Eli's Rehab Report

Manual, Mechanical Traction: How To Differentiate Between the Codes

Many physiatrists and therapists routinely use traction on their patients, particularly when treating herniated disks (722.0-722.2) and other causes of back and neck pain. However, coders must understand the differences between coding for manual traction (**CPT 97140**) and mechanical traction (97012). The diagnoses and policies for these two codes can vary greatly depending on the insurer, so coders must understand which codes to use and how often each therapy can be administered by Medicare's standards.

Private payers are cautious about reimbursing for extended periods of traction. For example, most of Aetna U.S. Healthcare's plans impose a 60-day annual limit on its therapy reimbursement coverage.

Manual traction is a "hands-on" therapy, administered directly by the therapist who is using his or her hands to deliver small amounts of force to the patient, allowing the space between spinal disks to enlarge and reduce any pain that patients may have due to disks being too close together or touching one another. Mechanical traction has the same goal of pain reduction, but instead of a therapist's hands placing force on the spine or limb, a machine is used.

Some coders will see "traction" on a therapist's notes and immediately bill 97012 (application of a modality... traction, mechanical), because it's the only PM&R code with "traction" in the main descriptor. However, manual traction should be billed as 97140 (manual therapy techniques [e.g., mobilization/manipulation, manual lymphatic drainage, manual traction], one or more regions, each 15 minutes).

Therapists who perform these modalities should write a complete description of what occurred during the session in their therapy notes, to document the activities performed and prove medical necessity. However, many coders complain that they receive therapy charts reading "traction, 15 minutes," and aren't sure which code to apply.

"If there is any reference to the patient being 'set up' to a machine, then you know that the traction is mechanical," says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H,** owner of A+ Medical Management and Education, a national coding and reimbursement school and consulting firm in Absecon, N.J. Manual therapy uses the therapist's hands, so no special equipment is necessary.

Because manual traction requires more of the therapist's time and hands-on skill, it reimburses more than mechanical traction. For example, 97140 brings in about $30 per unit; 97012 only pays about $22 per unit billed. In addition to a commitment to correct coding, this difference in payment is another important reason to code accurately for traction. The following tips can also help PM&R coders distinguish between the two forms of traction.

Manual Traction

"Our therapists are billing manual traction a few times a week for patients with back pain," says **Christian Thorpe,** billing and coding manager at Capitol Spine and Sports in Trenton, N.J "Several of our patients with cervical radiculitis (723.4) have been referred for at least two or three sessions of manual traction, and we have always been paid when using 97140." The problem, Thorpe says, is when manual traction is used for a period to treat the patient's condition and then is followed by sessions of other manual therapy techniques such as joint mobilization. "The insurer just sees that we are coding 97140 again and again, and occasionally we get denials based on the grounds that this much manual traction is unnecessary. The problem is that the insurer is aware that we have been performing manual traction for that patient, then they assume that all claims for 97140 are manual traction as well."

When other components of 97140, such as myofascial release or spinal joint mobilization, are performed at the same session as manual traction, the times should be added together and billed as additional 15-minute units of 97140. The

documentation must clearly demonstrate what modalities were performed during this session, since most insurers will not pay for five units of manual traction. They would probably be more willing to reimburse for two units of manual traction, two units of spinal joint mobilization and one unit of myofascial release, as long as each was medically necessary. In such cases, the coder would have an advantage by sending in the therapy notes with the claim, along with a cover letter explaining that different manual therapy techniques were performed during the session, and why the patient's condition necessitated such attention. This practice can "head off" unnecessary denials and save time.

Acceptable diagnoses for manual traction vary more widely among carriers than most PM&R codes. For example, Florida Medicare's policy states, "Manual traction may be considered reasonable and necessary if cervical radiculopathy is present and documented in the patient's medical records maintained by the provider." Other policies are more liberal, allowing payment for manual traction for conditions ranging from osteoarthritis (715.9) to pain in thoracic spine (724.1), lumbago (724.2), sciatica (724.3), unspecified backache (724.5) and other conditions.

Most carriers have broad policies for 97140, encompassing all of the components of that code (not just manual traction), so before billing for this service contact your carrier to determine if it has a more specific policy covering manual traction.

Code 97140 can be billed on the same date as a physiatrist's E/M code (99211-99215, established patient) or a physical therapist's evaluation (97001) because the codes are not bundled.

Mechanical Traction

Mechanical traction normally lasts from 15 to 30 minutes, and most policies allow payment of 97012 for up to four sessions per week for one month. Any treatment continuing past this time usually requires documentation supporting the medical necessity, unless mechanical traction is the only way a patient can adequately perform other therapies. For instance, if a patient has too much back pain to perform her therapeutic exercises, the therapist may administer mechanical traction to ease pain, so the patient can more comfortably do the exercises. In this case, bill both 97012 and 97110 (therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility).

In addition to the herniated disk codes (722.0-722.2), most carriers reimburse for 97012 with diagnoses for neck pain (723.1), torticollis (723.5), lumbar stenosis (724.02), low back pain (724.2), sciatica (724.3) and neck sprain (847.0), among other conditions. However, more conservative carriers, such as Florida Medicare, will reimburse for 97012 only if the patient has cervical or lumbar radiculopathy. You should get a copy of your carrier's policy in writing before coding for these services.

There are no CCI edits that preclude coders from billing 97012 along with a physiatrist's E/M code or a physical therapist's evaluation, so modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should not be necessary for these claims.