Position Paper on

Evaluation and Management Services (E/M) with
Osteopathic Manipulative Treatment (OMT)

Revised July 2006
AOA Division of Socioeconomic Affairs
AOA POSITION ON E/M AND OMT SERVICES

The position of the AOA is that an osteopathic physician should report E/M services with OMT on initial office visits as well as on follow-up visits, if the services are medically necessary and are supported with appropriate documentation according to the E/M Documentation Guidelines.

The modifier –25 must be used with the E/M service to indicate that the E/M service is separately identifiable from the OMT service. A separate diagnosis is not required for each of the services. The same diagnosis may be reported.

The term, “significant, separately identifiable E/M service” is not defined either in Current Procedural Terminology (CPT) or in Medicare guidelines. The AOA’s position is that “significant, separately identifiable” means that the physician has documented medically necessary care to the level specified in the E/M Guidelines.

Furthermore, osteopathic physicians as fully licensed medical providers are legally obligated for the total care of the patient. As such, they must document and provide an evaluation of that patient throughout their course of treatment.

Rationale for the AOA Position

♦ In establishing the Medicare Resource Based Relative Value Scale (RBRVS) fee schedule, the Hsiao (Harvard) survey separated the work of OMT from osteopathic E/M by having two separate survey forms with separate vignettes. It was never the intent of Hsiao or the osteopathic physicians involved in the creation of the survey to bundle E/M with the work of OMT.

♦ The CPT introductory language to the OMT codes indicate that the modifier –25 is to be used to indicate that the E/M services provided is a “significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure.”

♦ In 1999, an amendment to the CPT introductory language to the OMT codes clarified that a separate diagnosis is not required to report both an E/M and an OMT service on the same day.

♦ In 2002 The Relative Value Update Committee’s (RUC) Practice Expense Advisory Committee (PEAC) reviewed the OMT codes and identified all practice expenses associated with the five OMT codes. These practice expenses include only the work of the OMT procedure and do not include any E/M work. These practice expense inputs were recommended to the Centers for Medicare and Medicaid Services (CMS) and after adoption by CMS were published in the 2003 Final Rule and implemented as a part of the 2004 Medicare Fee Schedule.

♦ In 2003, the American Medical Association wrote a letter clarifying its position regarding the appropriate reporting of an OMT code along with an E/M code. The letter states, “As you
know, the PEAC/RUC assumed that in the typical scenario, a separate E/M service would be reported on the same date as an OMT service.” (See Attachment E)

The physician work RVUs assigned for the OMT codes reflect that separation. As an example, the lowest level of E/M service for an established patient which requires actual face-to-face contact between physician and patient is Code 99212 which has a work RVU of 0.45. The work RVU for OMT to 1-2 body regions (CPT Code 98925) is also 0.45. **Thus, the work of the E/M service CANNOT be considered to be included in the work value for the OMT procedure.**

**OSTEOPATHIC SERVICES VS. CHIROPRACTIC SERVICES**

Since osteopathic physicians are fully licensed for the unrestricted practice of medicine and surgery as well as OMT throughout the United States, an osteopathic physician’s decision to utilize OMT as part of a patient’s management is made in the context of overall medical/surgical evaluation. Doctors of chiropractic (D.C.) scope of practice limits do not allow full medical/surgical evaluation and management. Osteopathic physicians are held to a higher standard of care because of the broad scope of their training and licensure.

Unlike D.C.s, osteopathic physicians do not typically set a “treatment plan” i.e., initial evaluation followed by a recommendation of a defined series of treatments, followed by reevaluation at the completion of the “treatment plan”. Rather, an osteopathic physician’s decision to utilize manipulative treatment is made on a visit-by-visit basis depending on the condition of the patient at the time of each reevaluation. This requires that an E/M service be performed. While the osteopathic physician may provide more E/M services than a D.C., the osteopathic physician provides a significantly lower number of manipulative services rendered per patient on average than that typically provided by D.C.s.

*CPT 2006* introductory notes for the CMT codes state, “The chiropractic manipulative treatment codes include a pre-manipulation patient assessment”. This language is absent from the introductory notes for the OMT codes. This indicates that, unlike the OMT codes, the CMT codes include an E/M service as well as a procedure.

Based on the above, the American Osteopathic Association believes that it is not appropriate to include OMT in the same category of service or subject OMT to the same benefit limitations as those imposed for chiropractic or physical therapy services.

**THE STANDARD OF CARE FOR OMT AND E/M SERVICE**

**Osteopathic Patient Assessment**

The physician’s E/M service with a patient consists of the following: the history or subjective portion, the objective assessment, and the medical decision-making, which results in the diagnosis and plan for treatment at that encounter. Osteopathic physicians are fully licensed physicians and surgeons who practice a comprehensive system of medical care. While both allopathic and osteopathic physicians base their practices on the health care sciences, leading to
many similar diagnostic and therapeutic procedures, the practice of osteopathic medicine utilizes the uniquely osteopathic approach to diagnosis and treatment of the patient.

