Testimony submitted via email.

May 30, 2017

Dear Representatives;

I am writing to oppose SB 963 that requires a health benefit plan to reimburse evaluation and management charges (office visits) as well as the osteopathic manipulative treatment (OMT) charges (adjustments) provided on the same date of service.

I am an osteopathic physician, internal medicine, and I was 8 years on the Health Services Commission some years ago. It was our policy, when receiving input or testimony, to first clarify if there was any conflict of interest. Let me assure anyone reading this that there is no conflict of interest. I am not now, or ever in the past, been part of any health insurance plan. I will not benefit, or be harmed, one way or another with the outcome of this legislation.

I do have however a large amount of experience on this subject. I have practiced internal medicine for 27 years, and I have also specialized in medical-legal consulting work for 26 years. On average, I review around 450 medical legal files every year. Part of these reviews includes a review of services provided and billing for services. My practice is independent, and I also have expertise in billing correctly.

In my opinion, it would be an error and disservice to support this legislation. The use of manipulation (osteopathic or chiropractic) is accepted but there remains much controversy on indications as well as other details. Should someone have manipulation once month, once a week, twice a week, or daily? I have seen all of the above scenarios. Should someone with limited symptoms (say neck and upper back pain, 2 areas) have manipulation of 7 or 8 areas (CPT 98928) or 9 or 10 areas (CPT code 98929) costing $150 to $175 per treatment? In osteopathic school, training focused on exams to all areas and treatment of findings and not just symptoms. It is very common, from my review of billing of chiropractors and osteopathic physicians, that adjustment codes for many areas are often used even with limited complaints.

Individuals seen regularly or often for this kind of care usually do not have new complaints. This is why the rules for billing allow office visit charges if and only if there is a separate identifiable problem. In those situations, with proper documentation, evaluation service charges can be billed and reimbursed along with the OMT charges. On the other hand, if office visit (E+M) charges are supported even when there no new complaints, then costs will essentially double (typical 15-20 office visit, 99213, around $180 although many physicians up-code and use 99214, $225 range) yet with no additional work by the provider who would have documented (and was reimbursed) for that history of the complaint originally. This was not the intent when billing rules were determined and published.

There may be significant concerning repercussions if this legislation is approved. Other providers (chiropractors, acupuncture providers, naturopathic providers doing treatment like massage) could make the same requests or apply any such legislation to those services and could add E+M charges each time as well.

There is more I could write, but I am already late on providing this opinion. It was my intent to actually attend and offer my opinion directly but I learned that opportunity had passed.

Thank you for your time and consideration

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