoking cessation)

Medicaid

PacificSource Community Solutions (PCS) follows the general coverage, limitations, and exclusions outlined in OARs 410-141-3820, 410-141-3825, and 410-120-1200. Relevant coverage guidance in the Health Evidence Review Commission (HERC) Prioritized List of Health Services; as well as any applicable Oregon Administrative Rules (OARs) may be used to determine coverage of manual therapy.

PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements in OAR 410-151-0000 through 410-151-0003 for EPSDT beneficiaries. Relevant coverage guidance may be used to assist in informing a determination of medical necessity and medical appropriateness during the individual case review. A case-by-case review for EPSDT Medical Necessity and EPSDT Medical Appropriateness as defined in OAR 410-151-0001 is required prior to denying. Refer to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for details.

PacificSource follows Medically Unlikely Edits (MUEs) for coverage of Manual Therapy.

Medicare

PacificSource Medicare follows Medicare Benefit Policy Manual, Chapter 15, Section 30.5 for chiropractic services.

PacificSource Medicare follows CMS guidelines, criteria, and Medically Unlikely Edits (MUEs) for manual therapy. In the absence of CMS guidelines and criteria, and MUEs PacificSource Medicare will follow the PacificSource commercial criteria above for determination of coverage and medical necessity coverage of manual therapy.

Experimental/Investigational/Unproven

PacificSource considers Craniotherapy to include craniosacral therapy, to be experimental, investigational, or unproven for all indications.

PacificSource considers the Schroth Method experimental, investigational, or unproven for all indications.

Note: PacificSource Community Solutions (PCS) and PacificSource Medicare require items listed on this policy's E//U list, to be reviewed by medical necessity review guidelines. Please see related policy, "Clinical Criteria Used in UM Decisions" to review criteria hierarchy and "Medical Necessity Reviews" for determination of coverage and medical necessity guidelines.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

- 97012 Application of a modality to 1 or more areas; traction, mechanical
- 97112 Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
- 97139 Unlisted therapeutic procedure (specify)
- 97140 Manual therapy techniques (e.g., mobilization, manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- 97530 Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
- 97799 Unlisted physical medicine/rehabilitation service or procedure
- 98940 Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
- 98941 Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
- 98942 Chiropractic manipulative treatment (CMT); spinal, 5 regions
- 98943 Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions

CPT® codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

Definitions

Joint manipulation (thrust technique) - A skilled, high-velocity, low-amplitude manual technique applied to a joint beyond its physiological range of motion but within its anatomical limits.

Joint mobilization - A skilled passive movement applied to a joint or related soft tissue at varying speeds and amplitudes for the purpose of restoring joint mobility, decreasing pain, or improving function.

Lymphatic drainage - Manual massage to relieve swelling from Lymphedema.

Manual lymphatic drainage - A specialized form of manual therapy involving gentle, rhythmic, hands-on techniques intended to facilitate lymphatic flow and reduce clinically significant lymphedema when medically necessary and performed as part of a skilled treatment plan.

Maintenance therapy - Services provided to preserve a patient's current functional status or prevent expected decline when no significant functional improvement is anticipated. Maintenance therapy is not considered medically necessary.

Manual therapy - Skilled, hands-on therapeutic techniques performed by a qualified provider to treat soft tissues and joint structures in order to improve mobility, reduce pain or swelling, and enhance

function as part of an individualized, time-limited treatment plan with objective measurable outcomes.

Massage therapy - the practice of non-invasive manual, or hands-on, movement of body tissue, including muscle, connective tissue, tendons, and ligaments.

Musculoskeletal pain - Pain originating from muscles, joints, fascia, tendons, ligaments, or related structures that is provoked or alleviated by movement, position, or mechanical loading.

Skilled therapy services - Services that require the specialized clinical judgment, training, and continuous assessment of a qualified healthcare professional and cannot be safely or effectively performed independently by the member or a caregiver.

Soft Tissue - The non-bony connective and contractile tissues of the body, including muscles, tendons, fascia, ligaments, and related structures.

Wellness or preventive care - Services provided for general health promotion, relaxation, conditioning, or prevention of disease or dysfunction in the absence of a documented illness, injury, or functional impairment

Related Policies

Alternative Care

Clinical Criteria Used in UM Decisions

Clinical Resources Used for Medical Necessity Determinations When No Other UM Clinical Criteria or Guideline Exists

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

References

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Oregon Health Plan. The Health Evidence Review Commission (HERC) Prioritized List of Health Services <https://www.oregon.gov/oha/HSD/OHP/Pages/Prioritized-List.aspx>

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Appendix

Policy Number:

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Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s): 42 CFR § 422.101(b-c); OARs 410-131-0040 to through 0160, 410-120-1200, 410-141-3820, 410-141-3825, 410-141-3830, 410-151-0000 through 410-151-0003

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