The unique basis of osteopathic medicine utilizes the knowledge of the working relationship between structure and function, between anatomy and physiology. Osteopathic principles and practice recognize the interrelatedness of all body systems and the body’s own healing mechanisms. This philosophy of osteopathic medicine emphasizes the effect of restricted mobility in the impairment of homeostatic mechanisms.

Osteopathic physicians frequently assess altered mobility of the musculoskeletal system, as that system encompasses the entire body, and is intimately related to the organ systems and to the nervous system. Utilizing the anatomic relationships between the musculoskeletal and other body systems, osteopathic physicians diagnose and treat all organ systems. The standard of care for osteopathic medicine therefore results in an E/M service that often contains additional elements, beyond what would be expected for the traditional allopathic assessment for a given patient.

During the medical decision-making portion of the E/M service, the osteopathic physician utilizes the findings in the subjective and objective portions of the E/M service to formulate the plan for treatment on that visit. As osteopathic medicine offers the osteopathic physician additional approaches for treatment of the patient’s condition, additional or different treatment options are often recommended compared to those recommended by the traditional allopathic approach. These treatment options may include administering OMT. This treatment option can be formulated for either a new patient or an established patient.

Many medical conditions require one or more follow-up visits to assess the patient’s response to treatment. For example, medication changes in the treatment of diabetes, hypertension or rheumatoid arthritis typically require a return visit. Likewise, when the condition of the patient warrants follow-up assessment of the response to treatment, the osteopathic physician reassesses the patient in the form of an established patient E/M service. Standard of care considerations for both allopathic and osteopathic physicians mandate that the patient be assessed in the form of an E/M service every time the physician sees the patient. Based on the findings of the E/M service, OMT may or may not be indicated for treatment of the patient at that visit.

**Work Included in the Procedure of OMT**

OMT is an interactive procedure **beginning with the decision to treat** the area(s) diagnosed in the preceding E/M service. The “cursory history and palpatory exam” to which reference is made in the description of OMT in the Hsiao Study is part of work that occurs during the procedure and is separate and distinct from the E/M service. (See Attachment A, a portion of the Hsiao Study containing a description of the work involved in OMT.)
“Cursory History and Palpatory Examination” Definition

The term “cursory history” refers to verbal interaction with the patient during the course of the treatment procedure, including patient comments necessary to monitor the progress of the treatment.

The term “palpatory examination” refers to the physician/patient contact during the course of the treatment, necessary to achieve proper patient and physician positioning as well as the physician’s continuous sensory monitoring of the patient’s response as the treatment is in progress. The “cursory history and palpatory examination” may provide information to the physician that often necessitates adaptation of the various OMT procedures used during the course of treating an individual patient.

NOTE: It is important to be aware that the definition of “cursory history and palpatory examination” was created solely for use in the Hsiao Study and the subsequent valuation of work. This terminology is not part of standard osteopathic medical education or literature.

HISTORICAL PERSPECTIVE

Establishment of RBRVS
The Omnibus Budget Reconciliation Act (OBRA) of 1989, section 6102 (a), as amended by the OBRA 1990, required the establishment of a physician fee schedule for all Medicare providers to be instituted on January 1, 1992. The final rule to fulfill this requirement was published in the Federal Register of November 25, 1991.

The Medicare fee schedule was implemented January 1, 1992 through a physician fee schedule based on the RBRVS as researched and reported by William Hsiao, Ph.D., in three phases from 1988 to 1994. Dr. Hsiao developed Relative Value Units (RVUs) for existing service codes in the CPT and HCPCS manuals. These RVUs became the basis for the physician fee schedule that has been in use since January 1, 1992 for Medicare reimbursement.

Hsiao Study
The physician work Relative Value Units (RVUs) for the OMT codes were derived from the original Hsiao Study on the HCPCS codes M0702-M0730 that were used to report OMT services at the time the Hsiao Study was conducted. These M codes were originally adopted by HCFA in 1982. The osteopathic physicians who participated in the Hsiao Study were given instructions that clearly separated OMT from evaluation and management services. These work RVUs were then “crosswalked” to CPT when the OMT codes were first included (CPT 1994). (Attachment A contains copies of several pages from the Hsiao study directly dealing with the OMT and office visit codes.)
In the section on “Service Time” the following instructions are given:

“In all cases we want you to consider your time for the average or typical patient for the described service. **For the visit and consultative services do not include your time performing OMT. I will ask you to estimate the time for these services separately.**”

In Attachment A, the following directions are given for the time valuation of OMT:

“For the remaining services we would like you to estimate only your time spent performing the OMT service, including any cursory history or palpation examination. **In particular, do not include your time assessing a new problem, obtaining an initial history or performing an initial physical examination.**”

The same language appears in the “Magnitude Estimation” section of the survey and is in Attachment A. The survey specifically divides the “office visit” portion of patient care, now called E/M, from the OMT portion. The vignettes demonstrate that E/M is expected to be performed on the same date of service as the OMT and have separate RVUs.

