KMC University

Insurance & the Chiropractic Clinic

1

Our Discussion

- Commercial Insurance
- Pre-Authorization
- Medicare
- Medicare Advantage
- Importance of Payer Relationships

2

Foundations of the KMC University Reimbursement Process

Data Gathering: New Patient Phone Call, Identify Case Type, Insurance Verification, Compare Medical Review Policy

Billing: CPT/ICD Coding, Charge Entry, Paper or Electronic Submission, Patient Billing

Collections: Paper or Electronic Remittances, Payment Posting, Follow Up-Reactive and Proactive, Appeals & Reconciliation

3

What is Commercial Health Insurance?

4

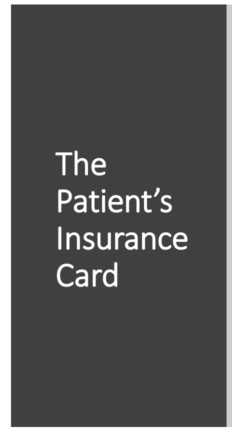
Insurance Policy

How Does a Patient Obtain Health Insurance?

5

Major Players

6



The Patient's Insurance Card

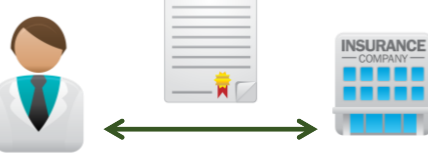
7

Provider Network Status

- In Network- Enrolled Provider
- Out of Network- Not enrolled with the payer plan

8

Doctor
Insurance Company

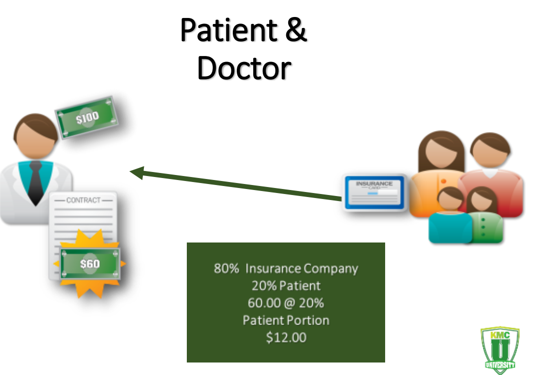


9

Insurance Company
Patient

10

Patient &
Doctor



11

Contracted Rate
Allowable Rate/Fee For Service

- Amounts that health insurance companies will pay to healthcare providers in their networks for services
- Negotiated and established in the insurers' contracts with in-network providers

Your Fee For Service 98941 =
65.00

Your Contracted Rate w/Ins. =
35.75

Your Write-Off =
29.25

12

Co-Payments

- The Patient Portion
- It's usually a flat amount
- After the allowable amount is applied for participating providers, the co-payment is applied, and then the carrier pays the balance

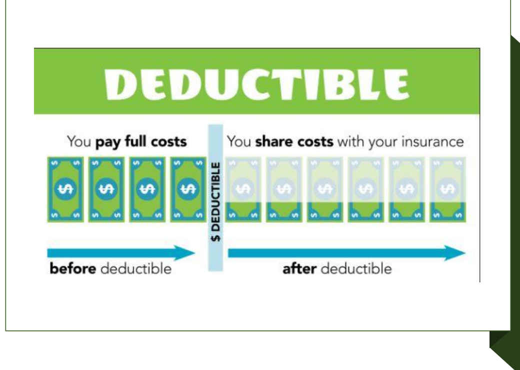
13

Co-Insurance

- Like copayments, it's the patient's portion
- Usually based on a percentage of the allowable fee vs. a flat fee

14

15



16

Benefit Maximums

Maximum number of visits covered per year

Maximum amount of charges covered per year

17

Benefit Period

- Also known as a benefit year
- Most are calendar years: January 1-December 31
- Might be a plan year: July 1-June 30

18

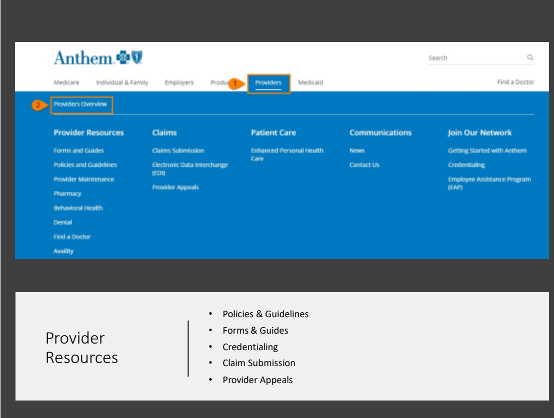
Out of Pocket Maximum

- Set dollar amount for the patient portion.
- Once satisfied, the insurance company will pay 100%.

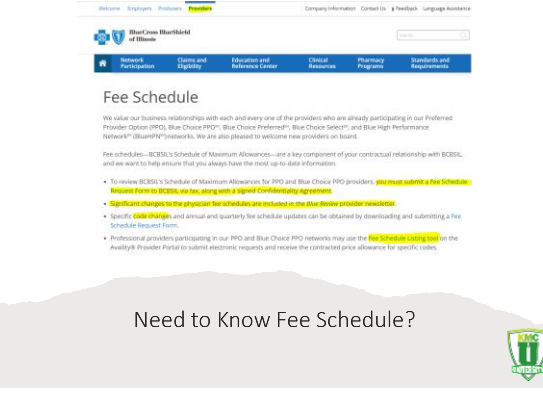
19

Payer Relationships

20

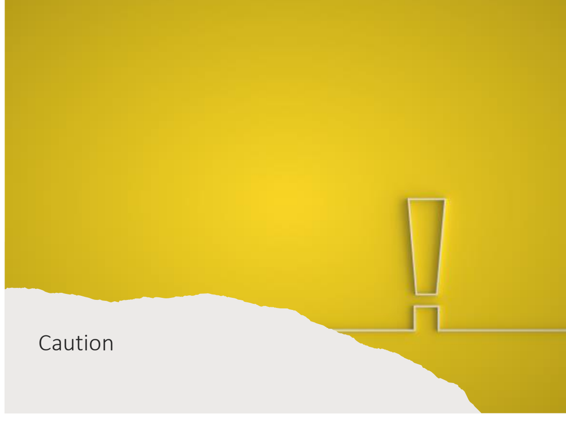


21

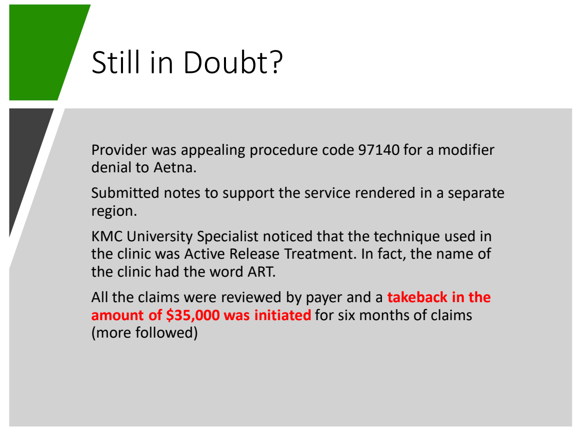


22

23



24



Still in Doubt?

Provider was appealing procedure code 97140 for a modifier denial to Aetna.

Submitted notes to support the service rendered in a separate region.

KMC University Specialist noticed that the technique used in the clinic was Active Release Treatment. In fact, the name of the clinic had the word ART.

