Codify
BY AAPC

Eli's Rehab Report

READER QUESTIONS: Get Confident With Your Modifier 59 Placement

Question: One of my therapists performed a suboccipital myofacial release with a patient for 10 minutes and charged for manual therapy (97140). Then she gave the patient mechanical traction for 15 minutes and charged 97012. I understand if they were separate and distinct procedures you can code 97140 with 97012 and append modifier 59. Which code, however, should get the modifier?

-- Wisconsin Subscriber

Answer: Based on what you wrote, and assuming the patient received no other one-on-one treatment you should append modifier 59 (Distinct procedural service) to the manual therapy code 97140. Here's how you know which code to attach it to on the claim form:

First, go to http://gawendaseminars.com/medicare_cci.aspx to easily access the most recent Correct Coding Initiative edits provided by the Centers for Medicare & Medicaid Services. Look for the relevant codes in the Excel file. When you find the code pair relevant to your situation, append the modifier to the code that appears in the second column (the one on the right-hand side).

In your case, manual therapy is mutually exclusive of mechanical traction if performed and billed on the same day to a Medicare patient receiving outpatient therapy services. By appending modifier 59 to the manual therapy code (97140), you are stating to your Medicare contractor that the therapist provided the services at separate and distinct times of each other and you want to be reimbursed for both services.

Careful: If you apply the modifier to the wrong code, you'll only get paid for that code, instead of both.