**OMT Status Code & Global Period**

The RVU’s derived from the Hsaio survey of OMT codes, as published in the Final Rule, are assigned a **STATUS CODE A**, with a global period of XXX. ADDENDUM B, p. B-1 through B-4 of the Final Rule clarifies this language (Attachment B). A global period of XXX was interpreted to mean that the global concept does not apply for this procedure.

On page B-1, 3 of Attachment B, the **STATUS CODE** is described:

“This indicator shows whether the code is in the fee schedule and whether it is separately payable if the service is covered.”

These codes are alphabetical indicators. The code for OMT is as follows:

“Indicator A=Active code: These codes are separately paid under the physician fee schedule if covered. There will be RVUs for codes with this status. The presence of an ‘A’ indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.”

**OMT Code Inclusion in CPT**

The American Osteopathic Association (AOA) petitioned the CPT Editorial Panel for inclusion of OMT codes into CPT from 1989-1993. The AOA was successful in this endeavor and OMT codes 98925-98929 first appeared in the CPT 1994. The basis for these new codes was the
HCPCS M0702-M0730, which were assigned RVUs through the RBRVS process outlined above. The relative work values of the original HCPCS codes were crosswalked to the new CPT OMT codes. No new survey was performed to revalue the codes.

**CPT Revision Adding –25 Modifier Language to OMT**

Confusion and subsequent misinterpretation of the Final Rule led the AOA to request that the CPT Editorial Panel consider adding language to the OMT section of CPT to indicate that E/M was a separately reportable service. The CPT Editorial Panel added the definition of the –25 modifier (defined by CPT) in order to “unbundle” the visit from the procedure of OMT. The decision to require a –25 modifier was intended to clarify that OMT and E/M are appropriately charged on the same visit.

However, the effect was to confuse the issue and actually seemed to encourage the interpretation of OMT as a bundled service. The practice became widespread nationally and is contrary to the methodology utilized in the Hsiao Study and the Final Rule as discussed above.

This confusion led HCFA to release a Policy Clarification on OMT on July 6, 1994. (Attachment D) This document underscores the misinterpretation of the Final Rule of 1992 to be rooted in the verbiage from the Hsiao study concerning “cursory history and palpatory examination.” As discussed above, if the Hsiao survey on **BOTH** E/M and OMT is reviewed, the intent and direction given to the physician survey respondent is clearly to isolate and separate the office visit from the procedure of OMT. The vignettes used in the study demonstrate that physician E/M services are expected and customary in the care of patients by osteopathic physicians.

**Modification to CPT in 1999 – Separate Diagnosis**

Several carriers have indicated that if an E/M service is performed on the same day as an OMT service for an established patient, each service must have a separate diagnosis. Beginning with CPT 1999, the introductory language to the OMT section clarifies that a separate diagnosis is not required to use an E/M service on the same day as an OMT service for an established patient. Both the E/M and OMT service may be related to the same diagnosis.

**AMA clarifies that services are unbundled - 1993 Letter**

Despite previous attempts to clarify that the E/M was not a bundled service within the OMT code, several carriers continued to express that this was their interpretation based on the AMA’s CPT language. Therefore, the AOA requested a clarification of this interpretation from the AMA. In the response letter, the AMA clarifies, “As you know, the PEAC/RUC assumed that in the typical scenario, a separate E/M service would be reported on the same date as an OMT service.” (See Attachment E) This clearly would not be the “typical” expectation if the E/M service were already bundled within the OMT procedure.
ATTACHMENTS –
Attachment A: Hsiao Study
Attachment B: Global Codes
Attachment C: Manual Medicine Work RVU Comparison
Attachment D: Booth Memo
Attachment E: AMA Letter
Attachment A: Hsiao Study
NATIONAL PHYSICIANS SURVEY

(OSTEOPATHIC MEDICINE)

Center for Survey Research
University of Massachusetts-Boston

and

Harvard School of Public Health
A. SERVICE TIME

First, I'd like you to tell me how many minutes it usually takes you to perform services in your specialty. I will ask you to estimate the amount of time you spend during the performance of each service. In addition, we will also ask you to estimate the total time you spend for the services indicated with an asterisk (*). The total time includes the time during and before and after the service. Have you reviewed the yellow sheet with the definitions of during and before and after the service? (if NO please ask RESPONDENT to take a minute to review this information).

