Billing and Coding for Osteopathic Manipulative Treatment

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Some osteopathic physicians are not properly reimbursed by insurance companies after providing osteopathic manipulative treatment (OMT) to their patients. Common problems associated with lack of reimbursements include insurers bundling OMT with the standard evaluation and management service and confusing OMT with chiropractic manipulative treatment or physical therapy services. The authors suggest methods of appeal for denied reimbursement claims that will also prevent future payment denials.

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The current procedural terminology (CPT) manual is updated on an annual basis and includes new, revised, and deleted reimbursement codes. The National Correct Coding Initiative identifies what services are typically bundled with procedures. Medical insurance bundling is the process by which payers group separately identifiable charges, as defined by CPT, and then pay for the “bundled” group at a lower rate than the sum of the individual charges.

For example, before 1993, the CPT definition for critical care allowed insurers to bundle physician critical care charges with procedures such as cardiopulmonary resuscitation.1 Even though the language was changed to specifically state which services can be bundled, such as gastric intubation and ventilatory management, the American College of Chest Physicians1 and the American College of Emergency Physicians2 have reported that physicians may still be denied payment for providing nonbundled procedures (eg, cardiopulmonary resuscitation) with an emergency department visit or critical care service. Likewise, physicians may be denied payment for interpreting an electrocardiogram when billed with inpatient evaluation and management services, again, because before 1993, the services were bundled.3

Even when insurance companies appropriately reimburse physicians, they may later request a refund if a third party incorrectly audits the services provided.2 Various payers may also bundle additional services aside from those specified in the CPT manual. However, these additional bundles should be defined in provider contracts.

Such reimbursement issues present a unique problem for osteopathic physicians (DOs) of all specialties. Specifically, we have found that reimbursement for evaluating a patient before providing osteopathic manipulative treatment (OMT) has been challenging. The present report discusses common OMT reimbursement problems and identifies solutions for avoiding future denials from insurers.

Common Reimbursement Problems
Lack of reimbursement for OMT most often results from insurers bundling services or misunderstanding this unique treatment modality.

Bundling Services
Insurance companies use many excuses for bundling evaluation and management with OMT or other services or procedures, therefore paying for only one of the services. In most cases, simple education is all that is necessary for insurance companies to understand the nature of the OMT service as well as why a separate evaluation and management service is generally billed with CPT codes4 for osteopathic manipulation.

To begin, physicians typically assess patients (ie, provide evaluation and management services) and use patient history and physical examination to determine when OMT is appropriate for a patient. When OMT is provided, the evaluation and management service should be billed using the appropriate code (eg, 99212 through 99215) with a -25 modifier to indicate that a separately identifiable service was performed on the same day.4 Heidelbaugh et al5 offer simple tables to help physicians determine which evaluation and management code is appropriate for each patient visit.

However, many insurance companies target the -25 mod-
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Misunderstanding Manipulative Treatment

Insurance companies may confuse OMT with chiropractic manipulative treatment, which, according to CPT codes, “include[s] a pre-manipulation patient assessment.” Insurance companies may mistakenly believe that OMT codes also include patient assessment.

Beginning April 1, 2005, chiropractors were allowed to bill for evaluation and management services for neuromusculoskeletal conditions “when there is a new condition, exacerbation or recurrence of the current condition or for a reassessment midway through treatment.” We have personally experienced insurers using similar language when denying claims for OMT provided on the same day as an evaluation and management service. Although private payers are allowed to use this language for OMT according to public notification laws, federal contractors for the Centers for Medicare and Medicaid Services (CMS) who use this language are overtly ignoring the rules set by the CMS (Charles R. Booth, written communication, July 1994).

During billing and coding workshops, we spoke with many physicians who use codes for physical therapy manipulation (97140) or massage (97124) instead of OMT. Most insurance companies, including Medicare, put a limit on the use of physical therapy allowed each year. In addition, physical therapy codes have specific requirements in order to be used, such as having an active written treatment plan that includes goals and objective evaluations. In some regions, the requirements for physical therapy manipulation are more onerous.

Suggestions for Obtaining Reimbursement

To obtain proper reimbursement, it is crucial that osteopathic physicians understand OMT not only from the standpoint of a therapy option but also from a billing perspective.

Understanding OMT

In most cases, the decision to provide OMT is based on the physical examination, which is used to evaluate a patient for his or her compliant. If somatic dysfunction is found during a physical examination, then OMT may be used as a therapeutic option. To understand when OMT is needed, an explanation of somatic dysfunction is needed.

Somatic dysfunction is defined in the AOA-sponsored textbook Foundations for Osteopathic Medicine as follows:

Impaired or altered function of related components of the somatic (body framework) system: skeletal, arthrodial, and myofascial structures, and related vascular, lymphatic, and neural elements. Somatic dysfunction is treatable using osteopathic manipulative treatment.

