



March 2, 2026

James D. Grant, MD
Senior Vice President & Chief Medical Officer
Blue Cross Blue Shield of Michigan
Attention: Office of the CMO
600 E. Lafayette Blvd
Detroit, MI 48226
jgrant@bcbsm.com

Dear Dr. Grant:

This letter is sent on behalf of the osteopathic physician and student members of the American Osteopathic Association (AOA), American Academy of Osteopathy (AAO), American College of Osteopathic Family Physicians (ACOFP), American Osteopathic College of Dermatology (AOCD) and the Michigan Osteopathic Association (MOA). We respectfully urge that Blue Cross Blue Shield of Michigan (BCBSM) immediately suspend plans to update how it reimburses for non-preventive E/M services appended with modifier 25 billed on the same date of service as procedure codes that have a global surgical period of 0, 10 or 90 days for services rendered on May 1, 2026, and after. The amended policy will reduce reimbursement by 50% for evaluation and management (E/M) services appended with modifier 25 when submitted on the same date of service as a global procedure code. This amended policy fails to recognize the distinct costs of providing separately identifiable E/M services. We strongly urge BCBSM to reconsider this policy to (1) avoid potential negative effects on patients, and (2) to ensure physician practices are fairly paid for their services in a manner that accurately reflects work and practice expense inputs.

The AOA represents more than 207,000 Doctors of Osteopathic Medicine (DOs) and osteopathic medical students nationwide including 26,000 family physicians through ACOFP, approximately 8,000 physicians and students through the MOA, more than 7,000 members of the AAO, and 800 osteopathic dermatologists through AOCD. DOs bring a unique, patient-centered approach to medicine, with approximately 53% of practicing DOs specializing in primary care specialties, reflecting their essential role across the continuum of care.

BCBSM's 50% payment reduction policy will result in a substantial reduction in pay that will broadly impact physicians nationwide, across all medical specialties. We are concerned that BCBSM may shortsightedly be prioritizing immediate savings over long-term plan costs and patient outcomes. BCBSM's amended policy will make it impractical for physicians to provide unscheduled services, as they would have to absorb the cost for rendering them, placing unnecessary financial strain on their practices. This may force patients to schedule multiple visits (with additional co-payments) to receive necessary treatment.

While BCBSM's new policy is likely to increase costs and disrupt patient care for a broad range of minor procedures and surgical services, we want to highlight the impact this payment reduction will have on the delivery of osteopathic manipulative treatment (OMT). AOA's OMT guidelines, which reflect CPT billing and current clinical practice guidelines, state that an osteopathic physician should report an E/M service along with the OMT procedure on initial office visits as well as subsequent visits if a new problem occurs or if original symptoms have changed. The decision to utilize OMT as part of the overall health care of patients is made on a visit-by-visit basis. As such, it is typical that on the initial and subsequent encounters a pertinent history and physical examination is performed. Based on the history and findings of the physical examination, the physician may decide to use OMT as part of the overall management of the patient on that date.

BCBSM justified the payment reduction by claiming it no longer reimburses the practice expense (PE) component twice, once for the E/M service and again for the global day code. However, this rationale reflects a misunderstanding of code valuation which includes the CPT process, RUC methodology, and CMS methodology for valuing physician services which relies on a combination of RUC recommendations, public comments, and other data sources. Under the Resource-Based Relative Value Scale (RBRVS), both E/M and procedure codes are appropriately valued, ensuring there is no duplication in payment when billed correctly.

The claim that professional practice expenses are reimbursed twice is inaccurate. The PE component of the relative value units (RVUs) accounts for the actual cost of providing a service and is comprised of direct practice expense (e.g., clinical staff time, equipment, supplies) and indirect practice expense (e.g. administrative overhead, non-clinical labor and staff time, health IT). When E/M and procedure codes are billed together, the expenses are not reimbursed twice; each service has its own allocated practice expense based on the resources required. If the codes are distinct and meet the criteria for billing separately, they are reimbursed appropriately, without duplication. The CPT and RUC process is designed to clearly define distinct services, value the work of such services, and establish guidelines on appropriate coding.

For services to receive unique CPT codes, they must not be duplicated by other codes within the code set through which they could be reported. Once codes are created or revised, they are reviewed by the RUC which makes recommendations to the Centers for Medicare and Medicaid Services' (CMS) on work relative values and direct practice expense components. This process ensures that RVUs reflect the distinct resources and time involved in each service to avoid overpayment. CMS then relies on these recommendations as it develops final work and PE RVUs.

