

Teaching the Business of Osteopathic Manipulative Medicine

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Faculty Development Workshop

Preparation for the Real World

- Know the environment
- Speak the language
- Understand the rules
- Master basics of finance and accounting
- Engage lifelong learning

Know the Environment

- Escalating healthcare costs and an aging population are fueling:
 - Rapidly changing policies, regulations, and stakeholder demands nationally and statewide
- Challenges abound in all segments of healthcare
 - Small and large practices, hospitals, networks and integrated delivery systems, support industries and consumers
- Payment reform continues to evolve
 - Performance incentives/penalties, value based initiatives, outcomes metrics, cost and risk shifting, accountable care organizations
- Healthcare reform is attempting to refocus healthcare into a care management model from a crisis intervention model

Understand why Cost drives Healthcare

- Value
 - Consumer *perception* directly related to a service, good, or product
- Quality
 - Presently the most common metric is customer satisfaction which is *subjective*
 - Standardized protocols, guidelines, decision-trees offer *inflexible metrics* and *disregard the uncertainty of disease expression and response to care*
- Cost
 - Expenditure necessary to obtain services, goods or products
 - *Easily measured, tracked and analyzed*

The Value Proposition

- Business principle: $\text{Value} = \text{Quality} / \text{Cost}$
 - Value is the highest quality for the lowest cost
- In healthcare quality has no clear definition
 - Since cost is the most defined, it drives the equation
 - This causes risk and cost shifting between stakeholders
- New proposition: $V(\text{health}) = Q(\text{effective care}) / \text{Cost}$
 - Care management driven
 - Value-based competition
- Therefore health may be more or less costly
 - One cancer treatment has better health outcomes at a higher cost than a different treatment with a lower cost

Stakeholder Power

- Four groups of stakeholders drive, power and control healthcare
 - Payers: individuals, government, businesses
 - Providers: physicians, hospitals, networks, clinics, etc.
 - Producers: pharmaceutical companies, IT, medical devices, etc.
 - Fiscal intermediaries: insurers, benefit managers, BWC, CMS
- Value chain is driven by fiscal intermediaries
- Utility chain is driven by payers
- Competition between the value chain and the utility chain
 - Results in consumer directed health plans and increased risk sharing and shifting
 - Premium, access and reimbursement manipulation
 - Utility driven choices

Physicians affect both Value and Utility

- Influence the power and control continuum
- Influence the value chain by considering utility in healthcare decisions and choices
- Focus management on maximizing health through
 - effective evidence-based care that affects costs
 - Application of knowledge-based utility decisions

Understand the Rules

- Complying with regulatory, accreditation and certification rules and standards
 - Agencies
 - Insurers
 - Hospitals, IDS, and facilities
- Understanding and obeying laws of medical practice
 - State
 - National
- Ethical behavior
 - Trust-based physician-patient relationship
 - Stewardship of limited healthcare resources

Understand how your hospital and network work

- Leadership triad and their duties
- Physicians
 - Medical executive committee and staff structure governs the clinical staff
 - Manages departments and sections ensuring quality clinical staff and services
 - Create, update and maintain Staff Bylaws and Manual of Procedures in accordance with state law
- Administration
 - Implements the policies of the Hospital Board
 - Supervision of all persons practicing medicine in the hospital
 - Select and retain competent physicians
- Governance
 - Formulate, adopt and enforce rules, regulations and policies that ensure quality care
 - Fiduciary responsibility

Speak the Language of Insurance

Health Maintenance Organization (HMO)

Open Panel PCP gatekeeper coordinates care without direct access to specialty care and must stay in network
Closed Panel has no coverage for services outside of the fixed provider/facility network

Preferred Provider Organization (PPO)

Direct access to providers without referral within the network
Higher deductible and less benefit coverage outside of the network

Consumer Directed High Deductible Health Plan with Health Savings Account

Ability to self refer and access additional health services with HSA/HRA pre-taxed dollars coupled with high deductible insurance plan

