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Demystifying Documentation and Billing for Osteopathic Manipulative Treatment

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Osteopathic manipulative treatment is indicated for several common ailments, but documenting and coding it can be daunting for beginners. Here's how it's done.

Osteopathic manipulative treatment (OMT) is a procedure used mainly by doctors of osteopathic medicine (DOs) for a range of medical conditions. For instance, there's evidence OMT can decrease pain and analgesic use in patients with chronic low-back pain and pregnancy-related low-back pain, can ease postoperative gastrointestinal issues, and may improve outcomes for elderly patients hospitalized with pneumonia.[1-4] Because of the commonality of these conditions, and others for which OMT is indicated, some allopathic physicians (MDs) have also sought training in this skill.

OMT CODING

Dysfunctional body region	ICD 10 code
Head	M99.00
Cervical	M99.01
Thoracic	M99.02
Lumbar	M99.03
Sacral	M99.04
Pelvic	M99.05
Lower extremity	M99.06
Upper extremity	M99.07
Rib cage	M99.08
Abdomen/viscera	M99.09

Number of treated body regions	CPT code
1-2	98925
3-4	98926
5-6	98927
7-8	98928
9-10	98929

But there is often confusion about how the procedure should be billed and reimbursed, particularly among physicians who are new to it. Institutional coding and compliance departments have used surgical compliance codes to determine that OMT has a surgical code of zero, which is considered a minor procedure. That means it can be billed the same day as an evaluation and management (E/M) office visit. But Centers for Medicare & Medicaid Services (CMS) guidelines for precepting procedures indicate that a minor procedure takes less than five minutes. It always takes longer than five minutes to do an evaluation and OMT treatment (though there does not need to be long-term follow-up as part of a global encounter as in other surgical procedures), so this gets complicated. Insurance companies often inappropriately bundle the OMT code with the E/M service or eliminate the E/M code altogether.[5] Not receiving appropriate reimbursement for OMT could lead physicians to no longer offer this beneficial service to their patients. That would be unfortunate, in part because OMT could be an alternative to opioids for chronic pain, reducing the billions of dollars that opioid misuse costs the U.S. economy every year.[6]

This article seeks to cut through the confusion and clarify documentation and billing requirements for OMT so more patients and health systems can benefit from it.

CODING AND DOCUMENTING OMT

OMT is billed based on the number of body regions treated. For purposes of OMT, there are 10 body regions, with ICD-10 codes corresponding to the dysfunction of each region. There are then five CPT codes that can be used depending on the number of regions treated. (See "OMT Coding.") Only one OMT service should be billed per day.

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For structures that cross body regions (e.g., psoas muscle or thoracic inlet), it is important to be consistent about which region you document as dysfunctional. If you occasionally document treatment of the psoas muscle as the lumbar region (where it originates), but sometimes document it as the lower extremity (where it inserts), that could cause a mismatch in your diagnosis codes and procedural codes.

Here's a quick example of the documentation for a common OMT indication,

KEY POINTS

- Osteopathic manipulative treatment (OMT) is indicated for a variety of conditions, but physicians may be confused about how to code and document OMT to get properly reimbursed.
- OMT can often be performed — and billed — with an evaluation and management (E/M) office visit.
- Documentation should support the medical necessity for the OMT, including identifying the somatic dysfunctions to be treated, and should also include the number of body regions treated, the technique, and the outcome.

neck pain: "Somatic dysfunction of cervical spine — hypertonic posterior cervical muscles, right > left, C4-C5 neutral, rotated right, side bent right (NRrSr)."

Every time physicians assess a patient for OMT, they must perform an examination, including history and physical. Unlike some procedures, the patient's response to OMT can be assessed immediately and the physician can note if there is improvement, without the need for a follow-up visit. Therefore, it is possible to bill an E/M code plus a procedure code with nearly every OMT visit.

> Make sure there's an osteopathic procedure note that can stand alone in the documentation.