While the RUC makes recommendations to CMS on work RVUs and direct PE inputs, CMS separately calculates total PE RVUs. In determining values for new codes and reviewing potentially misvalued codes, both CMS and the RUC consider how frequently particular codes are reported with E/M codes to account for potential overlap in resources. Because CMS expressly accounts for this potential duplication, it is unclear how BCBSM has determined that E/M services reported with a global day code have duplicative inputs.

The separate reporting of an E/M service and OMT service on the same date is an industry accepted practice and is further supported by the guidelines set forth by the CPT Editorial Panel, CMS, the RUC, and the National Correct Coding Initiative (NCCI) edits.

When specifically addressing OMT codes, multiple reviews of these codes have ensured that duplication in work and PE is avoided in RUC recommended values and CMS fee schedule values. In 2002, the AMA's RVS Update Committee (RUC) reviewed the practice expense RVUs for OMT codes (98925–98929). The committee recommended that only the practice expenses directly associated with the OMT procedure be included, excluding overlapping E/M services, which are billed separately when appropriate. CMS adopted these recommendations in 2003, and this principle remains in effect today.

As noted previously, when the RUC reviews codes to make valuation recommendations, the committee assesses codes that are commonly billed together to ensure that work and practice expense components are not duplicated. During the revaluation of OMT codes in February 2011, the RUC recommended removing duplicate direct practice expense inputs for CPT codes 98925-98929; medical supplies SB022 gloves non-sterile, SB026 gown patient and SB037 pillowcase, as these supplies are included in the Evaluation and Management service. However, other practice expense components were still deemed distinct to the OMT service.

Such payment reduction risks undermining the fair valuation of physician work and practice resources and may not align with standard reimbursement methodologies. BCBSM's policy change warrants further review to ensure compliance with established valuation frameworks and equitable provider reimbursement.

For example, comparing the CY2026 non-facility PE values of CPT codes 99213 (E/M) at 1.46 and 98926 (OMT) at 0.61 shows the OMT value is 0.85 less than the E/M. If the E/M service were included in the OMT, we would expect the OMT PE to be greater, but it is not. This discrepancy further confirms that there is no E/M component included in the OMT.

The AOA shares insurers' concerns with the rising cost of healthcare and recognizes the importance of payers' fraud, waste and abuse preventions and detection processes. We are committed to providing the osteopathic profession with the most up-to-date information related to coding, billing, and documentation compliance. However, we are deeply concerned that BCBSM's updated policies will threaten the ability of osteopathic physicians to provide accessible care to patients and obtain appropriate reimbursement that accurately reflects service input costs. Such financial pressure will threaten the existence of many osteopathic physician practices and access to care in the communities that they serve.

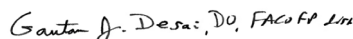
Based on the information provided, we strongly encourage Blue Cross Blue Shield of Michigan to reconsider a full withdrawal of its proposed 50% payment reduction policy.

Thank you for your consideration and commitment to providing support to contracted osteopathic physicians who provide high-quality, patient-centered care to Blue Cross Blue Shield Michigan's members. We welcome the opportunity to discuss this further and provide any additional information that may assist in your decision-making process. Please feel free to contact Kim Popernik at (312) 202-8032 or e-mail at physicianservices@osteopathic.org. We kindly request a response within thirty days from the date of this letter.

Sincerely,



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Sources of Information

American Medical Association Practice Expense Component <https://www.ama-assn.org/system/files/practice-expense-component.pdf>

American Osteopathic Association Policy H626-A-25 American Osteopathic Association OMT Coverage Determination Guidance (2025)

American Osteopathic Association Guide to Coding & Documentation: Osteopathic Manipulative Treatment Second Edition (2023)

American Medical Association (AMA) Current Procedural Terminology (CPT©) 2024 Manual

American Medical Association (AMA) Relative Value Update Committee (RUC) Database

Centers for Medicare & Medicaid Services PFS Relative Value Files (April 2024)

Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFP 410, 414, 485

<https://www.federalregister.gov/documents/2002/12/31/02-32503/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-for-calendar-year>

Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Part 414, Medicare Program; Five-Year Review of Work Relative Value Units Under the Physician Fee Schedule,

<https://www.federalregister.gov/d/2011-13052> (June 6, 2011)