

[Insert Doctor's Letterhead]

[Template Appeal Letter Aetna CPT® code 97140 Manual Therapy Techniques]

[Insert Date]

[Insert Address]

Re: Patient name: _____ ***[Insert Date of Service]***
Claim #: _____ ***[Insert Claim #]***
Policy #: _____ ***[Insert Patient's Policy #]***
Group #: _____ ***[Insert Patient's Group #]***

To whom it may concern:

I reviewed your correspondence regarding the above named patient's treatment on ***[Insert Date(s) of Service]***. The ***[Select: letter/EOB]*** explains that payment for CPT® code 97140, *manual therapy techniques*, is not allowed based on McKesson "clinical edit clarifications." We were informed by Aetna that this edit was used to develop Aetna's policy change, implemented on March 1, 2013, which states "Currently, procedure 97140 is not recommended for separate payment when submitted with procedure 98940-98943. Modifiers 25 and 59 do not override this edit." However, CPT® coding guidelines **support** performing these procedures on the same date of service *only when they are performed upon separate anatomic sites* which is the case in this patient's treatment.¹

We understand that Aetna has communicated to the American Chiropractic Association that reimbursement of these two services is allowed when performed on the same date of service to separate regions if medical necessity is documented. Therefore, with this information in mind, I have attached a copy of my clinical record for the date(s) of service in question, and ***[Select: it/they]*** clearly indicate that these services were provided to **separate** body regions. The documentation also supports that these services were necessary because ***[Insert statement of medical necessity showing functional improvement achieved, or attempting to be achieved, related to original goals in treatment plan and diagnosis of condition in separate region]***.

If you should require additional information specific to this patient or appeal, please feel free to contact me at ***[Insert contact information for treating provider]***, otherwise please forward payment for the ***[Select: denied/reduced]*** services within 30 days.

Sincerely,

[Type Treating Provider's Full Name], D.C.

Enc: ***[Clinical record for [Select: this/these] date(s) of service – [Insert patient's name]***

cc: American Chiropractic Association

¹ CPT Assistant, Volume 9, Issue 3, March 1999