Make sure there's an osteopathic procedure note that can stand alone in the documentation. You can add the procedure note to the end of your usual subjective, objective, assessment, and plan (SOAP) note. It should include a list of the dysfunctional regions, treatment techniques used, and the patient's response to treatment. (See "Osteopathic procedure note example.")

CODING OMT WITH AN E/M VISIT

As of January 2021, there are new guidelines for E/M codes 99202-99215 (99201 has been deleted).[7] Visit level can now be determined based on either medical decision making (MDM) or total time. When billing based on total time, you may include all time devoted to the visit on the date of service, but you may not include time spent on procedures, such as OMT, if you're billing separately for them.

Modifier -25. Under CMS rules it may be appropriate to bill an E/M service on the same day as a procedure, including OMT. The E/M service should be a separately identifiable service above and beyond what is normally included in the procedure. For example, if a patient presents for an E/M visit because of a common wart, the evaluating clinician could determine it is, in fact, a wart (an E/M service) and then offer cryoablation treatment (a procedure) for it on the same day. Documentation for the E/M portion of the visit would have to meet the criteria of either MDM or total time for the level of service billed. The clinician would then append modifier -25 to the E/M code to note that a procedure or other service occurred on the same day, and include the CPT code for cryoablation.

It's similar when you combine OMT with an E/M visit. Let's go back to the example of a patient with acute neck pain. The exam confirms the pain is due to muscular hypertonicity (an E/M service), so you perform OMT to address the cause of the pain. The patient complaints and symptoms support your evaluation and determination for using OMT, and the documentation would support the E/M service. To code this visit, you might use E/M code 99213 based on MDM (one acute uncomplicated injury with low risk of morbidity from additional diagnostic testing/treatment), append modifier -25, and then add CPT code 98925 for OMT of 1-2 body regions. (For more examples, see "Coding common OMT visits.")

Modifier -59. There are some occasions when you might use modifier -59 in addition to modifier -25 when performing OMT and E/M at the same visit. Essentially, modifier -59 is added for procedures/services not typically performed together, but appropriate under the clinical circumstances. For example, if you provide an OMT service (98925-98929), an E/M service (99202-99215), and an IV infusion (96361-96368) on the same day, you would add modifier -25 to the E/M code and modifier -59 to the IV infusion code. Your payers may have their own policies on modifier -59, though, so check with them.

OSTEOPATHIC PROCEDURE NOTE EXAMPLE

Somatic dysfunction of body region: cervical spine — hypertonic posterior cervical muscles, C4-C5 NRrSr; thoracic spine — thoracic inlet NRrSl, T3-T4 NRrSl; lumbar spine — hypertonic paraspinal muscles.

Techniques: soft tissue, myofascial release, and facilitated positional release (FPR).

Response: Patient's symptoms improved; somatic dysfunctions improved.

Follow-up: as needed.

CODING COMMON OMT VISITS

Osteopathic manipulative treatment (OMT) procedures may be performed with or without an evaluation and management (E/M) office visit. Here are some common OMT scenarios and how to code them.

Visit type	Example	Coding
E/M visit for new problem, plus OMT procedure.	Patient presents with central low-back pain after slip on ice. Physician evaluates and finds no structural red flags but does find left superior innominate dysfunction. Treats with OMT on five body regions and symptoms improve.	E/M code (based on level of service) plus modifier -25 and 98927 (for OMT on 5-6 body regions).
Follow-up E/M visit for existing problem previously treated with OMT, but with new or different symptoms.	Patient follows up two weeks after initial treatment for low-back pain. Pain recurred but is now more lateral on left lower back. Physician evaluates patient and finds no structural red flags but does find left hypertonic iliolumbar ligament dysfunction. Treats with OMT on three body regions and symptoms improve.	E/M code (based on level of service) plus modifier -25 and 98926 (for OMT on 3-4 body regions).
Visit for scheduled OMT treatment and evaluation of a separate concern.	Patient presents for follow-up OMT visit and complains of two days of nasal congestion, sore throat, fever, and cough. History and exam were done. Patient diagnosed with an upper respiratory infection. OMT was also performed on six body regions.	E/M code (based on level of service) plus modifier -25 and 98927 (for OMT on 5-6 body regions).
OMT procedure for existing problem (no E/M visit).	Patient follows up four weeks after treatment for low-back pain that improved but did not resolve with previous OMT. Pain has not worsened since last OMT. Physician again finds left hypertonic iliolumbar ligament dysfunction. Treats with OMT on three body regions and symptoms improve.	Only bill 98926 (for OMT on 3-4 body regions).
OMT procedure for new problem (physician previously completed osteopathic exam but did not have time to perform OMT that day).	Patient presents with central low-back pain after a slip on the ice. Physician evaluates patient and finds no structural red flags but does find left superior innominate and several other somatic dysfunctions that are documented in that encounter. Did not treat with OMT. Patient returns the following day for OMT on five body regions and symptoms improve.	E/M billing on initial visit, then only bill 98927 (for OMT on 5-6 body regions) for the second visit (during which OMT was performed).