The textbook further states that somatic dysfunction is “diagnosed by history and palpatory assessment of tenderness, asymmetry of motion and relative position, restriction of motion, and tissue texture change.”

Except for tissue texture changes, evaluation for somatic dysfunction is part of the standard musculoskeletal physical examination. As outlined by CMS, a complete single-organ system musculoskeletal examination consists of assessing the following elements:
Somatic dysfunction is documented based on the specific type of dysfunction found as well as the clinical scenario. For example, localized tenderness of the right third posterior rib angle in the absence of trauma or organic disease would apply to both regions. In the assessment portion, both the head and cervical regions and, thus, management of the dysfunction would also apply to both regions. In the assessment portion, both the head and cervical ICD-9-CM codes should be listed and billed. However, in the assessment portion, use of parenthetical descriptors such as “occipitoatlantal” should be avoided because they may be misinterpreted by reimbursement reviewers. For the upper and lower extremities, somatic dysfunction is bilateral. Therefore, if dysfunction is found in both arms, it will only count as one body region (ie, upper extremity).

Management of somatic dysfunction is specific to the findings present on physical examination. Therefore, to determine the appropriateness of OMT as a treatment option for an individual patient, a physical examination must be performed and properly documented. Physical examinations are medically necessary and are not considered part of the pre- or post-service of OMT. The exceptions to this rule are patients who are evaluated on one day and return on a different day specifically for OMT. In these patients, the need for OMT was predetermined. Barring any new or unrelated issue or perhaps an acute exacerbation requiring reevaluation, only OMT should be billed for the second visit in that scenario.

Billing

After recording the physical findings of somatic dysfunction during the objective evaluation of the patient, the physician should assess and document the body regions—rather than individual dysfunctions—in which somatic dysfunctions were found. These body regions and corresponding ICD-9-CM codes are presented in Figure 1. Because somatic dysfunction diagnoses are divided into 10 body regions, the treating physician may bill up to 10 total regions as long as physical findings are documented to support the diagnosis of somatic dysfunction for each region treated. Only one OMT code may be billed per patient visit.

Dysfunction at junctional regions that affects two or more regions, such as the occipitoatlantal joint and the thoracic inlet, should be recorded in the assessment as each region affected. For example, somatic dysfunction of the occipitoatlantal joint affects both the head and cervical regions and, thus, management of the dysfunction would also apply to both regions. In the assessment portion, both the head and cervical ICD-9-CM codes should be listed and billed. However, in the assessment portion, use of parenthetical descriptors such as “occipitoatlantal” should be avoided because they may be misinterpreted by reimbursement reviewers. For the upper and lower extremities, somatic dysfunction is bilateral. Therefore, if dysfunction is found in both arms, it will only count as one body region (ie, upper extremity).

Although these items are from the 1997 CMS Documentation Guidelines for Evaluation and Management Services,11 the 1995 documentation system12 allows for more subjective interpretation but can include these items as well.

Asymmetry, tenderness, and range of motion are of particular interest for DOs because these elements support the idea that the presence of somatic dysfunction should be determined as part of a standard physical examination. The majority of the components for an osteopathic “structural examination” are included in this musculoskeletal system examination. Other components of an osteopathic structural examination include a visceral abdominal examination, which is part of a standard gastrointestinal and abdominal examination, and evaluation of the lymphatic and circulatory systems, which are part of the standard lymphatic system and cardiovascular examinations, respectively.10,11

Findings of somatic dysfunction are documented based on the element of dysfunction found. Different findings will prompt the use of specific OMT techniques appropriate for the specific type of somatic dysfunction found as well as the clinical scenario. For example, localized tenderness of the right third posterior rib angle in the absence of trauma or organic disease is consistent with a right posterior third rib tender point.13 Osteopathic manipulative treatment uses specific techniques such as counterstrain or facilitated positional release to treat patients with this type of tender point.

Vertebral dysfunctions are most frequently recorded with reference to the relative freedom of the three planes of spinal motion.10 For example, a dysfunction may be documented as T4 PSR Rr. This nomenclature refers to the motion preference and positional asymmetry of the fourth thoracic vertebral segment (T4) as being flexed (F), sidebent right (Sr), and rotated right (Rr). It also implies motion restriction of the segment to extend, sidebend left, and rotate left. Such nomenclature should be documented to support the diagnosis of somatic dysfunction for each of the patient’s body regions that are eventually treated with OMT. A synopsis of the most commonly used nomenclature that describes the findings of the various somatic dysfunctions can be found in any of several reference books10,13-15 used for osteopathic manipulative medicine.

