Osteopathic Manipulations (OMT)

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➲ Instructions for Use

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Related Medicare Advantage Reimbursement Policy

- Global Days Policy, Professional

Coverage Rationale

Overview

Osteopathic manipulative treatment (OMT) is a treatment employed, primarily by osteopathic physicians, to facilitate a patient's recovery from somatic dysfunction, and is defined under the Glossary of Osteopathic Terminology as impaired or altered function of related components of the somatic (body framework) system; skeletal, arthroidal and myofascial structures, and related vascular, lymphatic, and neuro elements. The positional and motion aspects of somatic dysfunction are best described using at least one of three parameters:

1. The position of a body part as determined by palpation and reference to its adjacent defined structure;
2. The direction in which motion is freer; and
3. The direction in which motion is restricted.

The diagnosis of somatic dysfunction is made by determining the presence of one or more findings, described by the acronym TART (tenderness, asymmetry, restriction of motion, and tissue abnormality). Osteopathic manipulative treatment includes muscle energy, high velocity-low amplitude, counterstrain, myofascial release, visceral, and craniosacral. The chosen treatment will vary depending on patient's age and clinical condition.

Somatic dysfunction in one region can create compensatory somatic dysfunction in other regions. Osteopathic manipulative treatment is also utilized to treat the somatic component of visceral diseases. This component can manifest as changes in the skeletal, arthrodial, and myofascial tissues.

CMS National Coverage Determinations (NCDs)

Medicare does not have an NCD for osteopathic manipulations (OMT).

CMS Local Coverage Determinations (LCDs) and Articles

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. For specific LCDs/LCAs, refer to the table for Osteopathic Manipulative Treatment.

For coverage guidelines for states/territories with no LCDs/LCAs, osteopathic manipulative treatment is covered when medically necessary and performed by a qualified physician, in patients whose history and physical examination indicate the presence of somatic dysfunction of one or more regions.

Note: Osteopathic manipulative treatment specifically encompasses only the procedure itself. Evaluation and management (E&M) services are covered, as a separate and distinct service when medically necessary and appropriately documented.

Limitations

Osteopathic manipulative treatment is not covered when the indication of coverage is not met and conventional documentation of somatic dysfunction is not present in the patient's medical record.

Note: No E&M service is warranted for previously planned follow-up OMT treatments unless a new condition occurs or the patient's condition has changed substantially, necessitating an overall reassessment.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service; however, language may be included in the listing below to indicate if a code is non-covered. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
98925	Osteopathic manipulative treatment (OMT); 1-2 body regions involved
98926	Osteopathic manipulative treatment (OMT); 3-4 body regions involved
98927	Osteopathic manipulative treatment (OMT); 5-6 body regions involved
98928	Osteopathic manipulative treatment (OMT); 7-8 body regions involved
98929	Osteopathic manipulative treatment (OMT); 9-10 body regions involved

Diagnosis Code	Description
M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region
M99.06	Segmental and somatic dysfunction of lower extremity
M99.07	Segmental and somatic dysfunction of upper extremity
M99.08	Segmental and somatic dysfunction of rib cage
M99.09	Segmental and somatic dysfunction of abdomen and other regions

Definitions

Glossary of Osteopathic Terminology: The Glossary of Osteopathic Terminology is developed and revised by the Educational Council on Osteopathic Principles (ECOP) of the American Association of Colleges of Osteopathic Medicine (AACOM). The purpose of this osteopathic glossary is to present important and frequently used words, terms, and phrases that are unique or with special significance to the osteopathic profession. It is not meant to replace a dictionary. The glossary offers the consensus of a large segment of the osteopathic profession and serves to standardize terminology. The ECOP Glossary Review Committee specifically seeks to include those definitions that are uniquely osteopathic in their origin or common usage, distinctive in the osteopathic usage of a common word, and/or important in describing Osteopathic Principles and Practice (OPP)/OMT. (American Association of Colleges of Osteopathic Medicine, 2023)

Centers for Medicare and Medicaid Services (CMS) Related Documents

After checking the table below and searching the Medicare Coverage Database, if no NCD, LCD, or LCA is found, refer to the criteria as noted in the Coverage Rationale section above.

NCD	LCD	LCA	Contractor Type	Contractor Name
Osteopathic Manipulative Treatment				
N/A	N/A	A52435 Billing and Coding: Osteopathic Manipulative Treatment	Part A and B MAC	CGS
	L33616 Osteopathic Manipulative Treatment	A56954 Billing and Coding: Osteopathic Manipulative Treatment	Part A and B MAC	NGS

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

CMS Benefit Policy Manual

Chapter 15; § 30.5 Chiropractor's Services, § 40.4 Definition of Physician/Practitioner, § 240 Chiropractic Services - General

