

## Eli's Rehab Report

### Billing for DOs: E/M Is Not Included in OMT Codes

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 its performed with an evaluation and management (E/M) service ([CPT 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 confusing the OMT codes with the CMT series. But, says Boyd Buser, DO, associate dean for clinical affairs at the University of New England College of Osteopathic Medicine in Biddleford, Maine, and the American Osteopathic Associations representative to the CPT Advisory Committee, CPT clearly states that OMT services are to be performed by physicians.

Fully licensed physicians who perform manual therapy techniques should report their services using OMT codes, Buser says. Chiropractors who perform manual therapy can bill the CMT codes, and therapists usually bill 97140 for this type of therapy. He points out, however, 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. For example, the state of Washington specifically prohibits MDs from performing spinal manipulation, but in most other states, they probably could.

#### OMT Does Not Include the E/M Service

The top coding and reimbursement misconception regarding OMT billing is that there is an E/M included in the OMT, says **Yolanda Malone, RHIA**, manager of payer relations at the American Osteopathic Association in Chicago. Practices that aren't billing for the OMT and the E/M separately may be losing out on reimbursement owed to them.

Physical medicine practices familiar with chiropractic manipulation codes know that they already include a patient pre-assessment, which often precludes billing a separate E/M service. OMT codes, however, do not include any such language in their descriptors, and any E/M services performed the same day as an OMT should include modifier -25 to ensure proper reimbursement.

#### Same-day OMT and E/M

When the OMT codes were first introduced in CPT 1994, we had extreme difficulty getting paid for the E/M and an OMT on the same date of service because many of the payers thought the evaluation was included in the OMT code, Buser says. Even after HCFA issued a clarification memo stating that E/Ms should be billed with the -25 modifier, many carriers interpreted that by saying that the OMT should be for a separate problem. But in 1999, we met with the CPT editorial panel and new language was added to the introductory notes to the OMT section of CPT, stating that separate diagnoses are not required for an E/M and an OMT on the same date.

For example, if an established patient presented to the physiatrist complaining of lateral epicondylitis (726.32) and the DO performed a level-three E/M visit and an OMT of the patients left arm, he or she would code it using 99213-25 for the E/M and 98925 for the OMT.

In addition, Malone says, there are still DOs who are having problems with payers who don't know what an OMT is. We've worked hard with HCFA to recognize the codes, Buser says, but smaller payers may still give DOs difficulty when billing OMT and E/M services together.

The solution, Buser says, isn't asking patients to come in for an E/M on one day and to return for their OMT another day. The real issue is making sure that your insurer recognizes what an OMT is, and that it may be used with modifier -25. Write letters to these insurers so they begin to recognize modifier -25 with these claims.

### **OMT Not Performed at Every Visit**

Malone also clearly states that OMT is not performed at every visit to a DO. It's not true that a DO performs a manipulation every time he or she sees a patient, Malone says. If you go to the DO because you're recovering from a stroke, the DO might just perform an E/M and determine your status, checking for improvements and ensuring that the current plan of care is working, but he or she may not perform an OMT.

Likewise, Malone says, 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.

And as with any other procedure, if an OMT is performed along with other services, those can be reported separately. If an OMT, an E/M and a bursa injection (20600-20610) were performed on the same day, you would bill all three codes, with a modifier -25 for the E/M, Buser says. Modifier -59 (distinct procedural service) would not be necessary, since there isn't a Correct Coding Initiative (CCI) edit prohibiting you from billing the injection and the OMT together, although Medicare would probably reduce payment for one of the procedures because the claim would be subject to the multiple procedure reduction.

The CCI, however, does prohibit practitioners from billing OMT codes along with the manual therapy code 97140 because all manual therapy provided by the physician is included within the OMT codes. Coders should note that modifier -59 is not effective with OMT and 97140; if used together, one of the two codes will be rejected, regardless of whether modifier -59 is present.

### **MD/DO Visits on Same Day**

Suppose a multiple sclerosis (340) patient visits with her neurologist (an MD) in the morning, and the neurologist refers the patient to a physiatrist (DO) in the afternoon? The DO would bill a consult code (99241-99255) for the referral, Buser says, even if the neurologist and physiatrist were both DOs, as long as medical necessity and the documentation requirements of a consultation were met.

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.

**Note:** This article is the fourth and final installment in our series examining how to organize the coding process when a practice reports for practitioners other than MDs. Previous articles in the series covered billing issues for chiropractors, physical therapists and occupational therapists.