All the claims were reviewed by payer and a **takeback in the amount of $35,000 was initiated** for six months of claims (more followed)

25

aetna

II. Use of any of the following treatments is considered experimental, investigational

- Intensive Model of constraint-induced movement therapy(CIMT)
- Intensive Model of Therapy (IMOT) programs
- Dry hydrotherapy/aquamassage/hydromassage
- Non-invasive Interactive Neurostimulation (e.g., InterX®)
- Microcurrent Electrical Nerve Stimulation (MENS)
- H-WAVE ®
- Spinal manipul
- Equestrian the
- MEDEK Thera
- The Interactive
- Dry needling
- Elastic therape tape)
- Vertebral axial DRX5000, DR (Intervertebral Spinerx LDM)

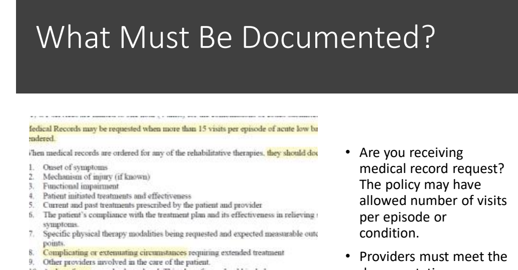
3. Chiropractic procedures:

a. Active Release Technique (see CPB 0388 - Complementary and Alternative Medicine);

x. Moire Contourographic Analysis;
y. Network Technique;
z. Neural Organizational Technique;
aa. Neuro Emotional Technique;
ab. NUCCA (National Upper Cervical Chiropractic Association) procedure;
ac. Origin insertion release technique;
ad. Positional release therapy;
ae. Sacro-Occipital Technique;
af. Spinal Adjusting Devices (ProAdjuster, PulStarFRAS, Activator);
ag. Therapeutic (Wobble) Chair;
ah. Upledger Technique and Cranio-Sacral Therapy;
ai. Webster Technique (for breech babies);
aj. Whitcomb Technique (see CPB 0388 - Complementary and Alternative Medicine);

26

What Must Be Documented?



Medical Records may be requested when more than 15 visits per episode of acute low ba... rendered.

When medical records are ordered for any of the rehabilitative therapies, they should doc...

1. Onset of symptoms
2. Mechanism of injury (if known)
3. Functional impairment
4. Patient initiated treatments and effectiveness
5. Current and past treatments prescribed by the patient and provider
6. The patient's compliance with the treatment plan and its effectiveness in relieving ... symptoms.
7. Specific physical therapy modalities being requested and expected measurable outc... points.
8. Complicating or extenuating circumstances requiring extended treatment
9. Other providers involved in the care of the patient.
10. A plan of care may also be ordered. This plan of care should include:
    a. specific statements of long - and short-term goals;
    b. measurable objectives;
    c. a reasonable estimate of when the goals will be reached;
    d. specific modalities and exercises to be used in treatment; and
    e. the frequency and duration of treatment.
11. The plan of care should be updated as the patient's condition changes.

- Are you receiving medical record request? The policy may have allowed number of visits per episode or condition.
- Providers must meet the documentation expectations for each commercial payer.

27

If coverage is available for physical therapy, the following conditions of coverage apply.

GUIDELINES

Medically Necessary

I. **A physical therapy evaluation is considered medically necessary for the assessment of a physical impairment.**

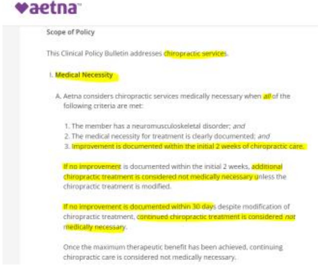
II. **Physical therapy services are considered medically necessary to improve, adapt or restore functions which have been impaired or permanently lost and/or to reduce pain as a result of illness, injury, loss of a body part, or congenital abnormality when ALL the following criteria are met:**

- The individual's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained; and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.
- Improvement is evidenced by successive objective measurements.
- The services are delivered by a qualified provider of physical therapy services (i.e., appropriately trained and licensed by the state to perform physical therapy services).
- Physical therapy occurs when the judgment, knowledge, and skills of a qualified provider of physical therapy services (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service due to the complexity and sophistication of the plan of care and the medical condition of the individual, with the goal of improvement of an impairment or functional limitation.

Medical Necessity Requirements ?

28

Must Have ALL the Components



aetna

Scope of Policy

This Clinical Policy Bulletin addresses chiropractic services.

I. **Medical Necessity**

A. Aetna considers chiropractic services medically necessary when *all* of the following criteria are met:

1. The member has a neuromusculoskeletal disorder; *and*
2. The medical necessity for treatment is clearly documented; *and*
3. Improvement is documented within the initial 2 weeks of chiropractic care.

If no improvement is documented within the initial 2 weeks, additional chiropractic treatment is considered *not* medically necessary unless the chiropractic treatment is modified.

If no improvement is documented within 30 days despite modification of chiropractic treatment, continued chiropractic treatment is considered *not* medically necessary.

Once the maximum therapeutic benefit has been achieved, continuing chiropractic care is considered not medically necessary.

29

Humana

Modifier 25
Tip Sheet

Making It Easier
for Physicians and Other Healthcare Providers
Humana.com/MakingItEasier

Humana

Modifiers 96 and 97
Tip Sheet

Making It Easier
for Physicians and Other Healthcare Providers
Humana.com/MakingItEasier

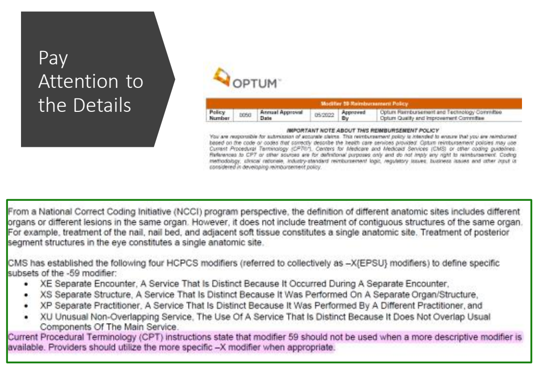
THIS INFORMATION APPLIES TO PROFESSIONAL AND FACILITY CLAIMS SUBMITTED FOR HABILITATIVE AND REHABILITATIVE SERVICES FOR YOUR PATIENTS COVERED BY HUMANA COMMERCIAL PLANS WITH ESSENTIAL HEALTH BENEFITS.

Habilitative and rehabilitative services

Humana policy

Modifier Requirements?

30



From a National Correct Coding Initiative (NCCI) program perspective, the definition of different anatomic sites includes different organs or different lesions in the same organ. However, it does not include treatment of contiguous structures of the same organ. For example, treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site. Treatment of posterior segment structures in the eye constitutes a single anatomic site.

CMS has established the following four HCPCS modifiers (referred to collectively as –X{EPSU} modifiers) to define specific subsets of the -59 modifier:

- XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,
- XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,
- XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

Current Procedural Terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. Providers should utilize the more specific –X modifier when appropriate.

31

97140 services will be denied as integral or incidental to 98940-98943 services unless submitted with a -59 modifier, indicating a distinct procedural service.

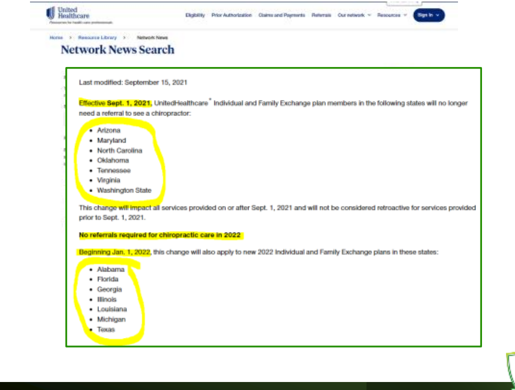
PT, OT services are limited to one hour (4 units) for the combinations of codes submitted.

Current Procedural Terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. Providers should utilize the more specific –X modifier when appropriate.

CPT code 97140 (manual therapy techniques) may not be billed on the same date of service as an extraspinal CMT code when the manual therapy service is provided to any extraspinal body region or area. In this instance, CPT 97140 is considered to be a component of the extraspinal CMT procedural code.

