



Chiropractic Associates of Minnesota, LLC

General Guidelines for the Performance of and Billing for Massage Therapy and Manual Therapy

I. Changes Effective July 1, 2005:

- A. CPT 97124 Massage: Only one (1) unit will be allowed per visit.
- B. CPT 97140 Manual Therapy: Only one (1) unit will be allowed per visit. The therapeutic value of massage therapy has come under scrutiny by current research and the insurance industry because it has not been proven to provide long-term therapeutic benefit. CAMN has been able to substantiate the allowance of one (1) unit of massage therapy - 97124 per visit if documentation justifies the necessity of the therapy performed. Because of the scrutiny massage therapy has come under, manual therapy - 97140 has also come under scrutiny. CAMN has substantiated allowing one (1) unit of manual therapy per visit if documentation justifies the necessity of the therapy performed.

II. These General Rules Apply to Soft Tissue Techniques:

- A. The time necessary to perform the procedures must be documented within the office notes.
- B. The technique used / performed must be documented within the office notes. This can range from massage, trigger point therapy, soft tissue manipulation, myofascial release, muscle energy techniques, and active release techniques.

III. The Following General Guidelines Need to be Documented Within the Subjective and Objective Portions of the Office Notes:

- A. The patient must have complaints through the region treated or the region treated must have a correlation to the patient's complaints.
- B. Documentation must consist of objective findings that warrant the necessity of this form of therapy. Information concerning palpatory findings includes groups of muscles or specific muscles being treated, describing the tone, texture, and tenderness.

C. Objective findings should not be limited to palpatory findings.

1. If a patient requires manual or massage therapy in addition to manipulation, there should be objective findings beyond palpatory findings to support the need for the additional therapy. It also assists in the review of the case. The more objective findings that are documented the easier it is to determine the response of the patient to the treatment. If only palpatory findings are documented, the only objective information available to determine improvement is the palpation. If observation, ROM, some ortho or neuro tests are documented then the improvement in these findings proves the benefit of the treatment.
2. It is the responsibility of the doctor, not the therapist, to document the necessity of care. The therapist should add additional documentation to the case from the findings they have during the massage or manual therapy. The ultimate responsibility lies with the doctor to prove necessity. Once the doctor determines necessity, based on subjective and objective findings, a referral of the patient to the therapist for a treatment occurs.
The therapist then performs the treatment to the region that the doctor referred the patient for. If the therapist goes beyond the treated region without doctor's orders this is considered a non-covered service.

For example, if the patient is presenting with low back pain on the right side and doctor documents tenderness and spasm through the right side of the lower back and pain in the right lumbosacral region with flexion, right lateral flexion and left lateral flexion and refers the patient for massage therapy and the massage therapist then documents spasms through the right erector spinae, through the glut, piriformis, TFL, and upper hamstring region along with left sided erector spinae spasm and tenderness, the only portion of this treatment that was referred to the massage therapist was the right lumbar treatment. Therefore, the treatment provided to the left lumbar, glut, piriformis, TFL, and hamstring would not be a reimbursable service. If the doctor would have stated there were complaints into the left lumbar, buttock and hamstring region and that there was generalized spasm and tenderness through the buttock and upper hamstring, and pain into this region with flexion and left lateral flexion then his referral would have included this area and would be a covered service.

3. This also applies to the problems through the neck and upper back region with radicular symptoms or pain extending into the thoracolumbar area, chest region or anterior cervical pain as well as posterior cervical pain.

IV. The Doctor Must Make a Specific Referral to the Massage Therapist in the Office Notes:

- A. It can be a simple statement such as patient was then referred to massage therapy for myofascial release or massage to the previously indicated regions.
 - 1. As stated earlier, the referral is for a specific region not a referral to be left up to the therapist's discretion.

V. Once the Appropriateness of the Massage Therapy or Myofascial Release is established:

- A. The questions to be answered are:
 - 1. The duration of treatment.
 - 2. The billing of that treatment:
- B. When performing a time based service it is important to recognize that 15 minutes must be spent in performing the pre-, intra, and post-service work. If less than 15 minutes is spent performing the service, the modifier –52 should be appended to the code, and the fee must be reduced to the appropriate fee. For example; If the time needed to perform the service is 5 minutes, the amount billed should be 1/3 of the billing for a full unit.

Special Note: The 8 minute rule is a Medicare rule and does not apply to CAMN policies. If you have questions please contact the CAMN Utilization Review Department.

VI. Once the Treatment Has Been Performed and Billed:

- A. We initially evaluate the code(s) / modifiers billed by the provider to make sure they match the amount of time documented in the notes that it took to perform the procedure.
- B. The next thing we do is evaluate, based on the subjective complaints and objective findings, the amount of area, the amount of muscles or groups of muscles that are involved and what would be an appropriate amount of time to perform the manual therapy or massage to this area.

VII. When Reviewing Cases, the Review Team Becomes Concerned When:

- A. The amount of time needed to perform manual or massage therapy on a patient is the same from visit to visit, even though the patient's condition changes or a new condition arises.
- B. The billing and time needed for all patients is the same, even when the conditions are different.
- C. Massage therapists are doing all of the documented soft tissue findings and the doctor fails to document any findings. Massage therapist's notes are very generalized and non-specific to the patient's condition.
- D. The massage or manual therapy appears to be a pre-manipulative procedure and part of the normal routine of the doctor.

VIII. For Continued Use of Massage or Manual Therapy:

- A. The doctor and therapist must document subjective and objective improvements of the patient's condition.
 - 1. This form of therapy will be considered a passive modality and criteria for multiple passive modalities being performed on patients will remain the same as it has been in the past.
 - a. Refer to the documentation guidelines of CAMN for details concerning the use of multiple passive modalities.

We hope these general guidelines give you more insight on how to document, perform and bill for manual therapy and massage therapy. If you have any questions, feel free to call one of the doctors on the Review Team.