Dynamic Chiropractic

CPT Confusion, Part II

CMT VS. OMT, OR BILLING SENSE VS. BILLING CENTS

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Conflicts clarify -- B.J. Palmer

Editor's note: Part one of this two-part series was published in the 3-24-1997 issue.

Hypothetical question: Since any physician can use any code in the CPT code book, in any section, what will prohibit MDs or DOs in managed care groups to list their PAs or PTs as offering chiropractic manipulative therapy, to show that they have a "full service" managed care clinic?

As recognized by state and federal funded programs, DCs are qualified "physicians." Thus, you have freedom of choice to use any CPT code numbers that best describe what you do based on your state laws, rules, and regulations. Don't forget your insurance equality and equity laws. Medicare CMTs "are not" for all patients: only Medicare patients. Don't be tricked into using CMTs for all types of patients, and carefully document all services.

The E&M or evaluation and management service codes may be reported separately and can be combined with other appropriate services provided, as long as they are documented in your patient chart records. "Caution," when using the E&M codes with Medicare CMT codes.

With an established patient, you must consider seven factors for every office call. The three primary factors are history, examination, and decision-making. You must have two of the three documented in your file.

The three contributory factors are: counseling, coordination of care, and the nature of the problem. These come into play when the decision has been made to either adjust the patient or to order therapy, rehabilitation, or laboratory work, etc.

The last factor is time. This is the least important factor. However, if 50 percent or more of your time is spent counseling the patient (i.e., report of findings) and/or coordinating their care (i.e., rehabilitation, exercise program), you would pick the appropriate code number based on the time you spent with the patient for these particular counseling procedures.

On establishing general patients, I again suggest that you use documented E&M codes for office calls (99211-99215) and the OMT codes for the adjustments/manipulations (98925-98929), plus any other clinical services performed. Also code your ancillary counseling or rehabilitation procedures performed, all of which are documented in your file and coded separately for billing.

I hope this type of documentation will establish a database in the United States for "all" procedures chiropractors perform daily, not only our "manipulations" of a subluxation as demonstrated by an exam and x-rays that are not paid for, along with the new noncovered 98943 (federal Medicare def.).

The CPT code book introduction states specifically that one is to select the code number(s) of the procedures that identify the service(s) performed. The physician then may list other additional

procedures performed or pertinent special services. When necessary, he/she must list any modifying or extenuating circumstances. Any service or procedure should be accurately documented in the patient's health care record (chart/travel card).

It is important to recognize that the listing of the services or procedures provided and their CPT code numbers may be in specific sections of the CPT book. However, these sections do not restrict the use by any specialty group. Any procedures or services in any section of the CPT book may be used to designate the services rendered by any licensed qualified physician. Again, this also means that any MD or DO could use CMTs in their managed care organization.

Question: If an MD or DO used CMT chiropractic manipulative treatment (CMT), who can now evaluate its necessity? The five (5) OMTs for clarification, address the number of areas (regions) involved by manipulation (i.e., 98925-98929).

98925 1-2 regions
98926 3-4 regions
98927 5-6 regions
98928 7-8 regions
98929 9-10 regions

These regions by definition are different from the Medicare CMT regions and extraspinal definitions.

You should not confuse OMT regions and codes with the HCFA II Medicare CMT regions and codes:

98940 1-2 regions
98941 3-4 regions
98942 5 regions
98943 extraspinal, 1 or more (noncovered Medicare)

It would be arbitrary and capricious for anyone to use Medicare CMT for all patients, and then oppose the use by doctors of chiropractic of the CPT E&M, the OMT codes, or the 97260-97261 (along with the physical therapy codes and rehabilitative exercise codes). To ever imply that the reason DCs utilize these codes is to circumvent policy limits or to increase their reimbursement of services rendered is absurd. The OMT codes are used to clarify clinical procedures performed by any doctor, including a DC. CMTs are for HCFA II Medicare patients. Today, the practicing DC and CA are always required to recognize and honor the parameters and limitations on federal, state, and specific patient health care contracts or specialty contracts. It is the same if a DC enters into a limited contract with Blue Cross/Shield, PPO, PPA, HMOs, or managed care, etc, which require specific code usage for limited care parameters. Every one of these contracted programs may have their own special code numbers to bill for the same procedures (i.e., manipulations). Medicare CMTs are not for all patients. I realize that many CAs want one set of codes to bill for all adjustments, but this is not possible because of the different types of patients and contracts involved.