Payer Specific Modifier Guidance

32



Network News Search

Last modified: September 15, 2021

Effective Sept. 1, 2021, UnitedHealthcare Individual and Family Exchange plan members in the following states will no longer need a referral to see a chiropractor:

- Arizona
- Maryland
- North Carolina
- Oklahoma
- Tennessee
- Virginia
- Washington State

This change will impact all services provided on or after Sept. 1, 2021 and will not be considered retroactive for services provided prior to Sept. 1, 2021.

No referrals required for chiropractic care in 2022

Beginning Jan. 1, 2022, this change will also apply to new 2022 Individual and Family Exchange plans in these states:

- Alabama
- Florida
- Georgia
- Illinois
- Louisiana
- Michigan
- Texas

33

Look for Review Dates

Policy History

Last Review 06/03/2022
Effective: 03/25/1995
Next Review: 01/26/2023

Review History

Definitions

Additional Information

Clinical Policy Bulletin Notes

History / Updates	
6/20/2018	New
4/2019	Annual review and update
04/2020	Annual review and update
04/2021	Annual review and update
05/2022	Annual review and update

34

35

Availity

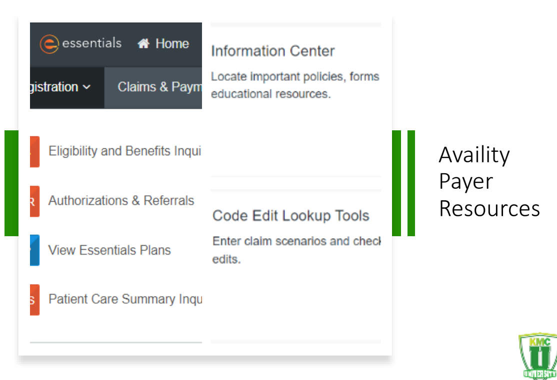
Availity is where healthcare connects

Payer-provider collaboration starts here!

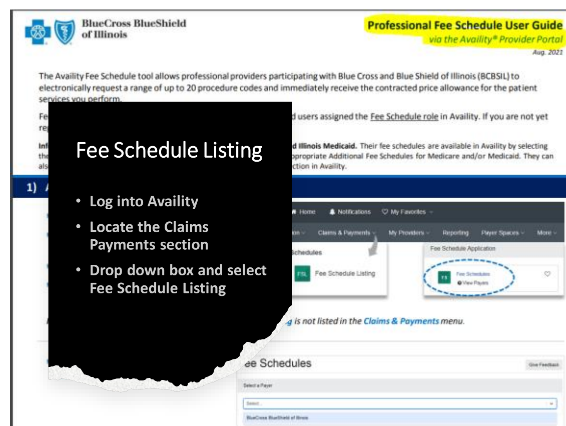
One stop log in to access a variety of payer portals

