Codify
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Chiropractic Coding & Compliance Alert

Coding/Reimbursement: Learn How to String 97140 and CMT Codes Together

Hold on to your dollars with these 2 simple facts.

Still facing denials while billing manual therapy and chiropractic manipulation services together? It's time you learn about the endeavors of the American Chiropractic Association (ACA) in this area. Over two years, the ACA has diligently worked with Aetna to amend the policy that instantly denies manual therapy when billed with spinal manipulation. Get smarter with these tips on how to successfully bill 97140 (Manual therapy techniques [e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction], 1 or more regions, each 15 minutes).

97140: The Code That Is Manual Therapy

As per the CPT® position paper, "Manual therapy techniques consist of, but are not limited to, connective tissue massage, joint mobilization and manipulation, manual traction, passive range of motion, soft tissue mobilization and manipulation, and therapeutic massage." Also, 97140 stands for the hands-on therapy only.

Manual therapy may be used to relive pain, improve joint range of movement, reduce inflammation, improve tissue extensibility, and induce relaxation. Therefore, it works well on stiff joints, muscle spasm, pain, and scar tissue.

"I see it in one out of every five offices being used. I always make the provider aware about how to use it and encourage notes to be clear," says **Doreen Boivin, CPC, CCA,** with Chiro Practice, Inc., in Saco, Maine.

You may report 97140 for each 15 minutes of therapy, provided for one or more regions. So, for 30 minutes of therapy, you should report the code twice, one for each 15 minute interval.

Remember: If you spend less than 15 minutes in the therapy, remember to append modifier 52 (Reduced services)**.**

Coding Scenario 1: Different Dates of Service

In a typical scenario, the provider performs manual therapy to a body part. Now, the provider, on another day, performs chiropractic manipulation (98940-98943, Chiropractic manipulative treatment [CMT]; spinal...) to another body region. This is a clear cut case where the manual therapy technique is distinct and can in no way be considered a part of the chiropractic manipulation.

Coding Scenario 2: Same Dates of Service

Let's take another scenario when manual therapy and CMT are imparted to the patient on the same day. The provider therefore bills 97140 with modifier 59 (Distinct procedural service) in combination with CMT codes 98940-98943.

Know this: Conceding to ACA's persistent efforts, Aetna accepts reimbursement of these two services as appropriate, even when performed on the same date of service, provided the requisite documentation of medical necessity is in order. A number of claims have been being denied in the past that include properly documented manual therapy performed to a separate region.

Henceforth, make sure to submit documentation with these "same day" services to substantiate separate reimbursement for 97140-59, performed on the same day as CMT services, 98940-43. This will save you from having to file an appeal later.

Caveat: The CPT® coding guidelines support performing these procedures on the same date of service when they are performed to separate anatomic sites.

As the CPT® position paper on 97140 states, "Under certain circumstances, it may be appropriate to additionally report CMT/OMT codes in addition to code 97140. For example, a patient has severe injuries from an auto accident with a neck injury that contraindicates CMT in the neck region. Therefore, the provider performs manual therapy techniques as described by code 97140 to the neck region and CMT to the lumbar region. As separate body regions are addressed, it would be appropriate in this instance to report both codes 97140 and 98940. In this example, the modifier -59 should be appended to indicate that a distinct procedural service was provided."

Boivin explains this further: "Make sure your documentation is legible, accurate, and falls within the usage of a -59 modifier. It needs to be documented or it didn't happen."

Remember: Use modifier -59 only in cases in which the two procedures are performed on a different region of the body, or else get ready for a refund or future adjustments. Don't forget assertive documentation with medical records to that effect as well.