Dynamic Chiropractic

BILLING / FEES / INSURANCE

Billing for Service to an Area Not Manipulated

Samuel A. Collins

Q: I have been requested to refund payments for 97140 services from Aetna insurance. They reviewed the files on 10 of my patients and now state that 97140 was improperly billed and reimbursed. Do I have to pay this back?

A: I have had several inquiries over the past six months on this issue, specifically regarding Aetna and Blue Cross Blue Shield, and it seems to be occurring with much greater frequency. As noted in a previous article in *Dynamic Chiropractic*, there is an increased level of audits by insurance carriers for medical claims. (This audit is not just for chiropractic, but all health professions, although our focus, of course, is chiropractic claims.) The request for review of records and request for reimbursement you received is part of this.

Before answering your question directly, we must address the core issues of 97140, manual therapy, which is commonly used in a chiropractic office for myofascial release, joint mobilization and/or manual traction. The services under this code are generally within the scope of practice for chiropractors in most states and may be used in conjunction with chiropractic treatment plans. As most are likely aware, the code 97140, when performed with chiropractic manipulative therapy, CMT (98940, 98941, 98942 and 98943), must be appended with modifier 59 to distinguish the services as separate. This is the crux of the problem with 97140, because when the 59 is used, the doctor is indicating that the 97140 service was performed to a separate region from the chiropractic manipulation. However, chiropractors most often don't perform the 97140 service to a separate region, but to the same regions they are manipulating. When this is the circumstance, the 97140 service is not separately reimbursable.

This rule comes from the Correct Coding Initiative Edits (CCI Edits) that define which treatment or diagnostic services are bundled; in other words, which services are not separately reimbursable when done together. Specifically, 97140 has this designation with a chiropractic manipulation in that it is considered integral and part of the overall global service of the chiropractic adjustment. This rule has been in place since the 97140 code came into existence in 1999. There have been a lot of arguments and angst on this topic, but the bundling rule remains essentially unchanged.

However, many (if not most) carriers would continue to pay for 97140 regardless of the regions, simply if it had the modifier. Bear in mind the carrier assumes that with the modifier, you are performing the 97140 service to an area not manipulated. This is where Blue Cross Blue Shield and Aetna are actively reviewing claims; hence your question.

Based on this, I have to pose two additional questions: Did you perform the 97140 service to the same region manipulated? If the service was to the same region, was the 97140 done to more regions than where the manipulation occurred? Your dilemma is that you must be able to demonstrate in your documentation that the 97140 service was done to a region not manipulated. If the adjustment was to the cervical spine and the 97140 service was to the thoracic, you would appeal this demand for repayment by demonstrating from your notes the differing regions of application. Proper documentation therefore will be the hallmark for protection against an audit of this type. When documenting 97140 services, the type (style or method) of service must be clearly

indicated along with the specific areas of application. Also considering that 97140 is a timed service, time spent performing it should also be documented. If you did not do a different region from manipulation, then Aetna is correct in its request for reimbursement.

If you did the same region, but also did a region not manipulated, it is possible you will not have to refund some or any of the fees paid. The key is that the regions of application are documented with time spent in each region. As long as adequate time is documented in the regions not manipulated and the units billed match that time, no refund would be due. The time or units applied to the same region may need to be refunded, based on the time and units billed in total. In any case, you must provide evidence to dispute and this should be from your chart notes, specifically the treatment plan and daily treatment notes. I have been worried about the 97140 code, and I have warned about its use in previous articles. Just because they pay with 59 does not mean it was correctly paid, and if the provider's notes cannot withstand a postpayment audit, there will be money going back. I have been involved in three such scenarios recently. In one, a doctor in Vermont was asked to refund a large sum for 97140 services. Fortunately, her treatment notes saved her from any refund, as she had specific documentation of the 97140 services being done to the gluteus and hamstrings while the adjustment was to the lumbar spine. At first the doctor was afraid that because her only diagnosis was to the lumbar, she was going to have to refund, but because she had additional documentation of the corresponding regions, Blue Cross Blue Shield backed away from its request.

In another case, Aetna audited a provider who billed a large amount of 97140 services with manipulation. In this case, most of the dates of service with 97140 were documented to regions not manipulated. However, there were several dates of service billed that were not in the chart, although the doctor swears they were legitimate and the patient was in the appointment log. Nonetheless, due to no documentation of the visit, those dates had to be refunded. There were also about 15 percent of the dates in which 97140 could not be differentiated from where the manipulation was applied, and those services had to be refunded. So, it does pay to do your own review, as these two doctors had audits by the insurance that stated all visits needed to be refunded.

The third example is a doctor who is a friend of mine and received a request for $175,000 for dates of service from 2005-2008. His issue is also mostly with 97140. Although we are actively looking and reviewing the file, there is no outcome yet. But imagine getting a letter requesting a refund of $175,000!

I am imploring all chiropractors to be very specific on documentation of their 97140 services. If they are not to a separate region from manipulation or a different date of service, do not separately bill for that service. Regardless of whether some may pay as long as the 59 modifier appears, you will be vulnerable to a postpayment audit and refund.

I am not in agreement that the work involved with doing the 97140 service (particularly when it takes 15-plus minutes to perform beyond the manipulation service) is included in the thrust or movement of manipulation, which is literally done in less than a second. I can imagine essentially nothing that would convince me the manipulation to a spinal region includes all the work that is done in myofascial release, manual traction or joint mobilization. However, my opinion is of no merit; the rule of the CCI edits stands until we can get it changed.

Of special note is that massage, 97124, does not require that you perform the service in a different region of the manipulation, but it does require modifier 59. The issue with massage is the medical necessity beyond the acute stages of care and whether the substitution of massage instead of myofascial release is the best medical decision. Please note: I am not stating to do myofascial

release and bill as massage, as that would be fraud. I am indicating that instead of doing myofascial release, massage could be substituted. The efficacy of the latter service is one for the doctor to decide with respect to if it can accomplish the goals of the treatment plan.

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