DOCUMENTING AN E/M VISIT WITH OMT

There are a number of things physicians should know when documenting E/M visits that include OMT.

When combining OMT with an E/M service, the chief complaint the rooming staff enters for the visit should not be OMT, but rather the patient's problem or concern (e.g., headache, low back pain, or concussion). If staff enter OMT in this field, it will indicate that the visit was a previously planned procedure and, therefore, you should not bill any E/M services.

When you're combining OMT with an E/M visit, your documentation must support the E/M level and include the somatic dysfunction of the body regions on which you performed OMT.

Here's an example of documentation for an E/M visit with an OMT procedure, coded based on MDM:

Patient is established with family medicine. Patient complains of acute on chronic low back pain for the past two days and describes sacroiliac (SI) joint pain as achy when sitting but sharp when changing positions.

OMT was performed for the low back pain and SI joint pain. Will refer to physical therapy to strengthen pelvic ring. Increase pregabalin to 75 mg for better myofascial pain control. ➤

Make sure to add your osteopathic procedure note as well.

Because the patient has two acute exacerbations of chronic conditions (low back pain and SI joint pain) and medication management, this visit meets two of the three MDM criteria for a level 4 E/M office visit. Therefore, you would code it as a 99214 with modifier -25 and an OMT procedure code.

When combining OMT with an E/M service, the chief complaint the rooming staff enters for the visit should not be OMT, but rather the patient's problem or concern.

When documenting an OMT consultation service, be aware of several nuances. The initial consult visit is excluded from the new MDM and time-based rules; it follows the previous E/M guidelines. However, subsequent consult visits would follow the new MDM or time-based rules. If a patient was referred to you for evaluation for OMT, the initial visit could be billed as a consult visit, but subsequent follow-up visits must be billed as established patient visits. The referral note must state "referral for possible OMT" in order for the consulting physician to bill for both an E/M service and the OMT procedure. If the referral note just states "referral for OMT," the consulting physician can only bill for the procedure because, based on documentation, the referring clinician has already determined that OMT is appropriate, even if the referring clinician is not educated in osteopathic evaluation.

Each Medicare Administrative Contractor (MAC) may have some differences in their OMT coding and documentation policies, so check with the MAC assigned to your geographic region, as well as other payers. This guidance reflects policies we have found across several different MACs.

FINAL THOUGHTS

OMT is helpful for patients with a variety of conditions and can improve health outcomes.

Physicians who perform OMT should be fairly compensated. Their documentation should support the medical necessity for OMT, and they should consider also billing an E/M service in most cases, based on the number and complexity of problems and risk assessment.

Though there are basic guidelines on how to document and code for OMT, regional variations can exist. The American Osteopathic Association (AOA) continues to advocate for equitable reimbursement practices for OMT, yet denial of reimbursement can occur at times. The AOA can be a resource for assistance in those instances.[8] With increased confidence in the coding, billing, and documentation of OMT procedures, more physicians may offer these evidence-based services to patients. FPM

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