Clinical Policy: Massage Therapy Expanded Benefit

Reference Number: FL.CP.MP.02
Effective Date: 11/25
Review/Revised Date: 10/31/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Massage therapy is considered medically necessary to restore muscle function, reduce edema, improve joint motion, or for relief of muscle spasm. Massage therapy is not considered medically necessary for prolonged periods and should be limited to the initial or acute phase of an injury or illness. This policy outlines medical necessity requirements for massage therapy as an expanded benefit for Sunshine Health's Managed Medical Assistance (MMA), Long Term Care (LTC), HIV/AIDS, and Serious Mental Illness (SMI) products.

Policy/Criteria

I. It is the policy of Sunshine Health that initial and ongoing massage therapy as an expanded benefit is **medically necessary** when all of the following criteria are met:

A. Member is ≥ 21 years of age;
B. Administered by a licensed massage therapist following a formal evaluation that includes the following:
   1. History of illness or disability;
   2. Relevant review of systems;
   3. Pertinent physical assessment;
   4. Current and previous level of functioning;
   5. Tests or measurements of physical function;
   6. Potential for improvement in the patient's physical function;
   7. Recommendations for treatment and patient and/or caregiver education.
C. Signs and symptoms of physical deterioration or impairment in one or more of the following areas:
   1. Paralyzed musculature contributing to impaired circulation;
   2. Excessive fluids in interstitial spaces or joints;
   3. Sensitivity of tissues to pressure;
   4. Tight muscles resulting in shortening and/or spasticity of affected muscles;
   5. Contractures and decreased range of motion.
D. Signs and symptoms of physical deterioration related to the following:
   1. Diagnosis of AIDS or a history of an AIDS-related opportunistic infection;
   2. Treatment of peripheral neuropathy;
   3. Treatment of severe neuromuscular pain;
   4. Lymphedema.

Note: If no clinical benefit is appreciated after four weeks of medical massage, then the treatment plan should be reevaluated. *Prior to the expiration of the initial authorization period*, the requesting practitioner must submit information on the member's status in order for a review for subsequent approvals to be completed

II. It is the policy of Sunshine Health that massage therapy as an expanded benefit is considered **not medically necessary** for maintenance treatment, where the member's symptoms are neither regressing nor improving after four weeks of medical massage.

III. It is the policy of Sunshine Health that continued massage therapy as an expanded benefit is considered **not medically necessary** if the member does not demonstrate meaningful improvement in symptoms, such as increase in functionality and/or decrease in circumference measurements in the affected extremities demonstrated by one or more of the following:

A. Decrease in fluids in interstitial space or joints;
B. Increased range of motion and improvement of contractures;
C. Decreased sensitivity of tissues to pressure;
D. Decrease in spasticity and muscle tightening and rigidity.

Note: Massage therapy and physical therapy will not be reimbursed if performed on the same date of service. Coverage is only applicable up to the benefit limit.

Background

Massage involves manual techniques that include applying fixed or movable pressure, holding and/or causing movement of or to the body, using primarily the hands. These techniques affect the musculoskeletal, circulatory-lymphatic, nervous, and other systems of the body with the intent of improving a person's health. Massage therapy, when added to traditional analgesic measures, can improve the efficacy of pain control. Furthermore, massage therapy as a component of complementary and alternative medicine (CAM), has been advocated for pain control by numerous professional and governmental societies, such as the American Society of Clinical Oncology, the National Comprehensive Cancer Network, and the Society of Critical Care Medicine.[6]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description

HCPCS Codes	Description

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Original approval date		06/18
Policy update; expanded benefit		07/18
Annual review; no changes		05/19
Policy update; addition of AHCA contract language		05/19
Annual review; no criteria changes		02/20
Policy update; updated language under expanded benefit.		06/20
Annual review; no changes		07/21
Policy update; Added unlimited with prior auth and SMI to product line.		11/21
Annual review; no changes		12/22
Updated information from policy FL.UM.11.00 and added to FL.CP.MP.02; sent to market for approval.	06/23	
Annual review; minor grammatical changes with no criteria changes		11/23
Annual review. Minor rewording with no clinical significance. Background updated. References reviewed and updated.	10/24	
Annual review. HIV/AIDS product added to Description. References reviewed and updated.	10/25	

References

1. Agency for Health Care Administration. Statewide Medicaid Managed Care Expanded Benefits. https://ahca.myflorida.com/content/download/25560/file/SMMC%203.0%20Expanded%20Benefits%20Grid_Health%20Plan_02012025v2.pdf. Effective February 1, 2025. Accessed August 22, 2025.
2. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, Fu R, Dana T, Kraegel P, Griffin J, Grusing S, Brodt E. Noninvasive Treatments for Low Back Pain. Comparative Effectiveness Review No. 169. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2012-00014-I.) AHRQ Publication No. 16-EHC004-EF. Rockville, MD: Agency for Healthcare Research and Quality; February 2016.
3. Skelly AC, Chou R, Dettori JR, et al. *Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review Update*. Rockville (MD): Agency for Healthcare Research and Quality (US); April 2020.
4. Hillier SL, Louw Q, Morris L, Uwimana J, Statham S. Massage therapy for people with HIV/AIDS. *Cochrane Database Syst Rev*. 2010;2010(1):CD007502. Published 2010 Jan 20. doi:10.1002/14651858.CD007502.pub2
5. National Center for Complementary and Alternative Medicine (NCCAM). National Institutes of Health. Massage therapy: what you need to know. https://nccih.nih.gov/health/massage/massageintroduction.htm. Published September 2006. Updated May 2019. Accessed August 27, 2025.
6. Liu C, Chen X, Wu S. The effect of massage therapy on pain after surgery: A comprehensive meta-analysis. *Complement Ther Med*. 2022;71:102892. doi:10.1016/j.ctim.2022.102892

7. Reychler G, Caty G, Arcq A, Lebrun L, Belkhir L, Yombi JC, Marot JC. Effects of massage therapy on anxiety, depression, hyperventilation and quality of life in HIV infected patients: A randomized controlled trial. *Complement Ther Med*. 2017 Jun;32:109-114. doi: 10.1016/j.ctim.2017.05.002. Epub 2017 May 11. PMID: 28619295.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.