CMS Claims Processing Manual

Chapter 12; § 10 General, § 220 Chiropractic Services

Clinical Evidence

Friedman et al. (2025) performed a systematic review on the effectiveness of osteopathic manipulative treatment (OMT) for chronic low back pain and musculoskeletal pain in remote underserved populations. Using Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines, 26 relevant studies were included in the review. Primary outcomes were effectiveness of OMT for chronic low back pain (CLBP), improved functional outcomes, psychosocial improvements, and long-term sustainability. The review revealed high prevalence of chronic musculoskeletal pain, especially CLBP in remote communities. Many rural residents experience daily pain, often associated with physically demanding labor. OMT has been shown to reduce the intensity of pain and functional disability by improving muscle tension, joint mobility, and modulating pain pathways. Psychosocially, this reduced anxiety, depression and pain catastrophizing. Benefits from OMT lasted 12 weeks to 12 months and may help prevent relapse. The authors concluded that the reviewed studies suggest that OMT can be an effective therapy for CLBP when used appropriately and in the correct context. In the last 10 years, advancements in OMT research are reflected in the growing number of randomized placebo-controlled and descriptive studies, indicating an increasing body of evidence supporting its efficacy. With continued research, OMT, along with telemedicine and rural health education, has the potential to become a cornerstone of holistic care for rural populations, offering improved quality of life and better clinical outcomes. The authors report study

limitations including inconsistencies in methodology, reporting questionnaires, quality assessments, potential for bias and high heterogeneity in existing reviews. Due to the high heterogeneity of the included studies, a meta-analysis was unable to be performed.

Hartz et al. (2025) reported on a blind randomized clinical trial on the effect of osteopathic manipulative treatment on pain, flexibility, energy, autonomic modulation of heart rate, and thermal profile in patients with chronic low back pain (CLBP). Twenty-eight volunteers with CLBP were included in the study and were randomized into two groups: osteopathic manipulative treatment (OMTG) (n = 14) and placebo group (PG) (n = 14). Primary outcomes were pain evaluated by the visual analogue scale (VAS) and algometry, flexibility by the Wells bench, energetic profile by bioelectrography, autonomic modulation by heart rate variability (HRV), and thermal profile of the lumbar spine by infrared thermography. OMTG was given three sessions based on osteopathic evaluation and evaluated again immediately after the first session and one week after the last session. The PG received a simulated transcutaneous electrical nerve stimulation for the same period. A significant interaction was seen (analysis of variance) between group x time for the flexibility ($F = 7.5$; $p = 0.001$) and VAS ($F = 2.8$; $p = 0.05$), low frequency ($F = 3.5$; $p = 0.04$), low frequency/high frequency ($F = 3.6$; $p = 0.04$) and total energy ($F = 4.4$; $p = 0.01$). A significant increase of flexibility, VAS, L3 algometry and total energy was seen after the OMTG's intervention. Significant decrease of low frequency (LF) and low frequency/high frequency (LF/HF) post-intervention for OMTG was observed. The authors concluded that in patients with CLBP, OMT displayed positive effects for pain reduction, increase in flexibility, total energy, and parasympathetic activities. The authors reported study limitations including that a comparison with an active treatment group and long-term follow-up could provide more information to their findings.

Rehman et al. (2025) performed a systematic review and meta-analysis on osteopathic manipulative treatment in the management of headaches associated with musculoskeletal dysfunction. Primary outcomes included headache severity and frequency measured with validated measuring scales such as a numerical rating scale, disability associated with headaches measured with assessments such as the Migraine Disability Assessment, return to work (RTW), and quality of life measured with tests such as the Headache Impact Test. Harm outcomes included dropouts due to inefficacy, all-cause dropout (ACD) rates, and adverse effects. Eighteen randomized controlled trials (RCTs) were included in the review that compared OMT techniques, such as articulatory (ART), high-velocity low-amplitude (HVLA), and soft tissues (ST), to another form of treatment or a different type of OMT technique. Moderate quality evidence indicated that combined ART-HVLA [SMD = -0.61, 95 % confidence interval (CI) = -1.0 to -0.23] and ST HVLA-ART [SMD = -0.48, 95% CI = -0.83 to -0.13] effectively decreased headache severity. Also, moderate quality evidence indicated that the combined techniques of ART-HVLA (SMD = -0.43, 95% CI = -0.74 to -0.13) and ST-ART-HVLA (SMD = -0.62, 95% CI = -0.89 to -0.35) effectively decreased headache frequency. Moderate quality evidence indicated improvement in quality of life with combined ART-HVLA (SMD = 0.57, 95% CI = 0.14 to 0.99). Low quality evidence indicated insignificant associations of OMT with disability or harm outcomes (all $p > 0.26$). The authors concluded that their findings suggested that a combination of multiple types of OMT techniques effectively decreased headache severity and frequency and also improved quality of life. However, high-quality RCTs with large sample sizes using a various techniques and combinations of techniques are needed to further evaluate the effectiveness of OMT for headache management. Study limitations reported by the authors included that none of the eligible RCTs met all of the Cochrane risk of bias criteria, lack of power, small sample sizes, ten studies were published by a single investigative team, and there were not enough studies to evaluate RTW.