Point of Service

Ability to self refer with higher deductible and coinsurance or stay within network with lower out of pocket cost

Physician Hospital Organization

Access to providers, hospitals and facilities belonging to a network for all care and services

Government Insurance Plans

- Medicare
 - Federal plan covers those 65 yrs and older and those with certain disabilities
- Medicaid
 - Joint federal and state public assistance program
 - Coverage varies by state
- State Children's Health Insurance Program (SCHIP)
 - State program to cover children of low income parents who do not qualify for Medicaid
- Military Health Care
 - TRICARE
- Indian Health Service
 - DHHS offers medical assistance to eligible Native Americans at HIS facilities
- Veteran's Affairs Health Plan
 - CHAMPVA

HIPPA mandated Code-sets

- National code sets for all protected individual healthcare data
- Diagnostic codes
 - As of October 1, 2015 ICD-10-CM
- Procedure and treatment codes
 - Most up-to-date Current Procedural Terminology (CPT) edition
 - HCPCS supplemental codes managed by CMS
 - Local coverage codes for emerging technology and services

Who manages the ICD-10-CM code set?

- The World Health Organization (WHO)
 - Maintains and updates
 - Publishes for use internationally
 - Encourages clearer communication between patients, providers, payers and researchers across the globe

ICD-10 Codes are Alpha-Numeric Codes

- Expands the code set with more specific code choices
- Identifies episodes
 - Initial, subsequent, sequella
- Uses familiar symptom descriptors
 - Fatigue, neck pain, back pain, etc.
- Expands choices for specific conditions
 - Diabetes, influenza, etc.
 - Fractures, sprain/strain, etc.

CPT: Procedure and Treatment Code Set

- CPT is a set of codes, descriptions, and guidelines
- Intended to describe procedures and services
- Performed by physicians and other health care professionals, or entities.

Who maintains CPT?

- CPT is updated, maintained, and published annually by the CPT Editorial Panel for the American Medical Association
- AOA participates with an Advisor and Alternate Advisor to the CPT Editorial Panel
- Through the AOA's Coding and Payment Advisory Panel (CPAP), osteopathic specialty societies review code change proposals and offer guidance to the Advisor in making comments and engaging in discussions at the CPT meetings

Types of CPT Codes

- Procedures and services
 - Surgeries, wart removals, EMG, lab panels, injections, OMT, etc.
- Evaluation and Management (E/M) codes
 - Office visits, hospital visits, consultations, ER visits, etc.
- Modifiers
- Place of service codes
- Category I main code set used for payment
- Category III used for experimental or new technologies

Coding Basics

- Use the most specific ICD-10 diagnosis code(s)
- Select the appropriate CPT code to describe services and procedures
- Link the appropriate ICD-10 code to the CPT code on the CMS 1500 electronic or paper billing form
- Select any modifiers that apply
- Make sure the encounter/procedure note clearly documents the diagnostic findings leading to the diagnosis
- Make sure the procedure is appropriate for the linked diagnosis

ICD-10 Somatic Dysfunction codes

- M99.00 Head region
 - Occipito-cervical region
- M99.01 Cervical region
 - Cervico-thoracic region
- M99.02 Thoracic region
 - Thoraco-lumbar region
- M99.03 Lumbar region
 - Lumbosacral region
- M99.04 Sacral region
 - Sacro-coccygeal & Sacroiliac regions
- M99.05 Pelvic region
 - Iliac, Ischia, & Pubic regions
- M99.06 Lower extremities
- M99.07 Upper extremities
 - Acromioclavicular & Sternoclavicular regions
- M99.08 Rib cage
 - Costovertebral, Costochondral, Sternochondral & Sternum regions
- M99.09 Abdomen & other
 - Viscera, Lymphatics, Diaphragms

