Best Practices in Clinical Record Keeping: Documenting Procedures

Introduction

Massage Therapists need to accurately record clinical information when providing or performing massage therapy services/procedures. Standards for Best Practices rely on these records to establish the clinical necessity and effectiveness of any given procedure, aid in the determination of member outcomes management, help with continuity of member care, and aid in the reduction of malpractice risk.

These services primarily include the following two CPT codes which are both time-based codes and require direct member-provider interaction:

- **97124 = Massage:** This code signifies a basic massage done by most massage therapists. It includes effleurage, petrissage and/or tapotement (stroking, compression, percussion). Skeletal adjusting in the same area on the same day may be denied unless modifier-59 is used. Even then, many insurance plans deny payment. The rule is often misused by insurance plans when a denial is made. Because 97124 may be considered a form of 'manual' therapy and so is skeletal manipulation, many insurers categorically deny both services when billed together considering it a 'duplication of service'.
    - This code must have time factors and should include location and specific type of massage performed.

- **97140 = Manual Therapy Techniques:** This code signifies a more complex type of soft tissue or manual therapy technique and may be performed by a DC, ND, LAc or a more experienced massage therapist. This code should not be combined with skeletal manipulation in the same area. This code may include but is not limited to the following: mobilization/manipulation, manual lymphatic drainage, manual traction, soft tissue mobilization, myofascial release, and trigger point therapy. Using this billing code requires documentation of the following 3 items:
    - Technique used must be clearly described, e.g. manual traction, myofascial release, soft tissue mobilization, active resistance, trigger point, etc.
    - Location of massage must be defined, e.g. with cervical, thoracic, lumbar, extraspinal muscles listed.
    - Time factors must be included.

Clinical documentation for these services should include a brief explanation of the necessity of the service, the nature of the procedure, e.g. massage, myofascial release, etc., location of application by region or segment (as specific as possible), duration and result.

In the event the CPT codes 97124 and 97140 are submitted for the same date of service, only 97140 will be reimbursed. A modifier is not allowed, as there are no circumstances in which both procedures should be paid for the same member on the same day by the same provider.

When billing any time-based modality or procedure, certain rules apply. While the AMA CPT Code Book defines time as a 15-minute unit, actual practice does not always fit such rigid parameters. Billing methods for time-based services, including these types of procedures allow for some flexibility, e.g. while one unit of time is 15 minutes, the individual service can vary between 8 minutes (just above the midpoint between 0 and 15) to 22 minutes (just below the midpoint between 15 and 30). Thus, a single unit of service may be billed when the involved time reaches 8 minutes. When multiple units of service are billed, only the last unit of service is subject to the range of time adjustment. All other units billed are based on the 15-minute definition. Two units of service would require 15 minutes for the first unit; the second unit could range between 8 and 22 minutes (total time of service would be from a low of 23 to a high of 37 minutes). Three units of service would require 30 minutes for the first two units; the third unit could range between 8 and 22 minutes (total time of service would be from a low of 38 minutes to a high of 52 minutes). The same method of calculation is used as additional units of modalities or procedures are added.

It is incumbent on the provider to document the time elements described above in such a manner that allows easy determination of when threshold parameters are met. Best Practice is to document both the start and stop times of the hands-on portion of treatment.