Popovich et al. (2024) reported on a single-blinded randomized controlled trial on the effects of osteopathic manipulative treatment on pain and disability in patients with chronic low back pain (LBP). Eligible participants (n = 80) were randomized to two trial arms: an immediate OMT intervention group and a delayed OMT (waiting period) group. The intervention consisted of 3-4 sessions of OMT over 4-6 weeks, after which the participants switched (crossed-over) groups. The primary outcomes were current pain, average pain, Patient-Reported Outcomes Measurement Information System (PROMIS) 29 v1.0 pain interference and physical function, and modified Oswestry Disability Index (ODI). Secondary outcomes included the Fear Avoidance Beliefs Questionnaire (FABQ) and the remaining PROMIS health domains. These measures were taken at baseline (T_0), after one session of OMT (T_1), at the crossover point (T_2), and at the trial's end (T_3). Only the outcomes obtained prior to T_2 were evaluated utilizing mixed-effects models and after adjusting for baseline values, due to the carryover effects of OMT intervention. Totals of 35 and 36 participants with chronic LBP were available for the analysis at T_1 in the immediate OMT and waiting period groups, respectively. Whereas 31 and 33 participants were available for the analysis at T_2 in the immediate OMT and waiting period groups, respectively. After one session of OMT (T_1), the analysis revealed a significant decrease in the secondary outcomes of anxiety and sleep disturbance compared to the waiting period group. After the entire intervention period (T_2), the immediate OMT group displayed a significantly better average pain outcome. The effect size was a 0.8 standard deviation (SD), showing that the reduction in pain was clinically significant. The improvement in anxiety also stood to be statistically significant. There were no study-related serious adverse events (AEs) reported. The authors concluded that in patients with chronic

LBP, OMT is effective and safe in decreasing pain while also improving sleep and anxiety profiles. The authors reported study limitations including lack of long-term follow-up.

Delgadillo et al. (2024) conducted a meta-analysis of randomized controlled trials on the efficacy of osteopathic manipulative treatment (OMT) for pain reduction in patients with patellofemoral pain syndrome (PFPS). The analysis included three studies. Primary outcomes were pain assessments, pre-treatment, and post-treatment follow-up of at least 30 days using a 10-cm visual analog scale (VAS). The mean difference in pain between OMT and no treatment (NT) groups using the random effects model was -3.95 (-6.39; -1.50) with a $p < 0.01$. The authors concluded that these findings suggested that OMT provided significant reduction in knee pain in patients with PFPS and is an effective treatment option in this population. However, a measure of heterogeneity (I^2), was found to be high at 97%, suggesting that these results should be interpreted with caution. Study limitations reported by the authors include minimal data points, lack of standardized OMT protocols, low number of trials, overall moderate amounts of bias, and high heterogeneity.

Liu et al. (2023) performed a systematic review and meta-analysis seeking to determine the effectiveness of manipulative therapy for chronic neck pain. Seventeen articles comprised of 1,190 participants with patients with chronic neck pain for more than three months in which manipulative therapy was the primary treatment were included. Primary outcomes were pain intensity measured by the Numberic Pain Rating Scale (NPRS) or the Visual Analog Scale (VAS) and neck disability assessed using the Neck Disability Index (NDI). Secondary outcomes were adverse events and medication use. The results showed that for overall effects of pain intensity, manipulative therapy resulted in significantly decreased pain intensity and disability when compared to exercise and control groups with no significant differences in adverse events reported. The authors concluded that despite high heterogeneity in treatment outcomes, manipulative therapy is effective in relieving chronic neck pain and disability. Future research should include the impact of patient selection and type of treatment on the heterogeneity of the treatment effects. The authors reported study limitations including that the quality of original studies widely varied, there was significant unexplained heterogeneity, and other factors like characteristics of patients and manual therapy may impact the outcomes of this study.