Osteopathic Manipulative Treatment Codes in CPT

- 98925 OMT one to two regions treated
- 98926 OMT three to four regions treated
- 98927 OMT five to six regions treated
- 98928 OMT seven to eight regions treated
- 98929 OMT nine to ten regions treated

Other CPT Manipulation Codes

- 98940-98943 Chiropractic manipulative treatment (CMT)
- CPT codes used by doctors of chiropractic (DC) to report their manual therapy services
- 97140 Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
- CPT codes used primarily by physical therapists to report their manual therapy services

Distinctions between OMT and Other Forms of Manual Therapy

- DO's decision to utilize OMT made in the context of overall medical/surgical management
- DOs usually do not set a “treatment plan” of defined number of treatments prior to re-evaluation
- DO's treatment plans include medical/diagnostic testing, medication management, rehabilitation considerations, imaging as well as OMT
 - This leads to significantly fewer treatments in the management of the typical patient than other providers of manual treatments

Modifier -25 use with E/M Services with OMT

- A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered
 - by some specific circumstance
 - but not changed in its definition or code.
- Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities.
 - CMS requirement for E/M + modifier-25 when provided with OMT
- The -25 modifier is used when a significant, separately identifiable E/M service is provided on the same day a procedure is provided.

OMT Introductory Notes in CPT

- Evaluation and Management services may be reported separately, using the modifier -25, if the patient's condition requires a:
 - Significant, separately identifiable Evaluation and Management service by the same physician on the same day of the procedure or other service
- 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.

What Makes Up an E/M Service?

- Documentation of history
 - Chief complaint
 - History of present illness
 - Review of systems
 - Past, family and social history
- Documentation of physical exam
- Documentation of complexity of medical decision making
 - Number of diagnoses and/or management options
 - Amount and/or complexity of data
 - Risk to the patient of the diagnoses and/or treatment options
- Time
- Only used if 50% or greater of time spent with patient is counselling

Components of E/M Services Not Included in the Work of OMT

- Evaluation of a new problem
- Substantial change in an existing condition
- New data interpretation (e.g., lab, imaging)
- New co-morbid condition
- Change in the status of a co-morbid condition
- Medication prescribed, changed or managed by you
- Medical decision making
- Transition of care
- Care coordination

When NOT to Report an E/M code when Performing OMT:

- The evaluation and decision to treat is made on a different day than the day the OMT is provided
- A set number of treatments is prescribed, and the patient returns to the office strictly to receive the prescribed OMT

Documentation Basics

- The documentation of each patient encounter should include or provide reference to:
 - The chief complaint and/or reason for the encounter
 - Appropriate, relevant history, examination findings and prior diagnostic test results
 - Medication list
 - Assessment, clinical impression and diagnosis
 - Plan of care
 - Date and legible identity of the physician providing the service
 - Identities of those entering information into the chart

Documentation Must Haves

- If not specifically documented, the reason for the encounter and/or chief complaint and the rationale for ordering diagnostic and other services should be easily inferred.
- Past and present diagnoses and conditions should be accessible.
- The patient's progress, response to and changes in treatment; planned follow-up care and instructions; and diagnosis should be documented.
- The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

Documentation Guidelines

- Documentation Guidelines for the use of E/M codes are found in CPT
- Each of the three key components has levels of complexity
 - Each level of complexity contains a variable number of elements
 - Some codes require “3 of 3” key components (e.g., new patient office visit); other codes require only “2 of 3”
- Definitions and instructions for choosing the level of E/M are used by clinicians, coders, payers and auditors

Office Visit – Established Patient

CPT Code	99211	99212	99213	99214	99215
History type	N/A	Problem Focused	Expanded PF	Detailed	Comprehensive
Examination type	N/A	Problem Focused	Expanded PF	Detailed	Comprehensive
Medical decision making type	N/A	Straightforward	Low	Moderate	High