[In all cases we want you to consider your time for the average or typical patient for the described service. For the visit and consultative services do not include your time performing OMT (osteopathic manipulative treatment). I will ask you to estimate the time of these services separately.

On average, how long does it take during the performance of (the/a/an)
(READ EACH).....

*******
(FOR ALL THE SERVICES INDICATED WITH AN ASTERISK, ...)

And on average, how long does it take to perform the total service, including minutes during and before and after this service....

<table>
<thead>
<tr>
<th></th>
<th>MINUTEST</th>
<th>MINUS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DURING</td>
<td>TOTAL</td>
</tr>
</tbody>
</table>

*Ala.1) Follow-up visit of a 55-year-old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen.                     

*Ala.2) Initial office consultation for a 65-year-old male with chronic low back pain radiating to the leg.                                  

*Alb.3) Initial office visit for a 25-year-old female, visiting from out of town, who needs her hayfever prescription refilled.         

*Alc.4) Home visit for a 66-year-old female one week after release from the hospital for a CVA (cerebral vascular accident) with right hemiparesis (not including travel time).  

*Ald.5) Initial office visit for a 70-year-old patient with recent back sprain.
For the remaining services we would like you to estimate only your time spent performing the OMT service, including any cursory history or palpatory examination. In particular, do not include your time assessing a new problem, obtaining an initial history or performing an initial physical examination. Have you reviewed the yellow sheet with the definition of the service period for OMT services? (if NO please ask RESPONDENT to take a minute to review this information)

On average, how long does it take you to perform (a/an) ... MINUTES

Alo.) Brief OMT (osteopathic manipulative treatment) performed in the office for a 25-year-old female with frontal area headache (includes up to two body regions).

Alp.) Limited OMT (osteopathic manipulative treatment) performed in the office for a 30-year-old secretary complaining of posterior (occipital area) headache and upper back/shoulder area tightness (includes up to four body regions).

Alq.) Intermediate OMT (osteopathic manipulative treatment) performed in the office for a 40-year-old laborer with acute lumbar strain/sprain and inguinal pain and lower extremity paresthesia (includes up to six body regions).

Alr.) Comprehensive OMT (osteopathic manipulative treatment) performed in the office for a 28-year-old male 3 weeks post auto accident-sustained sprain and strain of cervical, dorsal and lumbosacral spine and has frozen right shoulder (includes up to ten body regions).

Als.) Limited OMT (osteopathic manipulative treatment) performed in the hospital for a 65-year-old male 2 days post abdominal surgery, who complains of arthralgia and myalgia (includes up to four body regions).

Alt.) Extended OMT (osteopathic manipulative treatment) performed in the hospital for a 70-year-old female who has been bedridden for 7 days. Patient has generalized body stiffness and pain (includes up to eight body regions)
Next let's talk about how much work is involved during these services. The packet we sent to you discussed the method we would like you to use for comparing the services. If you have the packet handy, it would be helpful for you to look at a description of the magnitude estimation method as I review it briefly.

The reference service for all the ratings will be a follow-up visit of a 55-year-old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen. Call this 100. Now with the reference service as 100, compare it to each of the other services as I read them to you. If the service I mention is twice as much work, then your answer would be 200. A service half as much work would be 50, five times as much work would be 500 and so on.

I am going to ask you to compare each of the services to the reference service on work. In your estimation of work, please consider the time it takes to perform the service and the three dimensions that reflect the intensity of that time -- technical skill and physical effort, mental effort and judgment, and stress.

In all cases, we want you to try to respond in terms of the work during the described service for the average or typical patient. Do not count your work either before or after the service. For the visit and consultative services do not include your work performing CMT (osteopathic manipulative treatment). I will ask you to estimate the work of these services separately.

Do you have any questions about the way I want you to compare the services, or what we mean by work during the service?

O.K. let's start.

If the work during a follow-up visit of a 55-year-old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen has a rating of 100, what number would you assign to the work during (the/a/an) (READ EACH)....

**Bla.)** Initial office consultation for a 65-year-old male with chronic low back pain radiating to the leg.

**INTERVIEWER CHECK:** So this service requires about _____ times the amount of work as the reference service?

**Blb.)** Initial office visit for a 25-year-old female, visiting from out of town, who needs her hayfever prescription refilled.

**INTERVIEWER CHECK:** So this service requires about _____ times the amount of work as the reference service?
For the remaining services we would like you to estimate only the work spent performing the OMT service, including any cursory history or palpatory examination. In particular, do not include your work assessing a new problem obtaining an initial history or performing an initial physical examination.

O.K. let's start.