Chaudhuri et al. (2023) performed a systematic review and meta-analysis on physiotherapeutic interventions for upper cross syndrome. Upper cross syndrome is a postural dysfunction that can cause a variety of upper-body musculoskeletal problems. Primary outcomes were kyphotic angle, craniovertebral angle, and rounded shoulder. Secondary outcomes were neck range of motion, neck or shoulder pain, electromyographic activity of neck or scapular muscles, and functional limitations. Eighteen articles were included in the review. The postural variables including kyphotic angle, craniovertebral angle, and rounded shoulder displayed a significant improvement with the physiotherapy group compared to the no-treatment group [standardized mean difference = -1.78; 95% confidence interval (CI) = -2.68 to -0.87; $p = 0.0001$]. Secondary outcomes including pain and functional limitation revealed a significant difference when advanced manual therapy techniques were utilized compared to conventional therapy (standardized mean difference = -0.71; 95% CI = -1.04 to -0.39; $p < 0.0001$; and standardized mean difference = -0.57; 95% CI = -1.00 to -0.14; $p = 0.009$, respectively). Results showed that many manual therapy approaches, including active release technique, myofascial release, and muscular energy method, were beneficial in the treatment of upper cross syndrome. The short-term benefits of manual therapy over standard therapy were shown in several studies, and the effects on pain and functional outcome markers were discussed. Myofascial release technique in which sustained pressure is applied over the restricted fascia aids in relieving pain and movement restoration. Myofascial release technique in conjunction with stretching exercises produced better results than the technique alone. Muscular energy approaches showed greater effectiveness for both chronic and acute pain by increasing flexibility of contractile and non-contractile tissue and the stimulation of proprioceptors and mechanoreceptors compared to conventional stretching procedures. Myofascial rollers showed greater effectiveness than post-isometric relaxation therapy in pain reduction and postural alignment improvement. The authors concluded that their findings showed exercise therapy to be beneficial in correcting movement patterns and postural alignment and manual therapy showed to be similarly effective in functional improvement and reducing pain. The authors report study limitations including that in many studies, there was often a high to moderate risk of bias or it was unclear. Six studies had a high risk of bias, four had a moderate risk, three were unclear, and five were low risk. This resulted in a decreased level of confidence and reliability of the findings.

Satpute et al. (2022) performed a systematic review and meta-analysis on the efficacy of mobilization with movement (MWM) for shoulder conditions. Meta-analyses were conducted for the sub-category of shoulder pain and frozen shoulder with movement dysfunction to assess the effect of MWM in isolation or in addition to exercise therapy and/or electrotherapy when compared with other conservative treatments. Out of 25 studies, 21 were included in eight separate meta-analyses with primary outcomes for pain, range of motion (ROM), and disability in the two sub-categories. The addition of MWM significantly improved pain in frozen shoulder [standard mean differences (SMD) -1.23, 95% confidence interval (CI) -1.96, -0.51], flexion ROM (MD -11.73, 95% CI -17.83, -5.64), abduction ROM (mean difference -13.14, 95% CI -19.42, -6.87), and disability (SMD -1.50, 95% CI (-2.30, -0.7). The addition of MWM significantly improved pain in shoulder pain with movement dysfunction (SMD -1.07, 95% CI -1.87, -0.26), flexion ROM (mean difference -18.48, 95%

CI -32.43, -4.54), abduction ROM (MD -32.46, 95% CI -69.76, 4.84), and disability (SMD -0.88, 95% CI -2.18, 0.43). The authors concluded that MWM is associated with improved pain, function, and mobility in patients with various shoulder musculoskeletal disorders and the effects are clinically meaningful. Study limitations reported by the authors included that the majority of studies had high risk of bias due to their methodological weaknesses and did not assess long-term effects. Therefore, these findings need to be interpreted with caution.

Bagagiolo et al. (2022) performed an overview of systematic reviews (SRs) and meta-analyses (MAs) to summarize the available clinical evidence on the efficacy and safety of osteopathic manipulative treatment (OMT) for various conditions. The literature search revealed nine SRs or MAs conducted between 2013 and 2020, with 55 primary trials involving 3,740 participants. The SRs reported a wide range of conditions including acute and chronic non-specific low back pain (NSLBP, four SRs), chronic non-specific neck pain (CNSNP, one SR), chronic non-cancer pain (CNCP, one SR), pediatric (one SR), neurological (primary headache, one SR) and irritable bowel syndrome (IBS, one SR). Across the included SRs and MAs, the most common primary outcomes were pain intensity often measured by the Visual Analog Scale (VAS) or Numberic Rating Scale (NRS), functional status/disability assessed using various scales like the Roland Morris Disability Questionanaire (RMDQ), Oswestry Disability Index (ODI), or Neck Disability Index (NDI), and safety evaluated by reports of any adverse events. Although with a different effect size and quality of evidence, MAs reported that OMT is more effective than comparators in reducing pain and improving functional status in acute/chronic NSLBP, CNSNP and CNCP. No adverse events were reported in most SRs. According to AMSTAR-2, the methodological quality of the included SRs was rated low or critically low. The authors concluded that based on the currently available SRs and MAs, promising evidence suggests the possible effectiveness of OMT for musculoskeletal disorders. Limited and inconclusive evidence occurs for pediatric conditions, primary headache, and IBS. Due to small sample size, presence of conflicting results and high heterogeneity and questionable evidence existed on OMT efficacy for pediatric conditions, primary headache, and IBS. The available evidence is limited with overall poor-quality methodology and design, and diversity in reporting outcome measures. Therefore, no conclusions can be made regarding the relative efficacy, effectiveness, or safety of treatment. Study limitations reported by the authors were that since only randomized controlled trials performed by osteopaths or osteopathic physicians were included, some relevant systematic reviews could have been missed.