Another concern that I now have comes out of the East Coast of the United States. Recently there appeared to be a battle in Pennsylvania regarding manipulation parameters and coding between Blue Cross/Blue Shield and DCs. BCBS apparently has not indicated that DCs in Pennsylvania will use the "W" codes (not Medicare CMTs).

The most interesting thing that is now apparently happening in Maryland, Washington, D.C., and Virginia is an effort to indicate that these states may now have reciprocal agreements with Pennsylvania. This could circumvent any particular state's contractual language utilizing the

limiting parameters of the "W" codes (not Medicare CMTs) imposed by BCBS of Pennsylvania on DCs in the surrounding states. This was apparently done with the help of consulting DCs and BCBS DC consultants (again, no CMTs for BCBS Pennsylvania DCs).

It appears that when an agency (BCBS) in a state (Pennsylvania) is successful in a legal and/or legislative battle against a particular agency or group (DCs), the surrounding states and third-party administrators could immediately flock to that state to write reciprocal agreements to circumvent their state insurance laws. This means state equity laws and equality laws may be circumvented more easily now for additional denials. With this new ploy, this could be worse than hiding behind the ERISA rules.

For those of you who are still concerned that DCs should not be using the E&M and OMT codes on general patients, look at the enclosed letter from Palmer College of Chiropractic indicating that the E&M codes are taught to be used in conjunction with the OMT codes.

Palmer College of Chiropractic 1000 Brady Street, Davenport, IA 52803/(319) 326-9600 Fax (319) 326-9897
September 25, 1996
To Whom It May Concern:
In regards to the utilization of Evaluation and Management Codes, this section is taught in our Chiropractic Protocol courses which includes insurance reporting, jurisprudence, practice management, and finance. In the insurance reporting class we inform the student of proper code utilization, but also indicate that certain insurance companies will only reimburse for certain codes (whether appropriate or not). The new code which appeared in 1994 is the 98925 code. Osteopathic manipulative treatment (OMT). This 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 (American Medical Association, Physicians' Current Procedural Terminology CPT '96). This code best describes what we do as chiropractors. Barry Eisenberg, Director of the Division of Payment Policy and Programs stated in a letter on December 10, 1994, that "the instructions of CPT clearly indicate that any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician." So 98925 is the correct code of choice, not 97269. Code 98925 will probably soon replace A2000 too.
Evaluation and management codes/services may be reported separately if, and only if, the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual preservice and postservice work associated with the procedure.
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 OMT	one to two body regions
98926	three to four body regions
98927	five to six body regions
98928	seven to eight body regions
98929	nine to ten body regions

OMT (Osteopathic Manipulative Treatment) does not describe a specialty. It describes a service performed. Third-party payers need to recognize this service/code and pay the qualified physician who is providing the service, period!
Please let me know if you have any additional questions.
Sincerely,
Mark R. Doerfeld, DC

MRD/jdl

This of course should be based on a review of your state laws and scope of practice and patient reimbursement contracts being billed under Medicare. CMT should be used for Medicare patients.

Lastly, I would be remiss if I did not voice my concerns regarding the usage of the '97 Medicare CMT codes for all patients. Apparently, from reports I have received, at a number of ACA presentations throughout the United States (regarding CMT-usage) the instructors are teaching their opinions on the new Medicare CMT codes. Opinions differ. It was specifically stated that approximately 87 percent of all chiropractors today are only adjusting 1-3 areas with a breakdown of 1-2 areas by 24 percent, 3-4 areas of 63 percent, for a total of 87 percent adjusting 1-3 areas. I find this statement interesting, especially if you have a full spine subluxation-based practice.