Payer Collaboration Sites

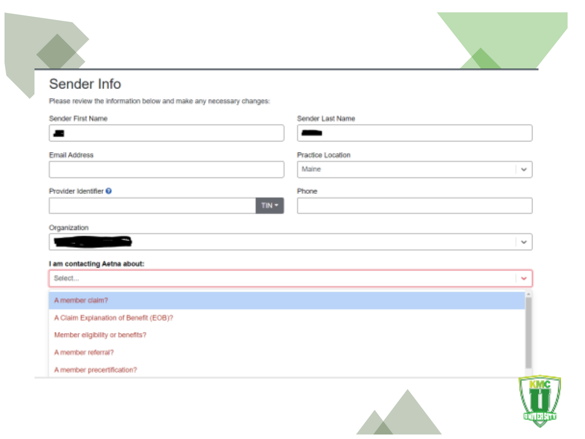
36



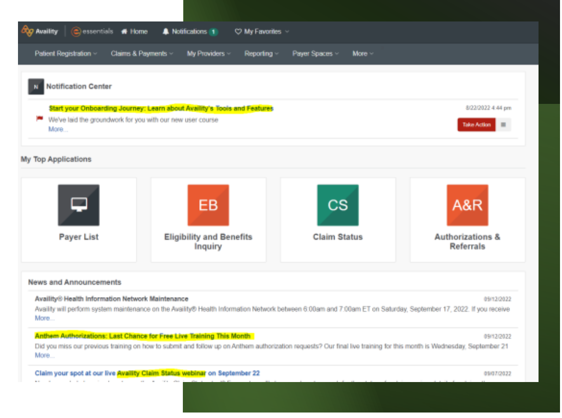
37



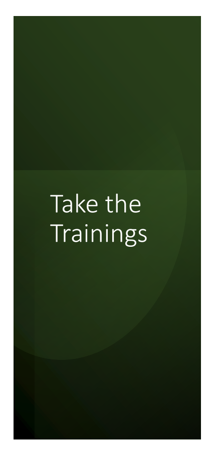
38

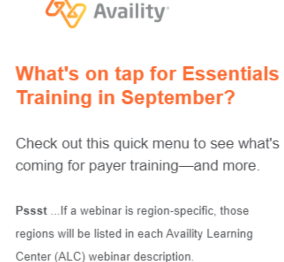


39

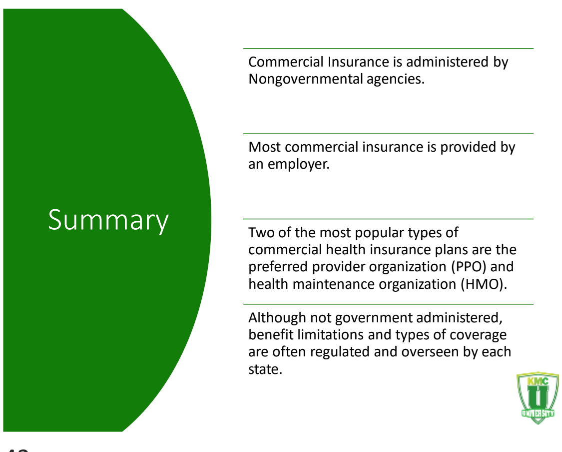


40

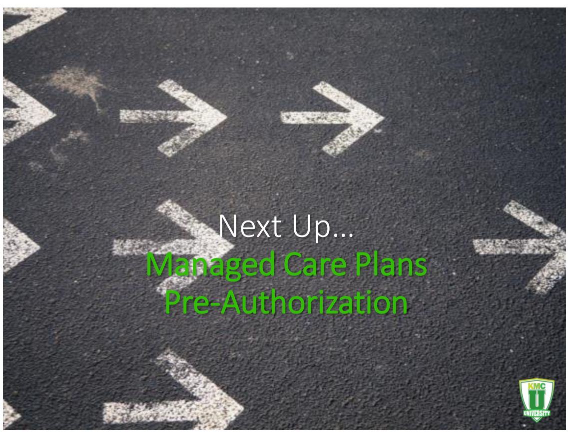




41



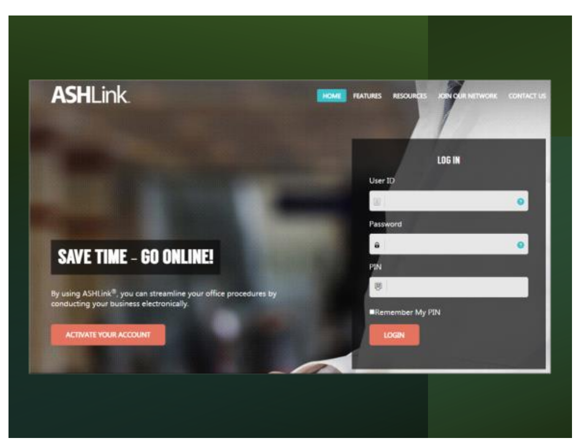
42



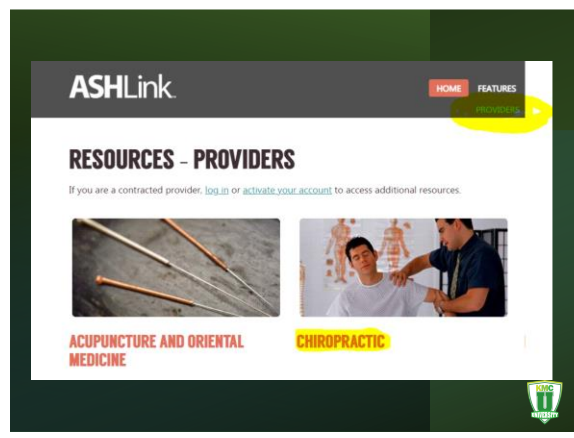
43

44

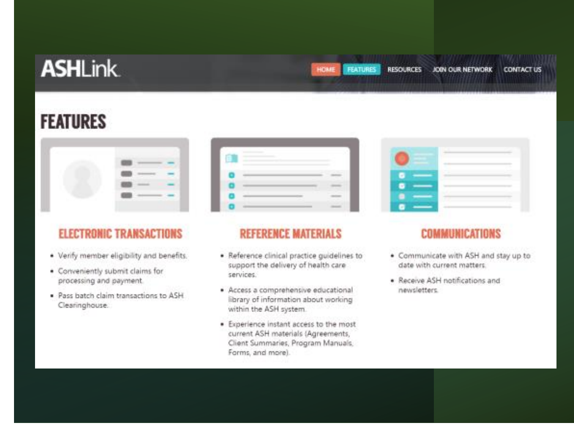
45



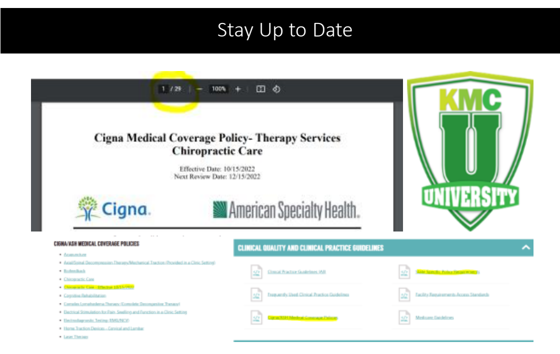
46



47



48



49

HOW TO OBTAIN VERIFICATION OF MEDICAL NECESSITY FOR CHIROPRACTIC SERVICES RENDERED BY NON-PARTICIPATING PRACTITIONERS

If your program requires verification of medical necessity for services rendered by non-participating practitioners, then coverage is limited to those services that are verified as medically necessary.

Send clinical documentation to verify the medical necessity of care to American Specialty Health Group, Inc. (ASH Group) for peer review.

You can do this by either:

Option A:

Obtain your medical records yourself for the dates of service you want verified as medically necessary and send that information by fax to the fax number below or by mail to ASH Group at the address below. The medical records should include any intake forms you completed in the practitioner's office describing your condition as well as copies of any examination forms used in assessing your condition or progress. And, tell us what dates of service you want us to review. These dates should be the first and last visit dates on the claims submitted.

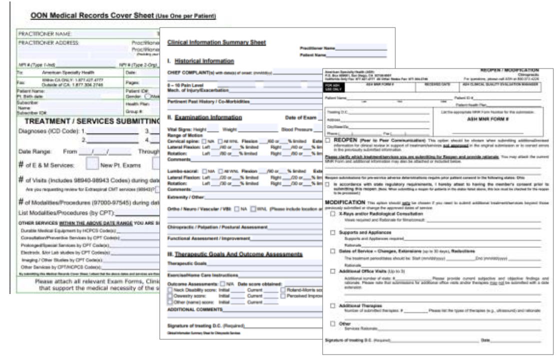
Option B:

Ask your non-participating practitioner to communicate directly with ASH Group to verify medical necessity. If your practitioner is willing to do this on your behalf, we have developed reporting tools for your practitioner to use. The practitioner can assist you in meeting your obligation to obtain medical necessity verification by:

1. Completing the Medical Records Cover Sheet which communicates the number of dates of services, manipulation services, adjunctive therapies, x-rays, etc.
2. Sending either the Clinical Information Summary Sheet or your **medical records** supporting your treatment plan for the dates of service to be reviewed. If **your practitioner** chooses to submit your medical records on your behalf, please ask him or her to attach the Medical Records Cover Sheet (and be sure to

Out-of-Network Provider Options

50



51

ASHG
American Specialty Health Group

Medical Necessity Review Response Form
PO Box 509001
San Diego, CA 92150-9001
(800) 972-4226
Fax (877) 304-2746

Batch # 254119 Practitioner# 54320

MNR Response Form No. 1191

Confidential Health Information Notice: The information in this fax may contain personal health information. It is being faxed to you after appropriate authorization from the patient has been obtained or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain this information in a safe, secure, and confidential manner. Re-disclosure without additional patient consent, or as permitted by law, is prohibited.

Patient's Name | Patient's Health Plan ID Number:
Health Plan: CIGNA | Employer Group Number:

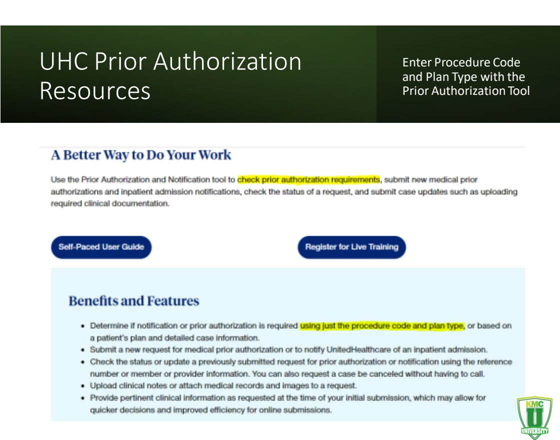
Received Date: 09/01/2017
Returned Date: 09/02/2017 10:00
Fax Number: 1-949/596-2745

Procedure	Submit	App	Set date of service	Procedure	Submit	App	CPT Codes			
New Pt. Exam	0	0	N/A	DME	0	0				
Est. Pt. Exam	0	0	N/A	Cervical X-Ray	0	0				
CMT/Adjustment	3	3	1	Lumbar X-Ray	0	0				
Therapies	3	3	1	Thoracic X-Ray	0	0				
Consultation / Preventive Svs.	0	0	N/A	Other	0	0				
				Prolonged / Special Services	0	0				
Submitted: 07/17/2017 - 08/07/2017				Lab	0	0				
Approved: 07/17/2017 - 08/07/2017										

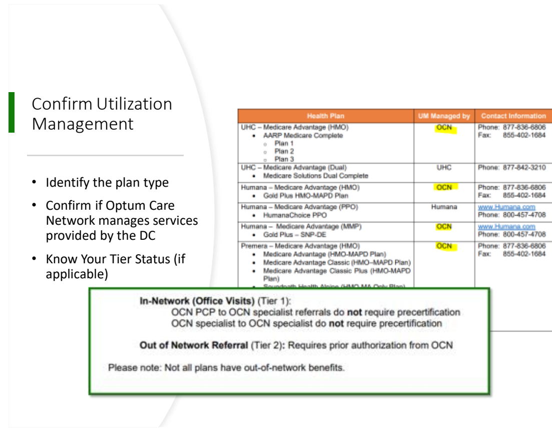
Diagnosis Code: M43.6 TORTICOLLIS
Services approved on this response form are for the condition described by this diagnosis code. Please note that when billing, you must submit claims with all diagnosis codes documented to the highest level of specificity per HIPAA coding standards.