Santos et al. (2022) conducted a systematic review and meta-analysis to determine whether or not manual therapy (MT) causes postural changes. In March 2022, the authors performed a search in the PUBMED, Cinahl, Embase, PEDro, and Cochrane Central databases that yielded 6,627 articles, of which 38 including 1,597 participants were eligible; of these, 35 could be grouped into 12 meta-analyses. The risk of bias was assessed using the PEDro scale and the certainty in the scientific evidence rated through the GRADE system. The clinical trials included in this review used different doses of MT sessions, ranging from one to 18 sessions. The most frequently studied primary outcomes were forward head posture, pelvic alignment, thoracic kyphosis, shoulder protrusion, and flat valgus foot. When compared to no intervention or sham, in the short and medium term, MT reduced the forward head posture [14 studies, 584 individuals, 95% confidence interval (CI) 0.38, 1.06], reduced thoracic kyphosis (five studies, 217 individuals, 95% CI 0.37, 0.94), improved lateral pelvic tilt (five studies, 211 individuals, 95% CI 0.11, 0.67) and pelvic torsion (two studies, 120 individuals, 95% CI 0.44, 1.19) and increased plantar area (three studies, 134 individuals, 95% CI 0.04, 0.74). With moderate certainty, there was no significant effect on shoulder protrusion (five studies, 176 individuals, 95% CI -0.11, 0.61), shoulder alignment in the frontal plane (three studies, 160 individuals, 95% CI -0.15, 0.52), scoliosis (two studies, 26 individuals, 95% CI -1.57, 2.19), and pelvic anteversion (five studies, 233 individuals, 95% CI -0.02, 0.51). With low certainty, MT had no effect on scapular upward rotation (two studies, 74 individuals, 95% CI -0.76, 2.17). With low to very low certainty, it is possible to conclude that MT was not superior to other interventions in the short or medium term regarding the improvement of forward head posture (five studies, 170 individuals, 95% CI -1.39, 0.67) and shoulder protrusion (three studies, 94 individuals, 95% CI -4.04, 0.97). The authors concluded MT can be recommended to improve forward head posture, thoracic kyphosis, and pelvic alignment in the short and medium term, but not shoulder posture and scoliosis. MT reduces the height of the plantar arch. Further research is needed to determine the clinical relevance of these findings. The review was limited due to no study achieved blinding of therapists and only seven studies included blinding of participants. The nature of the interventions makes blinding difficult.

Dal Farra et al. (2022) conducted a systematic review and meta-analysis to evaluate whether osteopathic manipulative interventions can reduce pain levels and enhance the functional status in patients with non-specific neck pain (NS-NP). Five articles were included in the review, and none of these was completely judged at low risk of bias (RoB). Four of these were included in the meta-analysis. Primary outcomes included pain intensity generally measured by the Visual Analong Scale (VAS) or Numberic Rating Scale (NRS) and functional status, typically assessed through validated questionnaires, most commonly the Neck Disability Index (NDI). Osteopathic interventions compared to no intervention/sham treatment showed statistically noteworthy results for pain levels [ES = -1.57 (-2.50, -0.65); p = 0.0008] and functional status [ES = -1.71 (-3.12, -0.31); p = 0.02]. The quality of evidence was “very low” for all the assessed outcomes. Other results were presented in a qualitative synthesis. The authors concluded that osteopathic interventions could be effective for pain levels and functional status improvements in adults with NS-NP. However, these findings are affected by a very low

quality of evidence. Further research with randomized controlled trials is needed to validate these findings. Study limitations reported by the authors included wide inclusion criteria for the intervention and publication bias was not assessed.

Núñez-Cabaleiro and Leirós-Rodríguez (2022) conducted a systematic review to identify the manual therapy (MT) methods and techniques that have been evaluated for the treatment of cervicogenic headache (CH) and their effectiveness. Two reviewers independently screened 365 articles for demographic information, characteristics of study design, study-specific intervention, and results. The Oxford 2011 Levels of Evidence and the Jadad scale were used. Of a total of 14 articles selected, 11 were randomized control trials and three were quasi-experimental studies published from 2015 to the present that studied interventions with MT techniques in patients with CH. The primary outcome was cervicogenic headache characteristics assessed by intensity, frequency, and duration. The techniques studied were spinal manipulative therapy, Mulligan's Sustained Natural Apophyseal Glides, muscle techniques, and translatory vertebral mobilization. In the short-term, the Jones technique on the trapezius and ischemic compression on the sternocleidomastoid achieved immediate improvements, whereas adding spinal manipulative therapy to the treatment can maintain long-term results. The authors concluded that manual therapy techniques could be effective in the treatment of patients with CH. The combined use of MT techniques improved the results compared with using them separately. The authors report that the review has methodological limitations, such as the inclusion of quasi-experimental studies and studies with small sample sizes that reduced the generalizability of the results obtained. Further investigation is needed before clinical usefulness of this procedure is proven.