If the work during a follow-up visit of a 55-year-old male for management of hypertension, mild fatigue, on beta blocker/thiazide regimen has a rating of 100, what number would you assign to the work during (the/a/an) (READ EACH).

Bl.) Brief OMT (osteopathic manipulative treatment) performed in the office for a 25-year-old female with frontal area headache (includes up to two body regions).

Blp.) Limited OMT (osteopathic manipulative treatment) performed in the office for a 30-year-old secretary complaining of posterior (occipital area) headache and upper back/shoulder area tightness (includes up to four body regions).

Blq.) Intermediate OMT (osteopathic manipulative treatment) performed in the office for a 40-year-old laborer with acute lumbar strain/sprain and inguinal pain and lower extremity paresthesia (includes up to six body regions).

Blr.) Comprehensive OMT (osteopathic manipulative treatment) performed in the office for a 28-year-old male 3 weeks post auto accident-sustained sprain and strain of cervical, dorsal and lumbosacral spine and has frozen right shoulder (includes up to ten body regions).

Bls.) Limited OMT (osteopathic manipulative treatment) performed in the hospital for a 65-year-old male 2 days post abdominal surgery, who complains of arthralgia and myalgia (includes up to four body regions).

Blt.) Extended OMT (osteopathic manipulative treatment) performed in the hospital for a 70-year-old female who has been bedridden for 7 days. Patient has generalized body stiffness and pain (includes up to eight body regions).
RELATIVE VALUE UNITS AND RELATED INFORMATION

This Addendum B contains the RVUs and other information for each HCPCS code in level 1 (CPT) and level 2 (alpha-numeric HCPCS), except for alpha-numeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), or L (orthotics) and codes for anesthesiology.

1. **HCPCS** -- this is the CPT or level 2 HCPCS number for the service. Level 2 HCPCS codes are included at the end of this Addendum.

2. **Mod (modifier if one applies)** -- a modifier is shown if there are technical component (TC) and professional component (26) for the service.

   If professional only (26) and TC modifiers apply, there are three entries for the code: one for the global values, one for the 26 modifier, and one for the TC modifier. Physicians should continue to bill using the code without a modifier if the physician furnishes both the professional component and TC of the service.

3. **Status code.** This indicator shows whether the code is in the fee schedule and whether it is separately payable if the service is covered. The presence of an "A" status does not mean that the service is covered by Medicare; carriers continue to be responsible for making coverage decisions on services in the absence of national coverage policy and in individual cases.

   **A = Active code.** These codes are separately paid under physician fee schedule if covered. There will be RVUs for codes with this status. The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

   **B = Bundled code.** Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amount for these codes and no separate payment is made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient. This service is not separately payable because it is included in the payment for other services such as hospital visits.)
Attachment C: Manual Medicine Work RVU Comparison
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Pre-service Time</th>
<th>Intra-service Time</th>
<th>Post-service Time</th>
<th>Total Time</th>
<th>Rec. RVW Actual RVW</th>
</tr>
</thead>
<tbody>
<tr>
<td>98940 1-2 regions, spinal</td>
<td>2.0</td>
<td>7.0</td>
<td>3.0</td>
<td>12.0</td>
<td>.45</td>
</tr>
<tr>
<td>98941 3-4 regions spinal</td>
<td>3.0</td>
<td>9.5</td>
<td>4.0</td>
<td>16.5</td>
<td>.65</td>
</tr>
<tr>
<td>98942 5 regions spinal</td>
<td>4.0</td>
<td>12.0</td>
<td>5.0</td>
<td>21.0</td>
<td>.87</td>
</tr>
<tr>
<td>98943 1 or more regions, extraspinal</td>
<td>3.0</td>
<td>8.0</td>
<td>5.0</td>
<td>16.0</td>
<td>.40</td>
</tr>
<tr>
<td>98925* 1-2 regions</td>
<td></td>
<td></td>
<td></td>
<td>13.0</td>
<td>.45</td>
</tr>
<tr>
<td>98926* 3-4 regions</td>
<td></td>
<td></td>
<td></td>
<td>18.0</td>
<td>.65</td>
</tr>
<tr>
<td>98927* 5-6 regions</td>
<td></td>
<td></td>
<td></td>
<td>25.0</td>
<td>.87</td>
</tr>
<tr>
<td>98928* 7-8 regions</td>
<td></td>
<td></td>
<td></td>
<td>29.0</td>
<td>1.03</td>
</tr>
<tr>
<td>98929* 9-10 regions</td>
<td></td>
<td></td>
<td></td>
<td>33.0</td>
<td>1.19</td>
</tr>
<tr>
<td>97250 1 or more regions</td>
<td>5.0</td>
<td>30.0</td>
<td>5.0</td>
<td>40.0</td>
<td>.45</td>
</tr>
<tr>
<td>97265 1 or more regions</td>
<td>5.0</td>
<td>15.0</td>
<td>5.0</td>
<td>25.0</td>
<td>.45</td>
</tr>
</tbody>
</table>

* OMT codes were surveyed by Harvard and therefore only total times are available.
Attachment D: Booth Memo (HCFA Policy)
We have been asked to clarify how osteopathic manipulative treatment (OMT) and evaluation and management (E/M) services provided on the same date are to be reported and paid. We have heard allegations that some carriers are routinely rejecting claims submitted with both an E/M code and an OMT code.