Clinical Quality Evaluator: R. Ploeger, D.C.
Phone Ext.: 3840

52



53



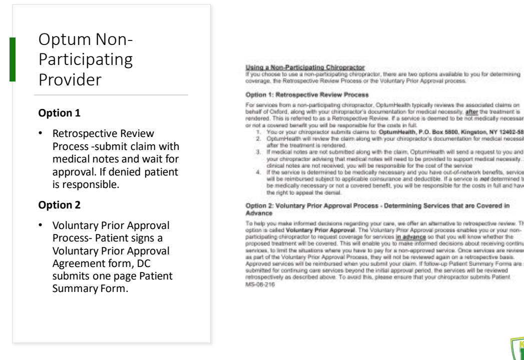
Health Plan	UM Managed by	Contact Information
UHC – Medicare Advantage (HMO) • AARP Medicare Complete ○ Plan 1 ○ Plan 2 ○ Plan 3	OCN	Phone: 877-836-6806 Fax: 855-402-1684
UHC – Medicare Advantage (Dual) • Medicare Solutions Dual Complete	UHC	Phone: 877-842-3210
Humana – Medicare Advantage (HMO) • Gold Plus HMO-MAPD Plan	OCN	Phone: 877-836-6806 Fax: 855-402-1684
Humana – Medicare Advantage (PPO) • HumanaChoice PPO	Humana	www.Humana.com Phone: 800-457-4708
Humana – Medicare Advantage (MMP) • Gold Plus – SNP-DE	OCN	www.Humana.com Phone: 800-457-4708
Premera – Medicare Advantage (HMO) • Medicare Advantage (HMO-MAPD Plan) • Medicare Advantage Classic (HMO–MAPD Plan) • Medicare Advantage Classic Plus (HMO-MAPD Plan)	OCN	Phone: 877-836-6806 Fax: 855-402-1684

In-Network (Office Visits) (Tier 1):
OCN PCP to OCN specialist referrals do **not** require precertification
OCN specialist to OCN specialist do **not** require precertification

Out of Network Referral (Tier 2): Requires prior authorization from OCN

Please note: Not all plans have out-of-network benefits.

54



Optum Non-Participating Provider

Option 1

- Retrospective Review Process -submit claim with medical notes and wait for approval. If denied patient is responsible.

Option 2

- Voluntary Prior Approval Process- Patient signs a Voluntary Prior Approval Agreement form, DC submits one page Patient Summary Form.

Using a Non-Participating Chiropractor

If you choose to use a non-participating chiropractor, there are two options available to you for determining coverage, the Retrospective Review Process or the Voluntary Prior Approval process.

Option 1: Retrospective Review Process

For services from a non-participating chiropractor, OptumHealth typically reviews the associated claims on behalf of Oxford, along with your chiropractor's documentation for medical necessity, **after** the treatment is rendered. This is referred to as a Retrospective Review. If a service is deemed to be not medically necessary or not a covered benefit you will be responsible for the costs in full.

1. You or your chiropractor submits claims to: **OptumHealth, P.O. Box 5800, Kingston, NY 12402-5800.**
2. OptumHealth will review the claim along with your chiropractor's documentation for medical necessity after the treatment is rendered.
3. If medical notes are not submitted along with the claim, OptumHealth will send a request to you and your chiropractor advising that medical notes will need to be provided to support medical necessity. If clinical notes are not received, you will be responsible for the cost of the service
4. If the service is determined to be medically necessary and you have out-of-network benefits, services will be reimbursed subject to applicable coinsurance and deductible. If a service is *not* determined to be medically necessary or not a covered benefit, you will be responsible for the costs in full and have the right to appeal the denial.

Option 2: Voluntary Prior Approval Process - Determining Services that are Covered in Advance

To help you make informed decisions regarding your care, we offer an alternative to retrospective review. This option is called **Voluntary Prior Approval**. The Voluntary Prior Approval process enables you or your non-participating chiropractor to request coverage for services **in advance** so that you will know whether the proposed treatment will be covered. This will enable you to make informed decisions about receiving continuing services, to limit the situations where you have to pay for a non-approved service. Once services are reviewed as part of the Voluntary Prior Approval Process, they will not be reviewed again on a retrospective basis. Approved services will be reimbursed when you submit your claim. If follow-up Patient Summary Forms are not submitted for continuing care services beyond the initial approval period, the services will be reviewed retrospectively as described above. To avoid this, please ensure that your chiropractor submits Patient

MS-06-216

55

OPTUM Care

PRIOR AUTHORIZATION FORM
Phone: (877) 370-2845 opt 2
Fax: (888) 992-2809

PLEASE MARK ONE OF THE FOLLOWING:
☐ ROUTINE (Normal, non-urgent request)
☐ DATE SENSITIVE (Date Sensitive is defined as an upcoming date of service)
☐ URGENT (Urgent is defined as significant impact to health of the member if not completed within 72 hours)

PATIENT INFORMATION:
LAST NAME: ____ FIRST NAME: ____ DOB: ____
PHONE: ____ INSURED ID: ____
ADDRESS: ____ CITY: ____ STATE: ____ ZIP: ____

REQUESTING PROVIDER INFORMATION:
PROVIDER NAME: ____
GROUP NAME: ____
SPECIALTY: ____
TAX ID #: ____
ADDRESS: ____
CITY: ____ STATE: ____ ZIP: ____
CONTACT NAME: ____
PHONE: ____ EXT: ____
FAX: ____

PLACE OF SERVICE INFORMATION:
PROVIDER/FACILITY: ____
GROUP NAME: ____
SPECIALTY: ____
TAX ID #: ____
ADDRESS: ____
CITY: ____ STATE: ____ ZIP: ____
CONTACT NAME: ____
PHONE: ____ EXT: ____
FAX: ____

SERVICES: DOS: ____ DME ITEMS (CHECK ONE): ☐ RENTAL ☐ PURCHASE
TYPE OF SERVICE: ☐ OUTPT ☐ INPT ☐ Office ☐ Surgery Ctr ☐ SNF ☐ Home ☐ Other: ____
DIAGNOSIS CODE(S): ____
CPT/HCPCS CODE(S) (INCLUDE NUMBER OF UNITS PER CODE): ____

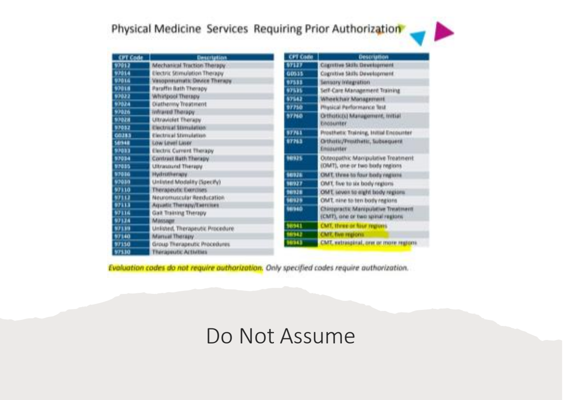
• PLEASE ATTACH SUPPORTING CLINICAL INFORMATION (E.G., PLAN OF CARE, MEDICAL RECORDS, LAB REPORTS, LETTER OF MEDICAL NECESSITY, PROGRESS NOTES, ETC.)

• ALL SECTIONS OF THIS FORM MUST BE COMPLETED.
• ON ADVERSE DETERMINATIONS, A RECONSIDERATION/EXPEDITED APPEAL MAY BE REQUESTED.

This referral/authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage.