Terrell et al. (2022) conducted a two-group, randomized controlled trial (RCT) to determine whether a single session of osteopathic manipulative treatment (OMT) or OMT plus osteopathic cranial manipulative medicine (OCMM) can improve the gait of individuals with Parkinson's disease (PD) by addressing joint restrictions in the sagittal plane and by increasing range of motion (ROM) in the lower limb. A total of 90 participants, individuals with PD (n = 45), and age-matched healthy control participants (n = 45) were included in this RCT. PD participants were included if they were otherwise healthy, able to stand and walk independently, had not received OMT or physical therapy (PT) within 30 days of data collection, and had idiopathic PD in Hoehn and Yahr stages 1.0-3.0. Primary outcomes were lower limb ROM and joint angle waveforms. PD participants were randomly assigned to one of three experimental treatment protocols: a 'whole-body' OMT protocol (OMT-WB), which included OMT and OCMM techniques; a 'neck-down' OMT protocol (OMT-ND), including only OMT techniques; and a sham treatment protocol. Control participants were age-matched to a PD participant and were provided the same OMT experimental protocol. An 18-camera motion analysis system was utilized to capture 3-dimensional (3D) position data in a treadmill walking trial before and after the assigned treatment protocol. Pretreatment and posttreatment hip, knee, and ankle ROM were compared with paired t-tests, and joint angle waveforms during the gait cycle were analyzed with statistical parametric mapping (SPM), which is a type of waveform analysis. Individuals with PD had reduced hip and knee extension in the stance phase compared to controls (32.9-71.2% and 32.4-56.0% of the gait cycle, respectively). Individuals with PD experienced an increase in total sagittal hip ROM ($p = 0.038$) following a single session of the standardized OMT-WB treatment protocol. However, waveform analysis found no differences in sagittal hip, knee, or ankle angles at individual points of the gait cycle following OMT-WB, OMT-ND, or sham treatment protocols. The authors concluded the increase in hip ROM observed following a single session of OMT-WB suggests that OCMM in conjunction with OMT may be useful for improving gait kinematics in individuals with PD. Study limitations reported by the authors include assessing the effects of only a single session of OMT and OCMM on Parkinsonian gait, and no follow-up. To determine the clinical relevance of these findings, longitudinal studies over multiple visits are needed to determine the long-term effect of regular OMT and OMT+OCMM treatments on Parkinsonian gait characteristics.

Zhou et al. (2022) conducted a systematic review to highlight the therapeutic benefits osteopathic manipulative treatment (OMT) can have in the postoperative management of total knee arthroplasty (TKA) with respect to range of motion, edema, pain perception, and ability to perform activities of daily living. All manuscripts that were published in English in the past 30 years were included in this systematic review, with the earliest in 1996. Eighteen studies met inclusion criteria and encompassed a wide variety, with the majority of studies performed being prospective studies (n = 10), followed by case reports (n = 3), cross-sectional studies (n = 2), literature reviews (n = 2), and case-control studies (n = 1). Among the prospective studies, the sample sizes ranged from 43 patients to 621 patients. Two cohort studies were used with a sample size of 8,325 patients. All studies were examined to evaluate at least one aspect of postsurgical complication or sequelae as the quality of the study: primary outcomes were hospital stay, pain control, activities of daily living (ADLs), edema, and mobility. The authors concluded that the use of OMT would positively influence range of motion by manipulation of localized musculature and can result in decreased demand for analgesics. This can, in turn, shorten hospital stay and return the ability of patients to perform activities of daily living earlier than without OMT. Increased research is needed to strengthen these findings on the benefits of OMT in the postoperative management of arthroplasty. Long-term evaluations of the results and prospective randomized studies are still needed. Study limitations reported by the authors include that many studies did not explicity include osteopathic manipulative medicine (OMM) or OMT as a treatment modality. Therefore, there is insufficient evidence to determine the true role of OMM/OMT in post-TKA patients.

Nguyen et al. (2021) reported on a randomized, sham-controlled group trial comparing the efficacy of standard osteopathic manipulative treatment (OMT) versus sham OMT for reducing low back pain (LBP) in patients with nonspecific subacute and chronic LBP. Three hundred ninety four patients were randomized into two groups with a primary end point of reducing LBP which was measured with the Quebec Back Pain Disability Index (QBPDI). The experimental group received standard OMT; the sham control group received a priori inert procedure which consisted of light touch which stimulated OMT without stimulating physiotherapy or massage. Both groups received therapy for six sessions, two weeks apart. The mean QBPDI score for the standard OMT group was 31.5 at baseline and 25.3 at three months; and in the sham OMT group the mean score was 27.2 at baseline and 26.1 at three months. At 12 months, both groups experienced a decrease in pain however the standard OMT group reported increased pain relief. The authors concluded OMT had a slightly better clinical effect than the sham for patients with LBP. Study limitations reported by the authors included a focus on standard OMT only and large loss to follow-up.

