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## **About Coding for Insurance Billing**

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According to the number of phone calls and e-mails I have received from massage professionals across the nation, as well as a recent survey by the American Massage Therapy Association (AMTA), there are a variety of current procedural terminology (CPT) codes used by massage therapists for billing insurance. Many of those codes used are deleted codes, codes not in our scope of practice, codes that raise red flags with insurers, and codes used in conjunction with correct codes.

When I began billing insurance in 1984-85, I billed using code 97139 (an unspecified procedure code). I used the term "soft tissue manipulation," eliminating the words "massage or massage therapy." This worked fine for several years, until Blue Cross came upon the scene and only reimbursed \$12 for an hour-long session.

As always, I tried to find ways to get into the system. I searched for ways to increase income from those whose reimbursement was extremely low and find exposure for massage therapists in general. I began to practice with other codes. Workers' compensation in Florida -- as with most states -- was way behind the times when it came to coding, so I had to bill differently with them. Over the years, we expanded the codes we used and were reimbursed for.

I had always thought that we massage therapists would be content if we were allowed to use just a few codes and were decently paid. As time went on and reimbursement began to increase, we began to reduce the number of codes we experimented with to simplify things. Because I am a CEU provider for insurance billing seminars and home-study courses, I became a lot more conservative in order to protect you, who now bill insurance companies.

Now it is to the point where the procedure codes 97124 (massage) and 97140 (manual therapy techniques) are the only ones necessary for basic Swedish massage, myofascial release and manual traction. Because

reimbursement is now at a fair rate, many "techniques" are aspects of massage or myofascial release. Of course, there are always those codes for other modalities, which may be used if within a therapist's scope of practice, such as whirlpool, infrared, contrast baths, electrical stimulation, hydrotherapy, paraffin baths, etc. Be sure you know the scope of practice for the state you live in.

Insurers often want to only reimburse for a 15-minute segment of time, even though American Medical Association CPT coding descriptions indicate the codes are for each 15 minutes. Usually, four 15-minute segments of time are the maximum allowed for hands-on procedures. Documentation is the key to getting paid for time and codes used, along with following the prescriptions written by treating or authorized physicians.

As time goes on, I am sure coding changes or definitions will work more in our favor, but until then, let's use common sense. Do not go overboard; it only raises red flags with insurance companies, and can set us back many years. Stay strictly within your scope of practice and to what the physician writes on the prescription. Make sure your notes reflect what the prescription calls for and that your bills reflect both the prescription orders and your documentation.

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