In addition, we have been asked to clarify how OMT is reported and whether it is necessary for OMT and an E/M service on the same date to be unrelated to each other in order for payment to be made for both services. To reiterate previous directives and to further clarify our policies, please note the following:

1. **CPT 1994** includes new codes for OMT. They replace HCPCS codes M0702 - M0730 which have been deleted and are no longer valid. The CPT codes and the introductory paragraphs preceding them are as follows:

   "Osteopathic manipulative treatment is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

   Body regions referred to are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

   **98925** Osteopathic manipulative treatment (OMT); one to two body regions involved

   **98926** three to four body regions involved

   **98927** five to six body regions involved
seven to eight body regions involved
nine to ten body regions involved"

These are the correct codes to report OMT services. OMT should not be reported by physicians with the codes in the Physical Medicine section of CPT (97260 and 97261) and claims for OMT submitted with the OMT codes should not be recoded to 97260 and 97261.

2. The work RVUs assigned to the OMT codes are consistent with the definitions above. For example, OMT on the cervical, thoracic, and lumbar regions would be reported with code 98926 since 3 different regions were treated.

3. Some physicians seem to believe the RVUs assigned to the OMT codes represent only the work of OMT and that any type of evaluation and management (E/M) service on the same date should be separately reported and paid. On the other hand, some carriers seem to believe that the OMT codes have been valued to include E/M services and therefore they will not pay a claim for an E/M service on the same date as an OMT service.

Neither point of view is completely correct. The actual instructions provided to physicians who participated in the Harvard Resource Based Relative Value Scale (RBRVS) study and who rated the work of OMT were as follows:

"For these services, the service period includes your work for the OMT from the time you begin the service until you complete it. Please consider only your work performing the OMT service, including any cursory history or palpatory examination. In particular, do not include your work assessing a new problem".

Because the work values include some services that could otherwise be reported with an E/M code, i.e., "any cursory history or palpatory examination", we decided to prohibit payment for E/M services on the same date as OMT unless the patient's condition required a significant, separately identifiable E/M service above and beyond the usual E/M services that are integral to the provision of OMT. To implement this policy, we instructed carriers to deny payment for E/M services on the same date as OMT unless the E/M code was appended with a -25 modifier.

4. On June 23, 1992 we issued a memorandum to our regional offices on the issue of the -25 modifier. It had come to our attention that some carriers were not paying for E/M codes with a -25 modifier unless they were "unrelated" to the OMT. We indicated in the memo that was not correct and stated: "A
documented, separately identifiable related service is to be paid for. We would define related as being caused or prompted by the same symptoms or conditions. Thus, carriers should not deny claims for OMT and an E/M service with a -25 modifier simply because they both are reported with the same diagnosis code. This policy applies whether or not it is a first or subsequent encounter with the patient.

5. When OMT and a significant separately identifiable E/M service are performed on the same date, they should be reported as described above. Physicians should not "upcode" the E/M service and omit the code for the OMT service. Neither should they report different diagnoses for the two services if both services are provided for the same diagnosis.

Please convey this information to the carriers in your region.

Charles R. Booth
March 10, 2003

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Coding and Reimbursement
American Osteopathic Association
142 East Ontario Street
Chicago, Illinois 60611-2864

Dear Ms. Doss:

I am responding to your letter of February 24, 2003 regarding clarification of the resources currently included in the Osteopathic Manipulative Treatment (OMT) CPT codes 98925-98929. Specifically, you are seeking any data or explanation to clarify that Evaluation and Management Services are not incorporated into the OMT codes.

As you stated in your correspondence, CPT codes 98925-98929 were cross-walked from HCPCS Level II codes (M0702-M0730) in 1994. At this time, the specialty proposed cross-walking the relative values from these old codes to the new CPT codes, and the AMA/Specialty Society RVS Update Committee (RUC) agreed that this would be appropriate. The RUC did not review survey data or other rationale regarding the new OMT codes. The physician time that is currently utilized for the OMT codes was also cross-walked from the HCPCS Level II codes, which was based on survey data from the Harvard studies.

