Managed care policy regarding OMT reimbursement illogical

To the Editor:
I am writing out of frustration over the lack of respect that the current healthcare system has for osteopathic physicians. I am currently in the middle of a drawn-out battle with two health management organizations (HMOs) over the issue of reimbursement for osteopathic manipulative treatment (OMT). One of the HMOs has contracted with a chiropractic organization to be the sole provider for manipulative services for their clients, effectively “locking out” osteopathic physicians. The other HMO has issued an official statement that recognizes osteopathic physicians as qualified to perform manipulation, yet refuses to reimburse for OMT procedural codes—a case of the “official statement” proclaiming one thing while policy indicates another.

I am a family practice physician who uses OMT daily because it is a part of my training and because I believe in its effectiveness. As a college student, I applied only to osteopathic medical schools because I agreed wholeheartedly with the philosophy and methods of practice. In contrast, some of my classmates held no esteem for anything osteopathic medicine had to offer and were only interested in becoming qualified to practice medicine. Fortunately such individuals were few and far between, and I never let them affect my aspirations.

After graduation, I saw the osteopathic distinction diminish, partly due to the camaraderie shared with fellow interns and residents, but mostly because OMT was not seen as cost-effective and therefore was not encouraged. Anyone who has been treated with OMT, or who applies the procedure, knows that, in the long run, it is inherently cost-effective.

Loss of distinction became more pronounced when I began private practice. Osteopathic physicians in my area are apathetic to the issue of OMT reimbursement, as most have accepted the status quo and have lost either their interest or skill involving the procedure. Some have told me that they would use OMT more often if it was reimbursed.

In an attempt to demonstrate to one of these HMOs the strength of osteopathic unity, I sent out 58 self-addressed, stamped letters to local osteopathic providers. Contained in the mailing was a form letter that indicated support for reimbursement for OMT services. The providers were asked to sign the letters and send them back to me so that I could forward them on to HMOs. The mailing was sent more than 3 months ago. I have received only 26 support letters as responses. Despite the fact that the only effort required of the osteopathic provider was a signature, the response rate was only 45%. It appears that in the osteopathic medical community, apathy runs deep.

Fortunately, my patients have far more interest in supporting this cause. I approached individual patients about this issue, asking them to sign a letter of support, and have been accommodated every time. In addition, I contacted my local congressional representatives, the American Osteopathic Association (AOA), the American Association of Family Physicians (AAFP), and some regional osteopathic internship programs, all of whom voiced support.

As I see it, the situation is as follows:
As managed care demands productivity, osteopathic physicians are experiencing increased workloads and decreased revenues. Additional time and skills are required to perform structural diagnosis and treatment. Therefore, unless OMT is reimbursed as a separate procedure, it becomes difficult, if not impossible, to administer OMT in a cost-effective manner to patients who would benefit from it, clearly a financial disincentive. However, if OMT is designated as a reimbursable procedure, it is likely that there would be an increase in its use and a subsequent decrease in such things as use of pain medication prescriptions, imaging studies, and referrals.

Osteopathic medicine has existed for more than 100 years, with a good portion of that time spent proving its equality with the allopathic profession. Perhaps we emphasized equality to the point of sacrificing our distinctness. I believe that the existence of osteopathic medicine faces a real threat, not of being forced out of the healthcare arena, but of giving in to elements that may strip away our uniqueness and allow us to be absorbed by the majority.
Yes, I am frustrated, but I am also immensely proud of the osteopathic medical profession and will continue to champion it. The resistance I have faced from managed care has caused me to become more determined and indignant. Part of the problem with the current healthcare environment is a lack of understanding of osteopathic medicine, with many viewing osteopathic providers as physicians who do manipulation “on the side.” What we need to make managed care (and for that matter, the general public) realize is that OMT is integral to the osteopathic philosophy and profession. Allowing osteopathic physicians to be providers but not recognizing OMT as a reimbursable procedure is not only illogical, but disrespectful. What is the exact argument against OMT managed care organizations offer? The fact that most HMOs cover chiropractic services indicates that they believe manipulation not only works, but is cost-effective. The fact that some managed care plans avoid reimbursing for OMT by contracting exclusively with chiropractic organizations for manipulative services further indicates the belief that manipulation is effective. As it is doubtful that any HMO director would say that osteopathic physicians are unqualified to perform manipulation, there is no problem on the effectiveness of treatment.

I will continue to work toward getting osteopathic medicine the recognition it deserves. Hopefully, continued pressures in the form of logical argument, advocacy by our patients, and advances in osteopathic research will favorably influence the healthcare system and give patients full access to what osteopathic medicine has to offer. I remain optimistic.

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Letters

Spirituality and end-of-life care

To the Editor:
The collection of articles in the October 2001 issue of the Journal of the American Osteopathic Association provides an excellent overview of the various aspects of end-of-life care; however, spiritual issues are given relatively brief attention.

We believe that spiritual care is the core issue of care for the dying. For thousands of years human beings of every culture have surrounded death with rites and religious considerations, reflecting a basic need to assume spirituality at the end of one’s life. Many patients near death welcome inquiry about their spiritual or religious beliefs, and it has been recognized that patients at the end of life may experience significant spiritual growth—facing death often causes one to question the purpose of life. As author John Hardwig said, “When I am dying, I am quite sure that the central issues for me will not be whether I am put on a ventilator, whether CPR is attempted when my heart stops, or whether I receive artificial feeding. Although each of these could be important, each will almost certainly be quite peripheral. Rather, my central concerns will be how to face my death, how to bring my life to a close, and how best to help my family go on without me. A ventilator will not help me to do these things, not unless all I need is a little more time to get the job done.”

It is important to be aware that for many dying patients spiritual issues and religious counsel will be the ultimate concern. As physicians we must assist terminally-ill patients with their spiritual issues and facilitate assistance from other sources who have the proper expertise. Treatment of terminally-ill patients that only attends to physical problems may ultimately be detrimental. For example, a tendency to focus on pain control and relief of anxiety with medications may diminish cognition and, therefore, hinder spiritual processes the patient desperately needs to complete, preventing the resolution of spiritual issues. Although we should never minimize the importance of alleviating physical suffering, if we are to treat the whole patient who is facing the end of life, we must assure that spiritual issues are also given proper priority.

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References

More on end-of-life care

To the Editor:
The excellent article by Kenneth M. Simon, DO, and Shannon A. Miller, PharmD, “Pain Management at the End of Life” (JAOA 2001;101:599-608) contains a paragraph that addresses potential pain management alternatives when the use of oral formulations is no longer feasible. I would like to address one major omission. Although transdermal fentanyl is included, the use of the buccal form of oral transmucosal fentanyl citrate (Actiq), available as a “lollipop,” is omitted.

This useful form of fentanyl depends on transbuccal absorption and has been useful when adjusting the dose of fentanyl patches with oral transmucosal fentanyl citrate (Actiq) for breakthrough pain, as well as for short-term administration before procedures or physical therapy that produce modest pain.

Physicians dealing with end-of-life care will find the buccal form of fentanyl a useful addition to their armamentarium.

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