Dal Farra et al. (2021) performed a systematic review and meta-analysis on the effectiveness of osteopathic interventions in non-specific chronic low back pain (NS-CLBP). Ten articles were included in the study. Studies evaluated osteopathic manipulative treatment (OMT, n = 6), craniosacral treatment (CST, n = 1), myofascial release (MFR, n = 2), and osteopathic visceral manipulation (OVM, n = 1). None of the studies were completely judged at low risk of bias. Primary outcomes were pain levels, most commonly measured by the Visual Analog Scale (VAS) and functional status, most commonly assessed through Oswestry Disability Index (ODI) or the Roland-Morris Disability Questionnaire (RMDQ). Findings showed that osteopathy was more effective than control interventions to decrease pain [effect size (ES): -0.59; 95% confidence interval (CI): -0.81, -0.36; p < 0.00,001] and improve functional status (ES: -0.42; 95% 95% CI: -0.68, -0.15; p = 0.002). Moderate quality evidence suggested that MFR is more effective than control treatments to decrease pain (ES: -0.69; 95% CI: -1.05, -0.33; p = 0.0002), even at follow-up (ES: -0.73; 95% CI: -1.09, -0.37; p < 0.0001). Low quality evidence suggested superiority of OMT in decreasing pain (ES: -0.57; 95% CI: -0.90, -0.25; p = 0.001) and in changing functional status (ES: -0.34; 95% CI: -0.65, -0.03; p = 0.001). Very low-quality evidence suggested that MFR is more effective than control interventions in functional improvements (ES: -0.73; 95% CI: -1.25, -0.21; p = 0.006). The authors concluded that their findings strengthen evidence that in patients with NS-CLBP, osteopathy is effective in pain levels and functional status improvements. MFR had better level of evidence for decreasing pain compared to other interventions. Additional high-quality randomized controlled trials, comparing different osteopathic modalities, are recommended to build evidence of higher quality. The authors reported study limitations including that data was not always retrievable or not presented in a modality that was useful to conduct a meta-analysis.

Reza et al. (2021) performed a randomized controlled trial containing a two-arm parallel-group with a total of (n = 32) individuals with known knee osteoarthritis. Group A received a supervised exercise protocol; and Group B received specified manual therapies in combination with a supervised exercise protocol. Pain intensity and functional disability were primary outcomes and assessed with the numeric pain rating scale (NPRS) and the Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC). The data was collected at baseline, 2 weeks, and 4 weeks post-intervention; all data was collected by the same assessor who was blind to the study. Group A was given specific strengthening exercises that included static quad knee extensions, standing terminal knee extension, seated leg press, partial squats, and step ups; stretching exercises included calf, hamstring and quadricep stretches. Group A performed 3 sessions every other day for two weeks. Group B received myofascial mobilization technique 10 times/session every other day for two weeks. The outcomes for NPRS and WOMAC demonstrated superiority for group B over group A. The authors concluded group B's interventions were found to be more effective than a group A's for improving the pain intensity and functional status of patients with knee osteoarthritis. Future studies are suggested to study the retention effects of the intervention protocols. Limitations included short intervention time frame, small sample size and no observation for long-term data. The study was limited, per the authors, due to the availability of the intervention protocols and the interventions not able to be carried out for a long period, such as 4 to 8 weeks. Future research is recommended to include studies that measure long-term effects and retention effects.

Groisman et al. (2020) reported on a randomized controlled trial assessing the effectiveness of OMT combined with stretching and strengthening exercises in the cervical region on patients with non-specific chronic neck pain. This single-blinded trial randomized 90 patients into two groups: either an exercise only group or an exercise group combined with OMT. The study included weekly exercise and/or OMT for 4 weeks. The primary outcomes were pain and disability which were evaluated by the Numeric Pain Rate Scale (NPRS) and Neck Disability Index (NDI). Secondary outcomes included Pressure Pain Threshold (PPT), range of motion, Fear-Avoidance Beliefs Questionnaire (FABQ), and Pain-self efficacy. The authors found the group that had received exercise combined with OMT had greater reductions in pain and disability than the group that received exercise only; this was evidenced by the lower NPRS and NDI scores. There were no significant differences in the secondary outcomes. Study limitations reported by the authors included lack of long-term effects, difficulty in blinding patients with osteopaths and those that received OMT had increased contact with osteopaths leading to potential placebo effect.