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<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Region of Somatic Dysfunction</th>
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<tbody>
<tr>
<td>739.0</td>
<td>Head (includes occipitoatlantal joint)</td>
</tr>
<tr>
<td>739.1</td>
<td>Cervical</td>
</tr>
<tr>
<td>739.2</td>
<td>Thoracic</td>
</tr>
<tr>
<td>739.3</td>
<td>Lumbar</td>
</tr>
<tr>
<td>739.4</td>
<td>Sacral/sacroiliac</td>
</tr>
<tr>
<td>739.5</td>
<td>Hip/pelvic</td>
</tr>
<tr>
<td>739.6</td>
<td>Lower extremity</td>
</tr>
<tr>
<td>739.7</td>
<td>Upper extremity</td>
</tr>
<tr>
<td>739.8</td>
<td>Rib</td>
</tr>
<tr>
<td>739.9</td>
<td>Abdomen</td>
</tr>
</tbody>
</table>

Figure 1. Documentation of somatic dysfunction by body region. Physicians should document the body regions in which somatic dysfunctions are found, as indicated in the ICD-9-CM codes, rather than individual dysfunctions. Source: Hart CH, Stegman MS, eds. ICD-9-CM Expert for Physicians. Vols 1 and 2. Salt Lake City, Utah: Ingenix; 2009:839-840.
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It is important for DOs to remember that the somatic dysfunction ICD-9-CM codes create medical necessity and justify the OMT CPT codes to be billed. In other words, physicians must document somatic dysfunction in examinations as physical findings and in assessments and plans as diagnoses in order to bill payers for OMT using the CPT codes.

Optimizing Documentation
Denied reimbursements may result when documentation fails to clearly establish the medical necessity of the evaluation and management services and OMT. For example, if the chief complaint is documented as “The patient is here for OMT,” then an insurance company may assume that the decision to perform OMT was planned before the visit. Instead, clearly state the patient’s chief complaint (ie, “The patient complains of low back pain”) along with any medical history relevant to the chief complaint.

Once an appropriate history is documented, the next step in establishing medical necessity is the physical examination. The 2009 CPT manual states that OMT is “a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders.” The physical examination must document any somatic dysfunction found, thus establishing the indication and creating the medical necessity for OMT.

Fighting the Good Fight
Some insurance companies may perform retrospective audits to detect overpayments or fraudulent billing patterns, such as double billing. If they determine that payments were made inappropriately, they may request a refund from the physician. Federal payers (eg, CMS) who perform an audit and find alleged overpayment for improper billing and coding practices withhold payment until a provider is proven correct in the appellate process. In the private payer setting, before refunding the money, the physician should fully research the reason for the requested refund. If there is any doubt about the appropriateness of the refund, the physician should demand that the carrier give a complete explanation for the requested refund. Physicians should check the provider contracts and state regulations to determine their responsibility regarding the requested refund. Many states and provider contracts have set time limits for detection and recovery of legitimate overpayment. Inappropriate requests, such as those that stem from improper bundling of services, should be appealed.

Perhaps as a result of physicians’ lack of time and opportunity to make appeals, in the first 9 months of 2005, insurance companies in the United States made $28 billion in profits18 over the course of the entire year made profits equivalent to the annual profit of the state of Nevada.18

In light of this information, physicians should take all incidents of inappropriate reimbursement for OMT very seriously and should actively pursue appropriate reimbursement for services provided. Diligent action on the part of the physician can decrease the total number of denials and refund requests from an individual insurance company while improving medical practices’ bottom lines.519 After all, processing appeals is time consuming for the insurance company as well. In our experience, physicians who conscientiously appeal each wrongful denial are less likely to be denied proper reimbursement in the future.

Fortunately, help is available. Physicians can contact their state osteopathic association or the AOA for assistance. In fact, the AOA has professional coding and reimbursement specialists who can contact insurance companies directly. Members of the AOA can find more information in Private Sector Advocacy under the “My Practice” tab on DO-Online.org. Alternatively, legal counsel can help physicians navigate the myriad rules and regulations surrounding billing and coding.

Physicians who have repeated problems with insurance companies bundling services should submit a complaint to the state or federal authorities. Physicians working together can help solve common billing problems.

Conclusion
Although physician-payer relations have improved from a reimbursement aspect—likely a result of numerous litigation efforts20—continued efforts are necessary to ensure lasting reform that will allow seamless prompt payment for physician services.

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References

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<thead>
<tr>
<th>CPT 2009 Codes</th>
<th>Body Regions Treated With OMT, No.</th>
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<tr>
<td>98925</td>
<td>1 or 2</td>
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<tr>
<td>98926</td>
<td>3 or 4</td>
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<tr>
<td>98927</td>
<td>5 or 6</td>
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<tr>
<td>98928</td>
<td>7 or 8</td>
</tr>
<tr>
<td>98929</td>
<td>9 or 10</td>
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</tbody>
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**Editor’s Note:** Osteopathic physicians can contact the American Osteopathic Association (AOA) coding and reimbursement specialists for assistance.

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