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Osteopathic Coding

ICD-9-CM

This classification system is used to report the diagnosis. The publication itself has three parts:

- **Volume 1:** Tabular list: Numeric, up to 5 digits for some diagnoses 739 Nonallopathic lesions, not elsewhere classified. Includes: segmental dysfunction and somatic dysfunction. In addition, there are specific fourth digits used to denote the specific body region involved.

Example: 739.3 Lumbar region lumbosacral

- **Volume 2:** Index to Diseases: Alphabetic by presenting symptom or disease

Example: Dysfunction somatic (Various regions listed with appropriate numbers)

- **Volume 3:** Procedures: Used for inpatient only.Â 93.6 Osteopathic manipulative treatment Specific techniques employed denoted by fourth digit.

Example: 93.62 Osteopathic manipulative treatment using high velocity, high amplitude forces

Springing forces

NOTE: As of March 1994, physicians filing claims with Medicare are required to use the ICD-9 codes for diagnosis. Medicare will no longer accept H-ICDA.

HCFA Common Procedural Coding System (HCPCS)

This alpha-numeric classification system is used to report the use of drugs, supplies and durable medical equipment as well as some procedures.

Example: L0180 Cervical, multiple post collar, occipital/mandibular supports, adjustable

Physicians' Current Procedural Terminology (CPT)*

This 5-digit classification system is used by physicians to report services and procedures. In 1994, the CPT Editorial Panel voted to accept the proposal of the AOA to move the osteopathic manipulative treatment codes from the HCPCS alphanumeric system into CPT. The CPT publication includes a definition of OMT as well as definitions of specific body regions. The OMT codes (98925-98929) are structured by the number of body regions treated, not the body site or the technique(s) employed. These codes should be used for both inpatient and outpatient treatment. (Note: HCPCS M codes and CPT codes 97260 and 97261 have all been deleted and therefore should no longer be used for OMT.)

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

In addition, there are two-digit modifiers, which may be attached to the 5-digit procedure code to indicate that a service or procedure that has been performed has been altered in some way from the code descriptor.

NOTE: For Medicare, the -25 modifier must be attached to the E/M code reported in conjunction with

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OMT.

In 1992, the entire coding system for evaluation and management (E/M) was changed. The new E/M codes range from 99201 to 99499 and are organized according to site of service; new vs. established patient and the level of care provided. The appropriate code to report is based on key components: history; examination; medical decision making; counseling; coordination of care; nature of presenting problem; and time. The first three components (history, examination and medical decision making) are considered the key components in selecting a level of E/M service.

Medicare RBRVS (Resource Based Relative Value System)

RBRVS is a physician payment schedule initiated in January 1, 1992. The RBRVS represents the first major change in how Medicare pays for physicians' services since Medicare's inception in 1965. The major components of the RBRVS are:

- The relative value scale
- The conversion factor
- Geographic adjustments
- Balance billing limitation.

Effective January 2000, Practice Expense Relative Value Units (RVUs) will be assigned for each CPT code. These values will assist in differentiating the true physician expenses that are related to the code based on site specific settings (ie. facility vs. non-facility) as well as the expenses related to Specialty specific expenses (ie. primary care vs. proceduralist).

Also January 2000, resource based Professional Liability Insurance (PLI) RVUs were effective, thereby providing a totally resource based work value that is calculated as follows: *Total RVU = Work RVU + Practice Expense RVU + PLI RVU*.

HCFA 1500 Form

The HCFA 1500 form is a universal billing form developed by HCFA for physicians and other providers to report services. This form was recently revised in 1992 to meet new government mandates for Medicare reimbursement. These forms are available through the AOA at a special member discount.

Appropriate Use of OMT Codes

After the physician evaluates the patient and arrives at a diagnosis, it is allowable to use an evaluation and management (E/M) code in addition to the appropriate OMT code (98925-98929) provided the physician has documented in the patient's record the E/M service provided. It is important that the E/M service is appropriately documented as well as the OMT service provided. However, separate diagnoses are not required for the separate services.

Coding Case Study

A 42-year old male with confusion and pain in the neck and upper back presents to a neurosurgeon. Patient also complains of exacerbation of previous lumbar disc herniation with radiculitis following a motorcycle accident. After evaluation of the patient, the diagnosis is:

1. closed head injury and

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2. somatic dysfunction of the head, cervical, lumbar, sacral and rib region.

The physician then utilizes osteopathic manipulative treatment to treat the patient's head, cervical, lumbar, sacral and rib regions.

Diagnosis Coding:

1) Somatic dysfunction, head 739.0

2) Somatic dysfunction, cervical 739.1

3) Somatic dysfunction, lumbar 739.3

4) Somatic dysfunction, sacral 739.4

5) Somatic dysfunction, rib 739.8

Procedure Coding:

1) Osteopathic manipulative treatment (OMT); five to seven body regions involved 98927

2) Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a detailed history
- a detailed examination
- medical decision making of moderate complexity 99214-25

Explanation of Code Selection

For the diagnosis coding of somatic dysfunction it is necessary to code to the fourth digit (eg. 739.1) as one should code to the most specific ICD-9 code. Not coding to the fourth digit could cause the payor to reject this claim.

Code 98927 was selected for the OMT provided as five regions were treated. In selecting the E/M code, since the patient had been seen by the physician within the past three years, this was an established patient. A detailed history and examination were performed and medical decision making of moderate complexity was provided, hence the selection of CPT code 99214. The -25 modifier was added as this indicates to the payor that a significant, separate identifiable evaluation and management service was provided in addition to the OMT.

Reviewing the Explanation of Benefits (EOB)

Review the Explanation of Benefits (EOB) provided by the payor. This will indicate what you billed and how it was recorded by the claims processor. Sometimes errors are made by the claims processor in entering data, so this could be one reason for rejection.

Make sure you have attached the -25 modifier to the E/M code reported as not doing this will flag the E/M service for nonpayment. Be sure that the patient has met all insurance deductibles and copayments. Also be sure that osteopathic manipulative treatment is covered under the patient's policy. A patient's

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insurance information should be updated each time the physician sees that patient to ensure that the patient has not changed payors or type of coverage.

Claims Appeal

When you are sure that all of the above conditions have been satisfied and you feel that an error has been made in processing, you need to send an appeal letter to the payor. The letter should include the claim number, which is listed on the EOB, the patient's identification number, the provider (physician) identification number and an explanation from the physician as to why (s)he is appealing this claim. Complete documentation should be attached, including a copy of the original claim filed as well as the EOB. If possible, you should address your appeal to a specific individual at the payor, such as the carrier medical director or claims manager. The claims processor who processed the original claim will have little or no authority to adjust the claim.

American Osteopathic Association
Division of Socioeconomic Affairs