The information contained in this form, including attachments, is privileged and confidential & is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

56



Physical Medicine Services Requiring Prior Authorization

CPT Code	Description
97012	Mechanical Traction Therapy
97014	Electric Stimulation Therapy
97016	Vasopneumatic Device Therapy
97018	Paraffin Bath Therapy
97022	Whirlpool Therapy
97024	Diathermy Treatment
97026	Infrared Therapy
97028	Ultraviolet Therapy
97032	Electrical Stimulation
G0283	Electrical Stimulation
S8948	Low Level Laser
97033	Electric Current Therapy
97034	Contrast Bath Therapy
97035	Ultrasound Therapy
97036	Hydrotherapy
97039	Unlisted Modality (Specify)
97110	Therapeutic Exercises
97112	Neuromuscular Reeducation
97113	Aquatic Therapy/Exercises
97116	Gait Training Therapy
97124	Massage
97139	Unlisted, Therapeutic Procedure
97140	Manual Therapy
97150	Group Therapeutic Procedures
97530	Therapeutic Activities

CPT Code	Description
97127	Cognitive Skills Development
G0515	Cognitive Skills Development
97533	Sensory Integration
97535	Self-Care Management Training
97542	Wheelchair Management
97750	Physical Performance Test
97760	Orthotic(s) Management, Initial Encounter
97761	Prosthetic Training, Initial Encounter
97763	Orthotic/Prosthetic, Subsequent Encounter
98925	Osteopathic Manipulative Treatment (OMT), one or two body regions
98926	OMT, three to four body regions
98927	OMT, five to six body regions
98928	OMT, seven to eight body regions
98929	OMT, nine to ten body regions
98940	Chiropractic Manipulative Treatment (CMT), one or two spinal regions
98941	CMT, three or four regions
98942	CMT, five regions
98943	CMT, extraspinal, one or more regions

Evaluation codes do not require authorization. Only specified codes require authorization.

Do Not Assume

57

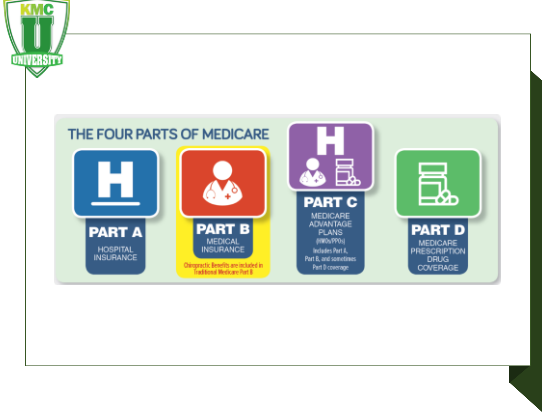
Summary

- Chiropractic has earned a good reputation with Optum
- Managed Plans are manageable if you follow the rule book
- Create a process to track authorizations in practice management software
- Strong communication with the patient is recommended
- Pay close attention to the rules when rendering services as an out of network provider

58

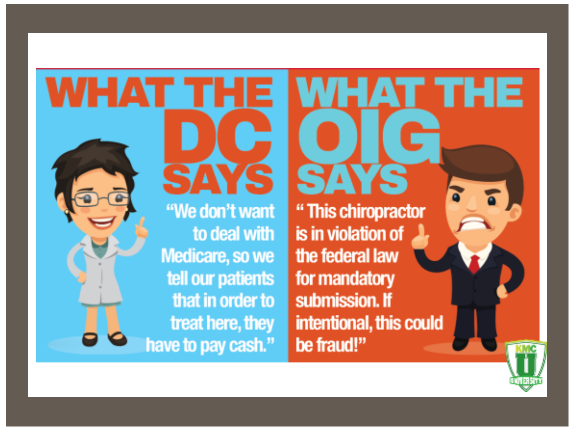
59

60



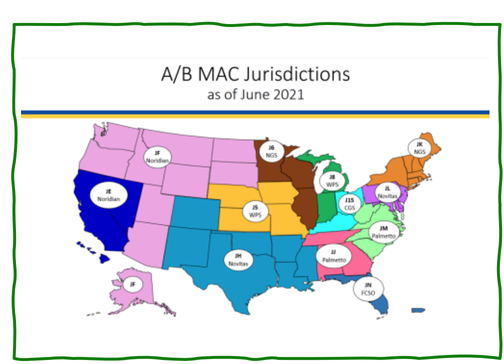
61

62

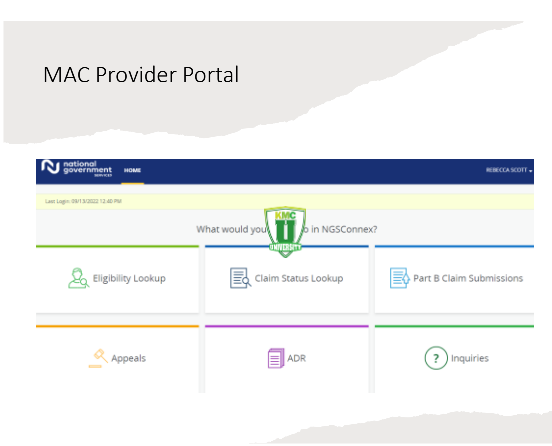


63

64



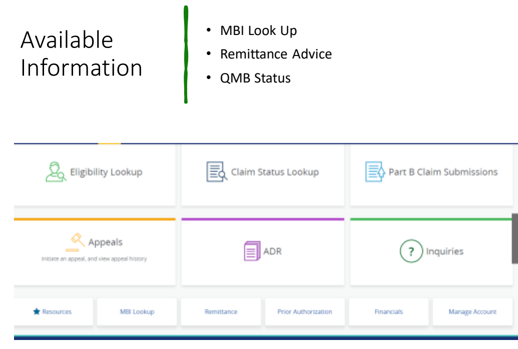
65



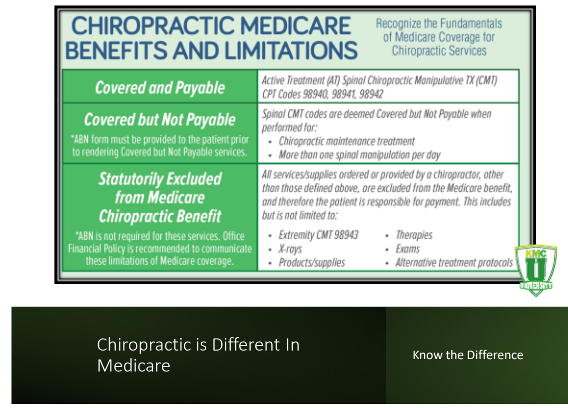
66

Available Information

- MBI Look Up
- Remittance Advice
- QMB Status



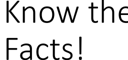
67



Chiropractic is Different In Medicare

Know the Difference

68



Know the Facts!

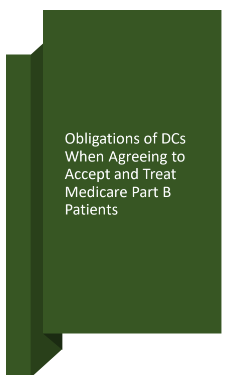
- Not allowed to Opt-Out
- Mandatory Submission rule applies to all covered services (CMT)
- Participation in Medicare is not the same as enrollment
- Claim submission required unless directed otherwise by the patient via the Advance Beneficiary Notice (ABN)

69

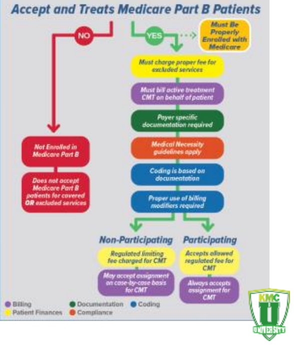
KMC University's Guide to PARTICIPATING (PAR) VS. NON-PARTICIPATING (NON-PAR) MEDICARE PROVIDER

Participating Provider (Par)	Non-Participating Provider (Non-Par)
Collects the participating allowable fee schedule amount for CMT services	Collects no more than the Limiting Fee set by Medicare at the time-of-service
Must submit claims to Medicare	Must submit claims to Medicare
Always accepts assignment in Item 27 of 1500 Claim Form	Usually does not accept assignment in Item 27 of 1500 Claim Form but may elect to accept assignment on a case-by-case basis
Submits to secondary/Medigap carriers	No obligation to submit to secondary/Medigap carriers
Reduces out-of-pocket expense for patient	Increases out-of-pocket expense for patient