It appears from ACA statistics and presenter recommendations that by utilizing the Medicare CMT codes for all patients, they are suggesting DCs should be moving towards the practice of area (region) and pain treatment only, and moving away from a vertebral subluxation complex-based/full spine-based practice.

All licensed doctors of chiropractic must make their individual "innate" decision whether they are a vertebral subluxation complex full spine-based practice, or a pain based/area only treatment practice.

There have been statements by different ACA Medicare CMT presenters indicating that those chiropractors who adhere to the VSC full spine method of treatment, and the VSC-based practice with the utilization of a 98942 (CMT 5 regions) or a 98927 OMT (5-6 regions), will be more closely scrutinized by HCFA and other third-party carriers and their paid chiropractic consultants.

Some ACA/DCs who were teaching the utilization of the '97 Medicare CMT codes, indicate that a 98927 code and/or a 98942 code, will also diminish our access in third-party systems or federal reimbursement programs in the future. One instructor also implied that even if you adjust 4 or 5 regions, you should really consider listing 98940 (1-2 regions) so we look good in the federal database or future third-party program inclusion.

I say, "Report and document what we do." Let's get compensated for what we do on a parity basis. We too pay taxes for the U.S. health care delivery system to operate.

I do not agree that the '97 Medicare CMT codes are what chiropractors needed or what we are looking for as an answer to our problems for all patient reporting. We need equality, not Medicare codes tracked in a computer which are then reimbursed to us less than CPT coded combinations.

In my opinion, we need to be paid for what we do clinically on a parity basis with MDs and DOs. Also, we legally should not be letting PTs, PAs, and nurse practitioners do manipulations to patients' spines.

The OMT codes served the chiropractic profession very well in 1994-1996. Of course, we also could not be discriminated against using these codes, as we historically had been by computer searchers to isolate our reimbursements. We all (MDs, DOs, DCs) used OMTs in the past.

What do we do now if all insurance companies adopt the '97 Medicare CMT codes. What if they all say now that we can't use the OMT codes or the 97260-97261 codes with the E&M codes and reduce our reimbursements again in '97?

Please look at the enclosed chart. You will see by the utilization of the E&M codes, other '97 CPT

code options, plus your PT and rehabilitation codes. Your reimbursement levels should be on a par with those physicians (MDs, DOs) who are utilizing those same codes (insurance equality law).

The reimbursement samples with the '97 Medicare CMT codes indicate that if they are now utilized for all types of patients (three examples), your reimbursement levels in the long run will drop, not increase.

The third-party administrators could now interpret that they do not have to pay for regular chiropractic office calls. The old bundling trick again! Of course, there is now also the danger that some insurance DC consultants will now say they also do not have to pay for other procedures (rehabilitation, PT, etc.) because they are now considered part of the pre/post work. Imagine PT services as part of our pre/post work (old Michigan law fight -- "preparatory to"). They could make these noncovered services or a bundling issue even within the insurance equality states.

Everyone now must make an intelligent decision based on factual information. Unfortunately there is no easy way to deal with these CPT codes questions and issues. There are many variable factors. My suggestion is, from now on, when a patient walks into your office, they should be pictured as wearing a specific colored hat. Each color of hat the patient puts on will tell you what your contractual obligation may be legally for you to bill under with a particular code. Therefore you may have:

1) a managed care contract, or a cash patient, or an in-house care contract with a "red hat" using the 97260 and 97261 codes.

2) a Medicare patient with a "white hat" utilizing the A2000 until your administrative agency implements the CMT codes (98940-98943) no later than April 1, 1997.

It should be noted that Medicare administrative agencies indicate that when you perform a CMT on a Medicare patient you need to have a spinal x-ray. There are proposals to HCFA presently that the x-ray requirement be limited to primary diagnosis (i.e., subluxation), provided there is clinical justification for adjustment for subsequent spinal problems documented in the patient chart. (I thought we always documented subluxations).