I have attached the RUC’s standardized survey document instructions which specifically describe the elements of physician work and defines pre-, intra-, and post-service activities. Please note that on page four of the survey, a definition of the pre-service period specifically states that distinct evaluation and management services provided in addition to the procedure (reported with a modifier -25) are not included in the pre-service work for the service.

The RUC’s Practice Expense Advisory Committee (PEAC) recently reviewed the OMT codes at its September 2002 meeting. The RUC has since approved these recommendations and has submitted them to the Centers for Medicare and Medicaid Services (CMS). It is expected that CMS will publish its consideration of the PEAC recommendations for this cycle in the Spring 2003 Proposed Rule and changes will be implemented on January 1, 2004.
As you know, the PEAC/RUC assumed that in the typical scenario, a separate E/M service would be reported on the same date as an OMT service. Therefore, the PEAC/RUC limited the resources (clinical staff time, medical supplies, and medical equipment) to those that are directly attributed to the OMT service. I have attached both the standard PEAC/RUC direct practice expense inputs for the E/M services and the recent recommendations for the OMT codes to this letter.

I hope that this information is helpful in providing additional clarification regarding the resources, both physician work and practice expense, that are currently included in the OMT codes. Please contact me if you require further assistance.

Sincerely,

[Signature]

Sherry L. Smith

Cc: Boyd R. Buser, DO
    David F. Hitzeman, DO
    Joseph R. Schlecht, DO
    Robert J. Stomel, DO
The American Medical Association/Specialty Society RVS Update Committee

PHYSICIAN WORK
RVS Update Survey

New/Revised CPT Code:  Global Period: 000

CPT Code Descriptor:

Typical Patient/Service:
INTRODUCTION

Why should I complete this survey?

The AMA/Specialty Society RVS Update Committee (RUC) and the _________________ needs your help to assure relative values will be accurately and fairly presented to CMS during this revision process. This is important to you and other physicians because these values determine the rate at which Medicare and other payers reimburse for procedures.

What if I have a question?

Contact: {Include Specialty Society Contact}

How is This Surveyed Organized?

Each new/revised code must be surveyed (i.e., there is one questionnaire per code), so you may have several questionnaires to complete. Each questionnaire is organized the same and is comprised of questions relating to physician work.

START HERE

The following information must be provided by the physician responsible for completing the questionnaire.

Physician Name: _______________________________
Business Name: _______________________________
Business Address: _______________________________
    City: _______________________________
    State: ________
    Zip: ________
Business Phone: (_____)________________________
Business Fax: (_____)________________________
E-mail Address: _______________________________
Physician Specialty: _______________________________
Years Practicing Specialty: ________
Primary Geographic Practice Setting: Rural____ Suburban____ Urban____
Primary Type of Practice: Solo Practice____
    Single Specialty Group____
    Multispecialty Group____
    Medical School Faculty Practice Plan____
PHYSICIAN WORK

INTRODUCTION

"Physician work" includes the following elements:

- Physician time it takes to perform the service
- Physician mental effort and judgment
- Physician technical skill and physical effort, and
- Physician psychological stress that occurs when an adverse outcome has serious consequences

All of these elements will be explained in greater detail as you complete this survey.

"Physician work" does not include the services provided by support staff who are employed by your practice and cannot bill separately, including registered nurses, licensed practical nurses, medical secretaries, receptionists, and technicians; these services are included in the practice cost relative values, a different component of the RBRVS.
Background for Question 1

Attached is a list Reference Services that have been selected for use as comparison services for this survey because their relative values are sufficiently accurate and stable to compare with other services. The “2002 Work RVU” column presents current Medicare RBRVS work RVUs (relative value units). Select one code which is most similar to the new/revised CPT code descriptor and typical patient/service described on the cover of this questionnaire.

It is very important to consider the global period when you are comparing the new/revised code to the reference services. A service paid on a global basis includes:

- visits and other physician services provided within 24 hours prior to the service;
- provision of the service; and
- visits and other physician services for a specified number of days after the service is provided.

The global periods listed on the cover of the survey refer to the number of post-service days of care that are included in the payment for the service as determined by the Health Care Financing Administration for Medicare payment purposes.

Categories of Global Period:

- **090** 90 days of post-service care are included in the work RVU
- **010** 10 days of post-service care are included in the work RVU
- **000** 0 days of post-service care are included in the work RVU
- **ZZZ** This code is reported in addition to a primary procedure and only the additional work to perform this service is included in the work RVU
- **XXX** A global period does not apply to the code and evaluation and management and other diagnostic tests or minor services performed, may be reported separately on the same day

**QUESTION 1:** Which of the Reference Services on the attached list is most similar to the new/revised CPT Code Descriptor and Typical Patient Service described on the cover of this questionnaire?