Office Visit – New Patient

CPT Code	99201	99202	99203	99204	99205
History type	Problem Focused	Expanded PF	Detailed	Comprehensive	Comprehensive
Examination type	Problem Focused	Expanded PF	Detailed	Comprehensive	Comprehensive
Medical decision making type	Straightforward	Straightforward	Low	Moderate	High

CMS Audits using the E/M Documentation Guidelines

- Developed jointly by the AMA CPT Editorial Panel, HCFA and then CMS, and specialty societies.
- Initial version published in 1995
 - General multisystem exam based on organ systems or body areas
- Updated in 1997
 - General multisystem exam more specifically defined
 - Single organ system exams defined for 8 organ systems
- Two versions are currently in use - 1995 and 1997
- Auditors apply the most favorable to the physician during an audit

E/M Audit Issues

- Does documentation support billed level of service?
- Is the chief complaint stated?
- Which elements are deficient?
 - HPI
 - ROS
 - PFSH
 - PE
 - MDM

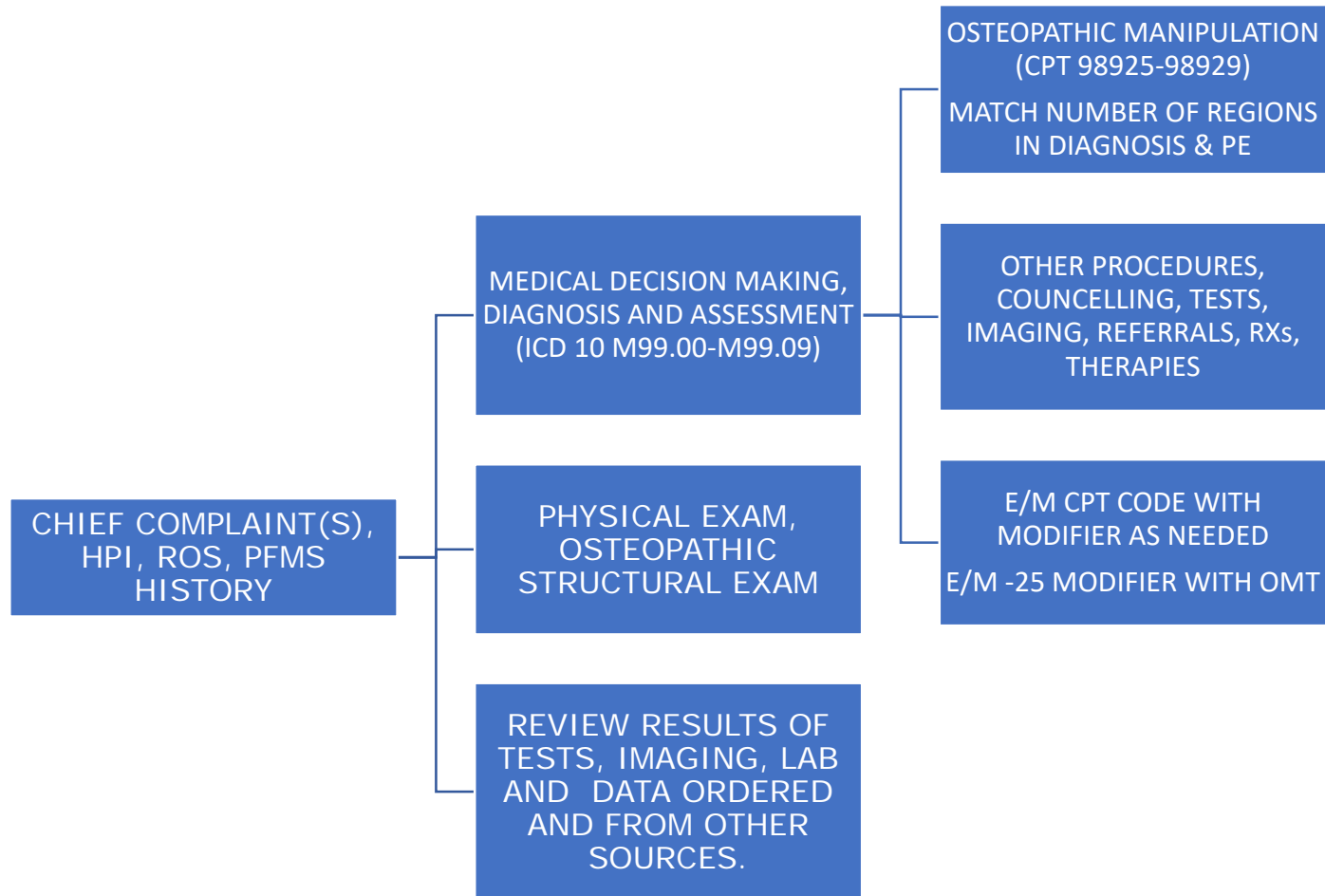
Modifier -25 Audit Issues

- -25 modifier
 - Is modifier being attached to the E/M code?
 - Does documentation support significant, separately identifiable E/M service?
 - If billed with OMT make sure that you have not created a physical therapy type treatment plan that can be viewed as needing only periodic re-evaluations

OMT Audit Issues

- Are the proper number of somatic dysfunction body regions clearly noted in the physical exam?
- Are the correct ICD-10 and CPT codes documented?
 - Body regions: Head, Cervical, Thoracic, Lumbar, Sacral, Pelvic, Upper Extremities, Lower Extremities, Rib Cage, Abdomen and Other
 - Do the OMT codes (98925-98929) match the number of Somatic Dysfunction codes (M99.00-M99.09) billed?

Decision Tree



Case #1: Problem Focused 99212

Subjective:

24 year old white female complains of sudden onset low back pain after lifting 25# child 2 days ago. Pain constant 5/10, localized in lumbar and right buttock. No weakness or numbness of lower extremities. No previous history of low back pain. Increased with forward bending. Decreased with backward bending, Motrin, hot bath.