Currently, you are still required to have a documented x-ray demonstrating the existence of a spinal subluxation. Some carriers require an x-ray for each region receiving a manipulation (adjustment).

3) You may have a "blue hat" for Blue Cross patients. In many states you may have to use the A2000 again, or maybe a "W" code or a new Blue Cross tracking code.

4) You could have a "gold hat" for those patients that are auto accidents, general health or personal injury. Utilize the OMT codes (98925-98929) or possibly the 97260-97261, plus the E&M codes, along with your PT and rehabilitation codes, etc.

5) You could use a "green hat" for workmens' compensation cases. Some states have their own state W.C. codes and limits dictated by specific state laws and care parameters.

6) The last hat could be a "purple hat" which could be for Medicaid, general or county assistance, etc. Again, they may have their own specific state rules and special "chiro-code" numbers for services provided, and for services tracked in a computer.

I wish all DCs and CAs good luck. I know you will have good coding sense and with proper clinical documentation and correct CPT interpretation and the utilization of the CPT, E&M, OMT, CMT

codes, physical medicine codes, and rehabilitation codes. If you do, you will all receive good billing "cents" for good billing "sense."

I sincerely hope that this article will also clarify some of the confusion and misinformation that has been disseminated regarding the new Medicare CMT codes. I know there is still confusion regarding the ICD subluxation codes 739.++ vs. 839.++. However, every third-party payer knows if a 739.++ diagnosis appears, it's a DC. We have separate codes.

Evaluation & Management									
Office or Other Outpatient Services									
Code	Description	PFR	PFR	PFR	FF	FF	FF		
		50th	75th90th	RVU	80%	90%	AVG		
								Z 40	Z 74
99201	OC/New	PT	45	54	78	0.79	30	45	33
99202	OC/New	PT	60	69	87	1.25	50	60	49
99203	OC/New	PT	80	97	1.25	1.72	75	90	70
99204	OC/New	PT	110	129	158	2.57	100	130	100
99205	OC/New	PT	149	175	212	3.22	130	175	136
99211	OC/EST	PT	30	35	40	0.38	17	30	20
99212	OC/EST	PT	40	45	55	0.68	27	40	32
99213	OC/EST	PT	55	65	75	0.96	50	60	46
99214	OC/EST	PT	75	87	100	1.48	75	80	66
99215	OC/EST	PT	111	140	160	2.34	100	125	96
A2000	Old HCFA	Man.	25.79	23.74	25.93	0.75			
97260	1 Area	44	54	78	0.41	32	35	31	
97261	Additional Areas22	27	39	0.24	16	17.5			
98925	1-2 Regions	37	45	53	0.72	38	45	33	
98926	3-4 Regions	40	71	80	1.08	52	60	45	
98927	5-6 Regions	67	72	76	1.28	65	80	57	
98928	7-8 Regions	84	99	118	1.49	80	90	68	
98929	9-10 Regions	98	112	140	1.61	93	100	79	
98940	1-2 Regions	25.79	23.74	25.93	0.75				
98941	3-4 Regions	32.26	29.93	32.69	0.95				
98942	5 Regions	39.38	36.75	40.15	1.17				
98943	Extraspinal Regions 1&2 Base Fees	Zone 40			0.7				
97250	Myofascial Release	63	70	1R	0.84	35	41	28	
97265	Joint Mobilization 1 + Areas	63	70	1R	0.84	38	42	31	
PFR = Physicians Fee Reference									
FF = Fee Facts									

RVU = Relative Value Unit
OC = Office Call
EST = Established

You must decide if it is really good to have separate codes for diagnosis and now care. Any subjects mentioned here and opinions are the author's.

Additional comments should all be addressed in writing to Dr. K.S.J. Murkowski at 645 St. Clair Avenue, Jackson, MI 49202.

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