70

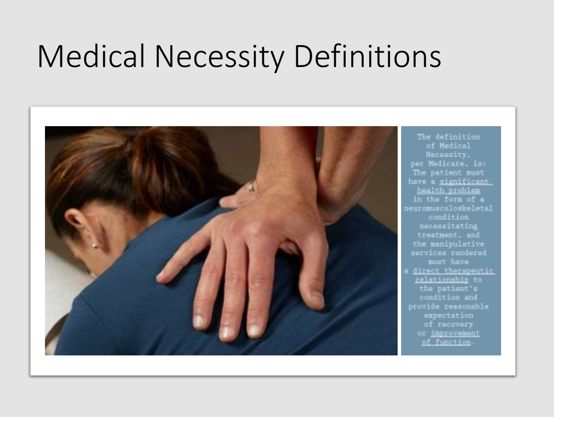


Obligations of DCs When Agreeing to Accept and Treat Medicare Part B Patients



71

Medical Necessity Definitions



72

73

The Opposite of Active Treatment

Maintenance therapy is defined (per Chapter 15, Section 30.5.B. of the Medicare Benefits Policy Manual) as a treatment plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life; or therapy that is performed to maintain or prevent deterioration of a chronic condition.

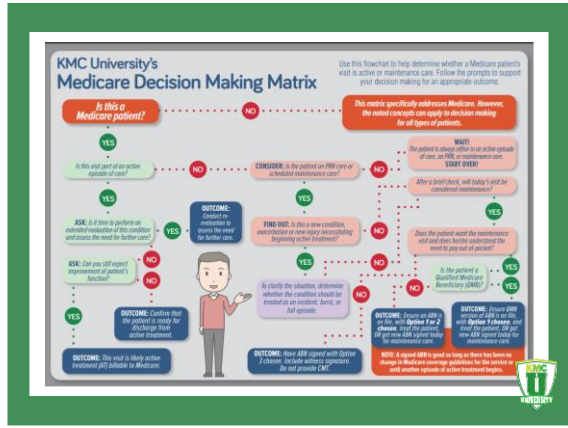
NORMAL SUBLUXATION

VERTEBRA

NERVE

DISC

74



75

MLN Matters® CMS

MLN Matters® Number: SE1101 Related Change Request (CR) #: N/A

Article Release Date: May 7, 2019 Effective Date: N/A

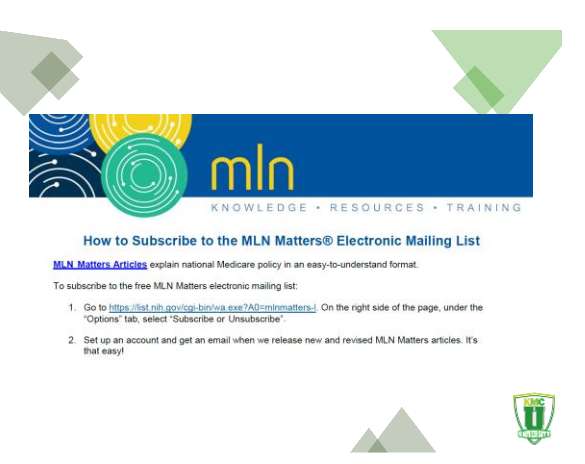
Related CR Transmittal #: N/A Implementation Date: N/A

Overview of Medicare Policy Regarding Chiropractic Services

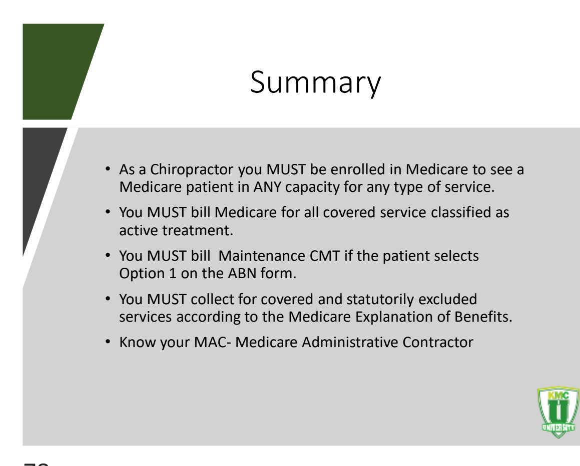
Note: CMS revised this article on May 7, 2019, to update sources of information regarding chiropractic services with additional references added to the Additional Information section of this article. We deleted several resource references that are no longer available. All other information remains the same.

Provider Types Affected

76

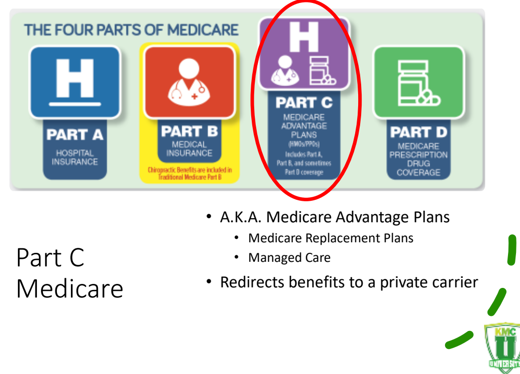


77



78

79



Part C Medicare

- A.K.A. Medicare Advantage Plans
  - Medicare Replacement Plans
  - Managed Care
- Redirects benefits to a private carrier

80

Private Health Insurance Plan

Medicare Advantage (Part C)

Private health insurance plans approved by Medicare

Medicare Advantage plans combine Medicare Part A, Part B, and often Part D into one plan with a network of providers.

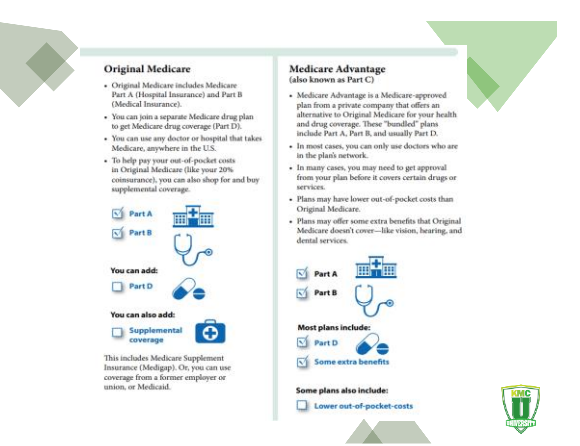
81

Original Medicare

PART A HOSPITAL + PART B DOCTOR + PART D DRUG + EXTRA BENEFITS

= Medicare Advantage (Part C)

82



Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).
- You can use any doctor or hospital that takes Medicare, anywhere in the U.S.
- To help pay your out-of-pocket costs in Original Medicare (like your 20% coinsurance), you can also shop for and buy supplemental coverage.

☑ Part A
☑ Part B

You can add:

☐ Part D

You can also add:

☐ Supplemental coverage

This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.

Medicare Advantage
(also known as Part C)

- Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These "bundled" plans include Part A, Part B, and usually Part D.
- In most cases, you can only use doctors who are in the plan's network.
- In many cases, you may need to get approval from your plan before it covers certain drugs or services.
- Plans may have lower out-of-pocket costs than Original Medicare.
- Plans may offer some extra benefits that Original Medicare doesn't cover—like vision, hearing, and dental services.

