Coding and Billing Massage Therapy (97124) and Manual Therapy (97140)

When should manual muscle work be described as ‘Massage Therapy,’ and when should it be described as ‘Manual Therapy?’ Because these services are similar and often ‘look’ the same to someone untrained in this area, choosing the appropriate code can be difficult. The following information applies to either code:

**Description** – One-on-one constant attendance manual therapy services, timed codes, billed in 15-minute increments.

**Documentation** – Ensure that your exam and documentation indicate a subjective loss of mobility, loss of strength or joint motion, pain, soft tissue swelling, inflammation or restriction, etc. to support medical necessity. The treatment plan should indicate a direct functional goal or outcome resulting from this service. An example of a direct functional goal is, “Able to bend over to tie shoes by himself within two weeks.” These services should be documented by the person actually performing the service, using a clock to time in and out, regions treated, techniques used, and patient progress since the last visit. The daily documentation should be signed and dated by the person performing the service and countersigned by the doctor overseeing or delegating the service.

**DISTINGUISHING FEATURES:**

**CPT Code 97124 - Massage Therapy**

The AMA CPT (Current Procedural Terminology) 2013 edition describes 97124 as, “A Therapeutic Procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion).” Massage therapy may be included as a part of an active treatment plan, with specific deficits and goals, expected outcomes, and stated objective measures used to evaluate the effectiveness of treatment. Massage therapy goals, especially when used as a service preparatory to another treatment, may include restoring muscle function, decreasing specific stiffness, reducing documented edema, improving joint motion by degrees, or relieving muscle spasms. It’s also prudent to link specific diagnosis codes to the massage procedure for clarity. Be cautious of prescribing massage therapy for relaxation, stress relief and other clinically appropriate, but perhaps not medically necessary, reasons when seeking reimbursement from a third-party payer. Third-party reimbursement for massage therapy is highly scrutinized when prescribed over long periods of time—especially if there are multiple, non-specific units of time billed per session. When billed on the same visit as a chiropractic manipulative treatment code (98940-98943), carriers often require the -59 (or XS) modifier appended to the 97124 code to clarify that it’s a distinct and separate procedure being performed in a body region different from the adjustment. Because this is a timed code, indicate the number of units received by the patient.

**CPT Code 97140 - Manual Therapy Techniques**

The AMA CPT 2013 edition describes 97140 as, “Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage and manual traction), one or more regions, each 15 minutes.” Other descriptions include manual trigger point therapy and myofascial release. Manual therapy techniques can be used to treat restricted motion of soft tissues in the extremities, neck, and trunk. It is also used in an active and/or passive fashion to help effect changes in the soft tissues, articular structures, and neural or vascular systems. Manual therapy can be prescribed and performed based on functional goals of improved, pain-free range of motion and restoration of healthy function. An example is the facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened...
connective tissue. It may also be medically necessary when a loss of motor ability impedes function. Because this is a timed code, indicate the number of units received by the patient.

The National Correct Coding Initiative (NCCI) edits created by the Centers for Medicare and Medicaid Services (CMS) require that manual therapy techniques be performed on a separate anatomic site than the chiropractic adjustments in order to be reimbursed separately. Append the -59 or XS modifier to 97140 in order to indicate that it is a distinct procedure and is being performed in a different anatomic region than the chiropractic adjustment that day. If applicable, it may be of benefit to use diagnosis pointers in box 24E of your CMS-1500 form to indicate which diagnosis is related to which distinct service. For example, you might link your cervical CMT code (98940) to your cervical diagnosis and your manual therapy code (97140) to your lumbar diagnosis.

Some carriers and Medicare now require the modifier “X” series instead of the -59. Be aware that not all major medical payers have made the transition to the X modifiers. As a result, the -59 modifier is still currently deemed necessary by many of these payers. If appending an X modifier to a claim for a payer that still requires -59, the claim will be denied.

Practices should review payer policies to determine required modifier usage and carefully review individual line items for services on the Explanation of Benefits (EOBs) as they are received in order to ensure correct processing of claims. If X modifiers are required, the XS modifier will be the most commonly used in the chiropractic office. The XS modifier means, “Separate Structure: a service that is distinct because it was performed on a separate organ/structure or body region.”

Should a payer deny this service with a remark code that indicates 97140 was included in another service billed (98940 or 98941), we suggest you send a letter to the insurance company requesting reconsideration. Be sure to send your well-documented notes, as well as include the following information concerning the American Chiropractic Association’s (ACA) stance on the use of code 97140: Based on the ACA’s knowledge of the development and valuation process for CPT codes 97140 and chiropractic manipulative treatment codes, their stance is that CPT code 97140 is an independent procedure when provided to a different anatomic region than the procedure described as chiropractic manipulative treatment. When these procedures are billed together, the modifier “-59” is used to communicate that independent procedures not normally billed together were performed and medically necessary under the circumstances.

**Which Should I Use?**

During a study performed by licensed massage therapists who claimed to be performing BOTH manual therapy and massage therapy in the same session, observers were unable to tell the difference between the two services when the LMT changed from one to the next. This illustrates the point that the service might LOOK very similar, but the difference should be clarified in the documentation and the INTENT of each service is clearly different. 97124 is often prescribed for the friction-based, relaxation-type massage that may be less specific than 97140. With manual therapy, one would expect to see the services ordered to address the objective loss of joint motion, strength or mobility, and they must be part of an active treatment plan directed at a specific outcome. For example, stated goals could say, “97140 is prescribed to increase the flexibility of the quadratus lumborum muscles, while activating and stretching the hamstring muscles, to help improve the patient’s capacity for walking up to a mile and standing longer than one hour at their job as a cashier.” Daily, routine visit documentation of the two services should also include progress toward those stated goals.

Third-party payers often have a very specific medical review policy regarding both 97124 and 97140, and it’s critical that you are familiar with those rules. For example, some medical review policies indicate that the only time muscle work (97124 or 97140) is reimbursable is when the service is provided by the licensed DC, PT or MD. If the work is delegated to a licensed massage therapist or some other unlicensed provider, like a chiropractic assistant (CA), it’s not payable. For

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practices that bill both the 97124 and 97140 on the same visit, it is important not only to identify medical necessity as defined within this document but also to be clear in documenting the transition from one therapy to the other. Auditors have indicated that medical necessity is often not clearly demonstrated for 97140 when billed with 97124 since the notes for both services can appear identical.

If you intend to bill these services to a third-party payer, it’s important to get clarification when you call to verify the insurance benefits for the patient. Ask questions such as:

- Do you cover either 97124 or 97140 when the service is delegated to a licensed massage therapist?
- Does the policy require that the doctor performs service 97124 and 97140?
- Must I use the doctor’s NPI number when billing services 97124 and 97140?
- Is 97124 only covered when billed under the licensed massage therapist’s NPI number?

This coding conundrum applies to all types of providers. Unfortunately, some providers abuse the medical payment system for short-term gain by offering non-medically indicated massage and inappropriately seeking third-party reimbursement. In the long term, this damages the reputations of all providers and harms the majority of providers that carefully evaluate their treatment plans and only order manual muscle therapy when those services are clearly medically necessary.