

Osteopathic Manipulative Treatment (OMT) Benefits to Change

Effective for dates of service on or after January 1, 2010, benefit criteria for osteopathic manipulative treatment (OMT) will change for Texas Medicaid.

OMT is a covered service when it is performed with the expectation of restoring the patient's level of function, which has been lost or reduced by injury or illness. Manipulations should be provided in accordance with an ongoing, written treatment plan that supports medical necessity. A model of documentation that supports medical necessity for the treatment plan includes the following:

- Specific modalities/procedures to be used in treatment.
- Diagnosis.
- Region treated.
- Degree of severity.
- Impairment characteristics.
- Physical examination findings - X-ray or other pertinent findings.
- Specific statements of long- and short-term goals.
- Reasonable estimate of when the goals will be reached (estimated duration of treatment).
- Frequency of treatment (number of times per week).
- Equipment and/or techniques used.

The treatment plan must be updated as the client's condition changes. Treatment plans must be maintained in the medical records and are subject to retrospective review.

The acute modifier AT must be submitted with the claim. Paper claims submitted without modifier AT will be denied; electronic claims will be rejected. The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client's condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

The following limitations apply to procedure codes 98925, 98926, 98927, 98928, and 98929:

- These procedure codes are limited to one per day for each client, by any provider.
- These procedure codes will be denied when billed on the same day by the same provider as any of the following procedure codes:

Procedure Codes						
00640	51701	51702	51703	62310	62311	62318
62319	64400	64402	64405	64408	64410	64412
64413	64415	64416	64417	64418	64420	64421

64425	64430	64435	64445	64446	64447	64448
64449	64450	64470	64472	64475	64476	64479
64480	64483	64484	64505	64508	64510	64517
64520	64530	96360	96365	96372	96374	96375
99201	99202	99203	99204	99205	99211	99212
99213	99214	99215	99217	99218	99219	99220
99221	99222	99223	99231	99232	99233	99234
99235	99236	99238	99239	99241	99242	99243
99244	99245	99251	99252	99253	99254	99255
99281	99282	99283	99284	99285	99291	99304
99305	99306	99307	99308	99309	99310	99315
99316	99318	99324	99325	99326	99327	99328
99334	99335	99336	99337	99341	99342	99343
99344	99345	99347	99348	99349	99350	99354
99356	99460	99461	99462	99463	99464	99465
99468	99469	99471	99472	99478	99479	99480

The following limitations apply to evaluation and management (E/M) procedure codes when billed with OMT:

- Providers must submit modifier 25 with the E/M procedure code to identify a separate and distinct service rendered on the same date of service as OMT.
- The E/M procedures are restricted to significant and separate identifiable issues beyond the usual pre- and post-OMT work. This restriction applies even if the E/M and OMT are related to the same symptom or diagnosis.
- Documentation must be submitted on appeal when it is medically necessary to render distinct services.