Review of Systems: Denies weakness, ataxia, neurosurgical deficits, bowel and bladder incontinence

Past medical & social history: noncontributory

Objective

Well dressed white female in moderate distress, gait antalgic right.
Neuro: DTR, SLR and strength L4, L5 and S1 intact.

Musculoskeletal: Tender paravertebral muscles lumbosacral, R > L;
psoas spasm on the right; right unilateral sacral flexion; L1 flexed,
sidebent and rotated right; L5 flexed, sidebent and rotated right.

Assessment (ICD-10 CODING)

1. Somatic dysfunction
 - lumbar M99.03,
 - sacrum M99.04,
2. Lumbar strain (choose the most appropriate)
 - Initial encounter S39.012A
 - Subsequent encounter S39.012D
 - Sequela encounter S39.012S
3. Low Back Pain M54.5

Treatment Plan and Medical Decision-making

1. OMT to two areas (98925):
 - ME to psoas, ST to lumbar, HVLA to lumbar, Articulatory to sacrum. All areas improved
2. Evaluation and Management 99212 (problem focused) with -25 modifier
 1. Ice, NSAIDS
 2. Consider muscle relaxant if spasms continue
 3. No imaging necessary at this time

Case #2: Detailed E/M

- 62 year old Asian male presents with a history of headaches that have been more frequent since he began taking a new medication Cymbalta for 2 weeks for recent situational depression prescribed by another provider. Headaches are occipital radiating to his temple on the right and last 2-3 hours. Denies aura, nausea or vomiting, sweating, tremors, twitching or restlessness. He states he is spending more time at the computer at work.
- Sinus congestion left facial with difficulty sleeping
- Blood pressure is well controlled with metoprolol
- Low back pain is less severe with tramadol. No spasms or radicular pain and ADLs better tolerated without severe flare ups
- Medications: tramadol 50 mg bid prn back pain, metoprolol XL 50 mg daily, and Cymbalta 30 mg daily
- PMH: hypertension, lumbar spondylosis on x-ray
- FSH: no change
- Trauma history: none