CPT Code
Background for Questions 2 & 3
SURGERY (000 Global Period)

PRE-SERVICE PERIOD
The pre-service period includes physician services provided from the day before the operative procedure until the time of the operative procedure and may include the following:

- Hospital admission work-up.
- The pre-operative evaluation may include the procedural work-up, review of records, communicating with other professionals, patient and family, and obtaining consent.
- Other pre-operative work may include dressing, scrubbing, and waiting before the operative procedure, preparing patient and needed equipment for the operative procedure, positioning the patient and other non "skin-to-skin" work in the OR.

The following services are not included:

- Consultation or evaluation at which the decision to provide the procedure was made (reported with modifier -57).
- Distinct evaluation and management services provided in addition to the procedure (reported with modifier -25).
- Mandated services (reported with modifier –32).

INTRA-SERVICE PERIOD
The intra-service period includes all "skin-to-skin" work that is a necessary part of the procedure.

POST-SERVICE PERIOD
The post-service period includes services provided on the day of the procedure if the global period is 000, post-service period may include the following:

- Day of Procedure: Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit, communicating with the patient and other professionals (including written and telephone reports and orders), and patient visits on the day of the operative procedure.

The following services are not included:

- Unrelated evaluation and management service provided during the postoperative period (reported with modifier -24)
- Return to the operating room for a related procedure during the postoperative period (reported with modifier -78)
- Unrelated procedure or service performed by the same physician during the postoperative period (reported with modifier -79)
QUESTION 2: How much of your own time is required per patient treated for each of the following steps in patient care related to this procedure? Indicate your time for the new/revised code on the front cover. (Refer to definitions)

a) Day Preceding Procedure
   - Pre-service evaluation time: _______ minutes

b) Day of Procedure
   - Pre-service evaluation: _______ minutes
   - Pre-service positioning time: _______ minutes
   - Pre-service scrub, dress, wait time: _______ minutes
   - Intra-service time: _______ minutes
   - Immediate post-service time*: _______ minutes

*Post-operative care on day of the procedure, includes non "skin-to-skin" work in the OR, patient stabilization in the recovery room or special unit and communicating with the patient and other professionals (including written and telephone reports and orders). Include patient visits on the day of the operative procedure (e.g., in their hospital room or in the ICU) in section c below for 90-day global procedures.

QUESTION 3: For the New/Revised CPT code and for the reference service you chose, rate the AVERAGE pre-, intra-, and post service complexity/intensity on a scale of 1 to 5 (circle one: 1 = low; 3 medium 5 = high). Please base your rankings on the universe of codes your specialty performs.

<table>
<thead>
<tr>
<th></th>
<th>New/Revised CPT:</th>
<th>Reference Service CPT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE-service</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>INTRA-service</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>POST-service</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
Background for Question 4

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following:

Time it takes to perform the service.

Mental Effort and Judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.

Technical Skill required with respect to knowledge, training and actual experience necessary to perform the service.

Physical Effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.

Psychological Stress – Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and an adverse outcome has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be a highly variable function of physician personality.
QUESTION 4: For the New/Revised CPT code and for the reference service you chose, rate the intensity for each component listed on a scale of 1 to 5. (circle one: 1= low; 3 medium 5 = high). Please base your rankings on the universe of codes your specialty performs.

<table>
<thead>
<tr>
<th>Mental Effort and Judgment</th>
<th>New/Revised CPT:</th>
<th>Ref. Service CPT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The range of possible diagnoses and/or management options that must be considered</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>The amount and/or complexity of medical records, diagnostic tests, or other information that must be analyzed</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Urgency of medical decision making</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Technical Skill/Physical Effort</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical skill required</td>
</tr>
<tr>
<td>Physical effort required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychological Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>The risk of significant complications, morbidity and/or mortality</td>
</tr>
<tr>
<td>Outcome depends on skill and judgment of physician</td>
</tr>
<tr>
<td>Estimated risk of malpractice suit with poor outcome</td>
</tr>
</tbody>
</table>

QUESTION 5: How many times have you personally performed these procedures in the past year? New/Revised Code: _____ Reference Service Code: _____

QUESTION 6: Is your typical patient for this procedure similar to the typical patient described on the cover?

Yes ☐ No ☐

If no, please describe your typical patient for this procedure:

**********************************************************VERY IMPORTANT**********************************************************

QUESTION 7: Based on your review of all previous steps, please provide your Estimate work RVU for the new/revised CPT code:

For example, if the new/revised code involves the same amount of physician work as the reference service you choose, you would assign the same work RVU. If the new/revised code involves twice as much (or half as much) work as the reference service, you would calculate and assign a work RVU value that is twice as much (or half as much) as the work RVU of the reference service. This methodology attempts to set the work RVU of the new or revised service relative to the work RVU of comparable and established reference services.