Iqbal et al. (2020) reported on a single blinded randomized controlled trial comparing the effects of the Spencer muscle energy technique (SMET) and passive stretching on 60 patients with idiopathic frozen shoulder or a stiff painful shoulder joint for at least three months. Primary outcomes were pain intensity using the Number Pain Rating Scale (NPRS), shoulder range of motion (ROM) measured with a standardized manual goniometer, and functional status assessed using Quick-DASH (Disabilities of the Arm, Shoulder, and Hand) and Shoulder Pain and Disability Index (SPADI) questionnaires. The participants were randomized into two equal groups. Group 1 contained patients that were treated with a hot pack for 7-10 minutes and then received the SMET; this was repeated 3-5 times with rest intervals over 3 sessions/week on alternate days for 4 weeks. Group 2 contained patients that were treated with a hot pack for 7-10 minutes and then received specific passive stretching (PS) exercises. The shoulder was stretched and rotated for 20 seconds with a ten second rest interval and then repeated ten times over the course of 3 sessions per week every other day. The SMET group had a mean reduction in pain of about five points and the PS group had a mean reduction in pain of about three points. Significant improvements in functional status were shown on the Quick-DASH score with a 27-point improvement in the SMET group compared to a 14-point improvement in the PS group. The SMET group showed a 30-point reduction in disability on the SPADI score, compared to a 19-point reduction in the PS group. The authors found that SMET was more effective than passive stretching for decreasing pain shoulder pain and increasing ROM. Study limitations reported by the authors included short duration of the study and the lack of appropriate registration with trial registry. It was concluded that future additional long-term RCTs are needed along with long-term follow ups.

Schwerla et al. (2020) evaluated the effectiveness of osteopathic treatments in 70 patients suffering from shoulder pain. Participants were randomized into either the intervention group that received osteopathic treatment or a control group (which remained untreated for eight weeks, but later treated with osteopathic treatment upon conclusion of the study). The main outcome was shoulder pain, and this was assessed using the standard visual analogue scale (VAS) for self-pain measurement. Secondary outcomes were specific shoulder pain and disability determined by the should pain and disability index (SPADI) and quality of life assessed by a SF-36 generic questionnaire. Participants in the intervention group received five osteopathic examinations and treatments of 40-60 minutes each delivered every two weeks for eight weeks. Before each visit and two weeks after the last visit, the VAS and SPADI were completed. The SF-36 generic questionnaire was completed at four and 10 weeks. The control group was required to fill out the VAS, SPADI and generic questionnaire at their baseline visit and then told they would be placed on the waiting list for osteopathic treatment to be scheduled eight weeks later. In both groups, on demand pain mediation was allowed. In the control group, 21 patients had no change in their pain and only eight patients showed improvement; in comparison the intervention group had a decrease in pain frequency for 33 patients. Secondary outcome measures had similar findings between the two groups; improvement in quality of life was seen for the intervention group but not the control group. The authors concluded osteopathic treatments over a defined period might be beneficial for patients suffering from shoulder pain, but further studies are needed to validate this finding. Limitations included the control group itself (receiving no treatment until after the study), small sample size and lack of long-term data.

Clinical Practice Guidelines

American College of Physicians (ACP)/American Pain Society (APS)

The American College of Physicians clinical practice guideline, “Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain (LBP),” recommends nonpharmacologic treatment including manipulative therapy as a first line approach for individuals with acute, subacute, or chronic LBP (Qaseem et al., 2017).

Clinical guidelines published jointly by the ACP and the APS for the diagnosis and treatment of low back pain recommend spinal manipulation for patients who do not improve with self-care options along with several other nonpharmacological therapies (Chou et al., 2017).

American Osteopathic Association (AOA)

The AOA’s guideline for osteopathic manipulative treatment (OMT) (2015, reaffirmed 2020) states that the American Association of Colleges of Osteopathic Medicine (AACOM) Glossary of Osteopathic Terminology defines OMT as, “the therapeutic application of manually guided forces by an osteopathic physician to improve physiologic function and/or support homeostasis that has been altered by somatic dysfunction.” Somatic dysfunction in one region may lead to compensatory somatic dysfunction in other regions. The glossary defines somatic dysfunction as, "impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial and myofascial structures, and their related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment. The positional and motion aspects of somatic dysfunction are best described using at least one of three parameters: (1) the position of a body part as determined by palpation and referenced to its adjacent defined structure, (2) the directions in which motion is freer, and (3) the directions in which motion is restricted." OMT can also be used to treat the somatic component of visceral disease and any organ system, which has the potential to manifest as changes in the skeletal, arthrodial and myofascial tissues. Somatic dysfunction is identified on the physical exam by one

or more elements of TART (Tissue texture changes, positional Asymmetry, Range of motion alterations, or changes in palpatory sensitivity, e.g., Tenderness). OMT is performed by a qualified doctor of osteopathic medicine (DO) or medical doctor (MD). The AOA guideline states that OMT is payable when somatic dysfunction is documented in the history and/or the physical examination. OMT is not payable when somatic dysfunction is not documented in the patient's history or physical examination.

National Institute for Health and Care Excellence (NICE)

In a 2016 guideline on low back pain and sciatica, updated in 2020, NICE recommends considering manual therapy (mobilization or soft tissue techniques such as massage, spinal manipulation) for the management of low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy.

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Policy History/Revision Information

Date	Summary of Changes
05/01/2026	**Related Polices** • Added reference link to the UnitedHealthcare Medicare Advantage Reimbursement Policy titled *Global Days Policy, Professional* **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information • Archived previous policy version MMP227.12

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

You are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate’s requirements need to be followed.