Examination

- Vitals: BP: 110/65 Pulse: 62 bpm Resp: 16/min in no acute distress
- Cardiopulmonary: Heart RRR without murmur, pulses intact, no bruit or JVD, no edema; breathing normal with clear lungs to A/P
- Neuro: DTRs intact x4, sensation intact, CN 2-12 intact, no radicular pain elicited in upper and lower extremities, no tremors, good balance
- ENT: congested left sinus with poor air motion through left nares; moist mucous membranes, no erythema or tonsillar swelling, no lymph nodes in head neck and supraclavicular region

Musculoskeletal and Osteopathic Structural Exam

- MS: loss of normal lordosis lumbar, stiffness without spasm lumbar paraspinals with active and passive range of motion. Stiff neck affects posture and motion contributing to occipital headache. Normal motion and strength of extremities x4
- Lumbar: L4 flexed, sidebent right and rotated right, L5 extended bilaterally, loss of lordosis, moderate loss of extension affecting posture and gait
- Cervical: C2 flexed with suboccipital trigger point right causing accentuation of headache, C5 extended sidebent right rotated right limiting rotation left of neck, no spasms or radicular pain into upper extremities,
- Cranial: SBS torsion right with tender point pterion right contributing to headache, jaw and facial bone motion stiff with tenderness over maxillary sinus left.
- Thoracic, ribs, sacrum, pelvis, upper and lower extremities normal

Assessment Discussion

- Change in headaches with increase in computer work is consistent with his right sided headache. Concern that Cymbalta is causing headache as a side effect or reacting with tramadol and will communicate with other provider about this issue.
- Left sided sinus congestion is not consistent with presenting headache. To use saline nasal spray when needed. No testing necessary at this time.
- BP is well controlled and is to continue present medication
- Low back pain improved and is to stop tramadol. He is to go to yoga class and stretch daily to reduce stiffness and pain. Assess work space and adjust as needed to reduce postural stressors.
- OMT is appropriate to address the somatic dysfunction which is contributing to headache, neck and low back pain

Medical Decision Making and Coding

- Diagnoses and treatment
 - G44.216 Episodic tension type headache not intractable
 - D/C tramadol, headache diary, computer stretches handout given for work
 - J01.00 Left maxillary sinus congestion
 - Saline nasal spray
 - M47.16 Lumbar spondylosis without myelopathy
 - Yoga, stretching handout given, D/C tramadol and may use acetaminophen 500 mg prn
 - Somatic dysfunction
 - M99.00 Cranial: osteopathy in the cranial field
 - M99.01 Cervical: soft tissue, balanced ligamentous tension, myofascial release
 - M99.03 Lumbar: muscle energy, myofascial release
 - 98926 CPT for OMT
 - 99214 -25 Detailed E/M

Procedure Note for OMT

- The patient consented to the application of OMT and was positioned appropriately for the technique(s) and repositioned as needed. Appropriate hand positioning for provision and monitoring of the techniques applied was performed. Reassessment of the effectiveness of the technique(s) used was performed.
 - Cranial: osteopathy in the cranial field
 - Cervical: soft tissue, balanced ligamentous tension, myofascial release
 - Lumbar: muscle energy, myofascial release
- The patient tolerated the procedure, was given post procedure directions and is to call with any problems.

Summary

- Document what you do!
 - Documentation guidelines give good template for components of encounters
- Accurately code what you do with most current codes!
 - Purchase annually for accurate updates as codes may change or be deleted!
 - ICD-10
 - CPT
 - HCPCS
- Be paid appropriately for what you do!
 - Link proper ICD-10 and CPT codes
 - Use modifiers appropriately
 - Bill in a timely manner

Professional Resources

- AOA Guide to Coding & Documentation: Osteopathic Manipulative Treatment
- AOA Online Learning
- AOA On-demand learning modules
- AOA Webinars
- AAO OMEC

