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BY AAPC

Part B Insider (Multispecialty) Coding Alert

D.O. Billing: E/M With Osteopathic Manipulation May Be Billable--If You Know the Rules

Avoid appending modifier 25 to all cases--instead, focus on medical necessity in the notes.

Because osteopathic physicians (DOs, or osteopaths) are fully licensed physicians who operate under the same licensing and certification rules as medical doctors (MDs), most of their billing matters are handled in the traditional manner. But because DOs also perform osteopathic manipulative treatment, or OMT (98925-98929), many coders have trouble distinguishing between OMT and chiropractic manipulative treatment (CMT, 98940-98943) or manual therapy techniques (97140).

Coders who bill for osteopathic services should remember to treat OMT as any other procedure or modality: If it's performed with an E/M service (99201-99215, outpatient), the E/M code should be appended with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service).

Clearing the Issue: OMT vs. CMT

One common mistake that coders who are new to DO claims make is when they confuse the OMT codes with the CMT series. But CPT clearly states that OMT services are to be performed by physicians, noting, "OMT is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders."

Fully licensed physicians who perform manipulation techniques should report their services using OMT codes. Chiropractors who perform manual therapy can bill the CMT codes, and therapists usually bill 97140 for this type of therapy. Keep in mind that individual states have their own licensure requirements for which practitioners may perform manipulation. What qualifies an MD to perform manual therapy is a matter of state licensure, and some states have stricter requirements than others.

OMT Does Not Include the E/M Service

Another of the biggest coding and reimbursement misconceptions regarding OMT billing is that there is an E/M included in the OMT. In reality, however, a separately identifiable E/M can be reported under CCI rules, as long as the documentation reflects the separate nature and a modifier is used. Practices that aren't billing for the OMT and the E/M separately may be losing out on reimbursement owed to them.

CPT's introductory notes before the OMT codes states, "The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for the reporting of the OMT and E/M service on the same date."

Same-day OMT and E/M

Suppose an established patient presents to the physician complaining of a new case of lateral epicondylitis (726.32) and the DO performs a level-three E/M visit to evaluate the problem, followed by an OMT of the patient's left arm. He should code the visit using 99213-25 for the E/M and 98925 for the OMT.

Don't abuse it: OMT is not performed at every visit to a DO. If a patient presents to the DO because she's recovering from a stroke, the DO might just perform an E/M and determine the patient's status, checking for improvements and ensuring that the current plan of care is working, but he may not perform an OMT.

Likewise, some patients may not need an E/M service at every visit. You can bill an OMT alone, without an E/M visit. It should be billed as any other procedure would be.

Case in point: Last spring, a DO in Connecticut had to repay $379,764 back to the government after improperly billing E/M services with 95 percent of his OMT claims. When the government reviewed the doctor's records, its analysts concluded that he often had "no documentation of a significant, separately identifiable reason for the patient's visit (i.e., the patient was there only for regularly scheduled OMT services)," and in fact most records lacked documentation of any E/M service being performed at all.

Watch Your Units

Coders should note that different OMT codes exist for billing between one and 10 body regions. Therefore, if the physician's chart reads, "OMT to lumbar, sacral, leg and pelvic regions," the coder should not record the visit as 98925 X 4. Instead, the practice would report 98926, which covers OMT for three to four body regions.