Priority Health	BILLING POLICY No. 200
Osteopathic Manipulation Treatment (OMT)	
Date of origin: June 2026	Review dates: None yet recorded

DEFINITION

Manipulative treatment or therapy is hands-on-care that involves using the hands to diagnose, treat, and prevent illness or injury. The treatment involves movement of muscles and joints using techniques including stretching, gentle pressure, and resistance. The treatment may be used to treat muscle pain and other disorders, promote healing, and increase overall mobility. - American Osteopathic Association

MEDICAL POLICY

- Rehabilitative and Habilitative Medicine Services No. 91318

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Note: Priority Health Medicare Advantage plans follow Medicare coverage and billing rules.

Coverage for manipulations

Priority Health offers many different types of benefit plans. Some include the manipulation benefit under short-term rehabilitative coverage, which means all services, including physical and occupational therapy, biofeedback and manipulation, count to the same benefit limit.

- Before treatment, verify if a patient has exhausted his/her short-term rehabilitative benefits. You can do this in **prism**'s Cost Estimator tool (preferred) or by calling oPrism's
- Benefits renew annually on the patient's contract renewal date, which may or may not be January 1.
- Also see the section on billing for physical therapy in this Manual.

Manipulations billing

Radiology

Only one provider should bill for a written interpretation of the X-ray. If you are only reviewing what the radiologist or the other physician has interpreted, do not bill for this service.

Chiropractic manipulative treatment billing

Priority Health follows national standards for documentation and billing of these services. Reference to the documentation guidelines above.

Chiropractic treatment codes include pre-manipulation of patient assessment. Priority Health recognizes that an additional evaluation and management service may be needed if the patient's condition requires a significant, separately identifiable E&M service above and beyond the usual pre- and post-service work associated with the chiropractic service. The medical record documentation needs to support all procedure codes billed.

Osteopathic Services Billing

Priority Health follows national standards for documentation and billing osteopathic manipulative treatment services.

- Osteopathic manipulation treatment (OMT) is billed based on the number of body regions treated.
- Only one OMT service should be billed per day.
- The type, duration, and frequency of services must be reasonable and consistent with the standards of practice in the medical community.
- E/M services may be reported separately, using modifier 25 if the patient's condition requires a significant separately identifiable E/M service above and beyond the usual pre- and post-treatment service.
- The E/M service may be for the same conditions for which the OMT is provided, so it may be billed with the same diagnosis.
- The documentation should clearly distinguish between the services that support the E/M service and the OMT service.
- The American Osteopathic Association recommends reporting an E/M service appended with modifier 25 with OMT on both initial and follow-up visits provided that the services are medically necessary and supported by the clinical documentation.
- Billing must be supported by Priority Health documentation requirements.

There are 10 body regions, with ICD-10 codes corresponding to the dysfunction for each region. There are five CPT codes that can be used depending on the number of regions treated:

- **98925**: Osteopathic manipulative treatment (OMT); 1-2 body regions involved
- **98926**: Osteopathic manipulative treatment (OMT); 3-4 body regions involved
- **98927**: Osteopathic manipulative treatment (OMT); 5-6 body regions involved
- **98928**: Osteopathic manipulative treatment (OMT); 7-8 body regions involved
- **98929**: Osteopathic manipulative treatment (OMT); 9-10 body regions involved

Place of service

Summary of pertinent information (if applicable).

Documentation requirements

Summary of expected documentation within medical records.

Coding specifics

- What specific codes and/or revenue codes are impacted by this category?
- What specific coding guidelines or elements do we want to call out associated with this topic?
- Does NCCI, CMS, other payers call out anything specific associated to billing and coding requirements, not payable, etc.

Modifiers

If a provider does both the technical and professional components of a procedure, the procedure code should be billed without a modifier to show it is a global service.

- **AT modifier**: See Chiropractic manipulative treatment billing, below.
- **TC modifier**: If the X-rays are taken in the office and interpreted by another provider outside your practice, append the modifier TC (technical component) to the procedure code.
- **26 modifier**: If the X-rays are taken by another provider and you provide the written interpretation, append modifier 26 (professional component) to the procedure code

References:

The American Chiropractic Association states, in article titled "Coding Misuse Prompts Fraud Investigations":
Billing an Evaluation and Management (E/M) Code on Every Visit with CMT: In general, it is inappropriate to bill an established office/outpatient E/M code (99211-99215) on the same visit as Chiropractic Manipulative Treatment (98940-98943) because CMT codes already include a brief pre-manipulation assessment. There are times when it would be appropriate, but it should not be routine.

Examples of when it may be appropriate to bill an additional E/M service would be the evaluation of new patients, new injuries, exacerbations, or periodic re-evaluations. If you are told that billing an E/M code on every visit is a proper form of billing, it is incorrect. Refer to the American Chiropractic Association (ACA) website www.acatoday.org, Insurance and Reimbursement, for specific guidance on the proper use of E/M with a Chiropractic Manipulative Treatment Code (CMT).

- Visit the American Chiropractic Association website: www.acatoday.org
- Read the ACA Commentary on the Centers for Medicare and Medicaid Services Clinical Documentation Guidelines

- LCD for Osteopathic Manipulative Treatment (L3206) on the CMS website (you may have to accept the license agreement first)
- American Academy of Osteopathy Series on use of the SOAP note to record data on patient encounters to support research on osteopathic principles and practices

Related policies

- Link to relevant related policies here

Related denial language

Include any denial language here

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements are appropriate to procedure; diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standards, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding

accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
June 2026	Moved existing content to billing policy format