☑ Part A
☑ Part B

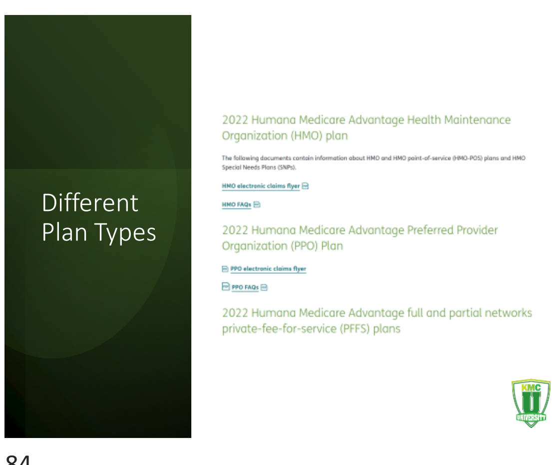
Most plans include:

☑ Part D
☑ Some extra benefits

Some plans also include:

☐ Lower out-of-pocket-costs

83



84

Identify the Plan Type & Your Network Status

85

Find the Specific Provider Manual

- Resources available online
- Simple Google Search "Medicare Advantage Provider Manual'

86

Locate Payer Policies

87

Pay Close Attention to Details

Medicare coverage of chiropractic service is specifically limited to treatment by means of manual manipulation of the spine to correct a subluxation (that is, by use of the hands). The patient must require treatment by means of manual manipulation of the spine to correct a subluxation and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement of function. Additionally, manual devices (i.e., those that are handheld with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

The mere statement or diagnosis of "pain" is not sufficient to support medical necessity for the treatments. The precise level(s) of the subluxation(s) must be specified by the chiropractor to substantiate a claim for manipulation of each spinal region(s). The need for an extensive, prolonged course of treatment should be appropriate to the reported procedure code(s) and must be documented clearly in the medical record.

For Medicare purposes, a chiropractor must place an AT modifier on a claim when providing active/corrective treatment to treat acute or chronic subluxation. However the presence of the AT modifier may not in all instances indicate that the service is reasonable and necessary. As always, UnitedHealthcare may deny if appropriate after medical review. Modifier AT must only be used when the chiropractic manipulation is "reasonable and necessary" as defined by national policy and the LCDs. Modifier AT must not be used when maintenance therapy has been performed.

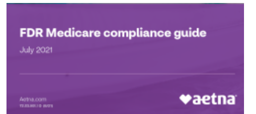
88

A provider is not required to agree to accept a PFFS plan's terms and conditions of payment or agree to treat a PFFS plan member. If a provider does not agree to accept the plan's terms and conditions of payment or refuses to treat the member, then the member will need to find another provider that will accept the plan's terms and conditions of payment. PFFS plans should assist members to locate another provider in the member's area who will accept the plan's terms and conditions of payment. For example, if there are providers in the area that the PFFS plan knows have accepted its terms and conditions of payment it should identify those providers to its members who are seeking a provider willing to be deemed as possible sources of care.

A provider that decides not to accept the plan's terms and conditions of payment should not provide services to a member, except in emergencies. If the provider nonetheless

89

FDR Compliance- A MA Requirement



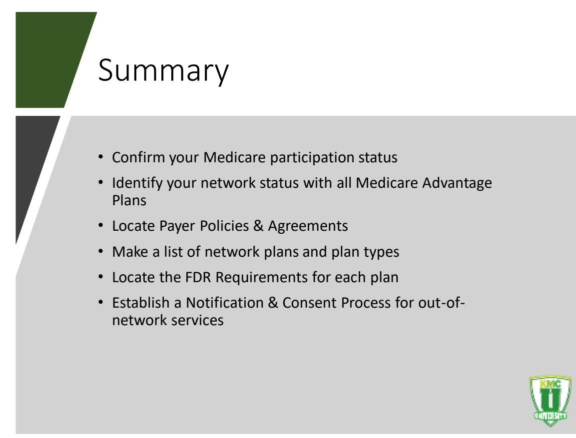
Review compliance program requirements

This guide summarizes Medicare compliance program requirements. Be sure to review it and comply with these requirements each calendar year. Here are some of the actions you must take:

- Distribute a code of conduct or a compliance policy
- Distribute general compliance and FWA education and training
- Complete exclusion list screenings
- Make employees aware of reporting mechanisms
- Report FWA and compliance concerns to us
- Report and request to use offshore operations
- Fulfill specific federal and state compliance obligations
- Monitor and audit first tier, downstream and related entities

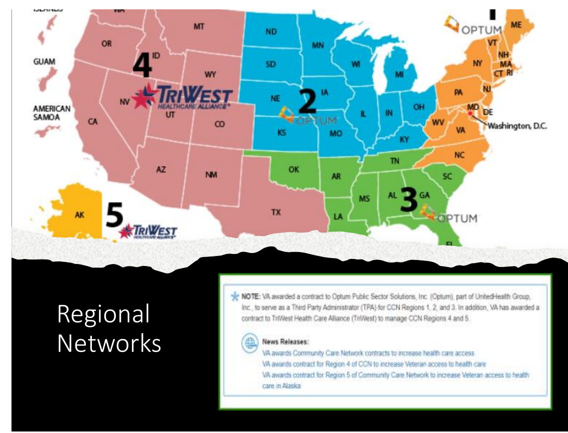
90

91

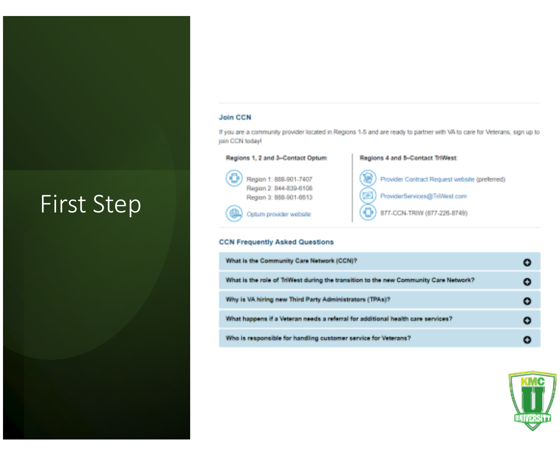


92

93

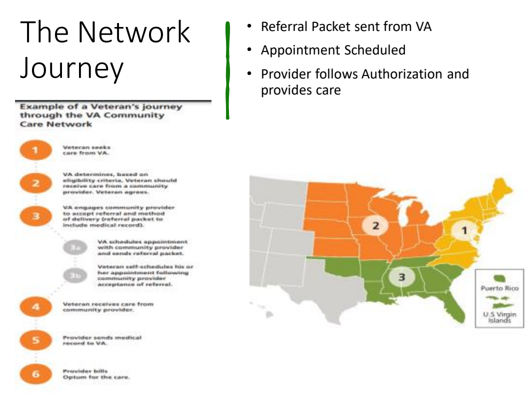


94



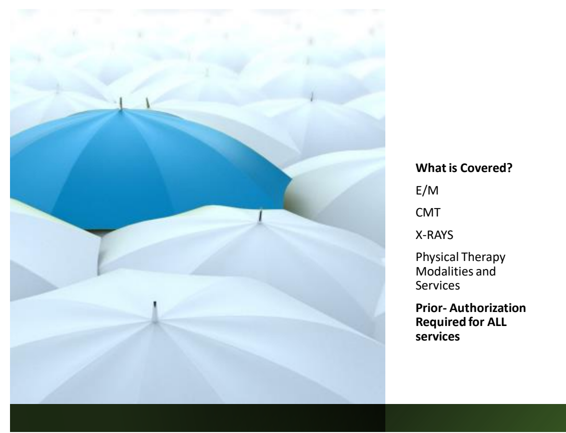
95

96



- Referral Packet sent from VA
- Appointment Scheduled
- Provider follows Authorization and provides care

97



What is Covered?

E/M

CMT

X-RAYS

Physical Therapy Modalities and Services

Prior- Authorization Required for ALL services

98

TriWest HEALTHCARE ALLIANCE

TriWest Healthcare Alliance Provider Pre-Appointing Request

THIS IS NOT AN AUTHORIZATION TO START DELIVERY OF CARE

PROVIDER INFORMATION *	VETERAN INFORMATION	AUTH INFC
Name:	Name:	Authorized (
Group name:	Address:	Chiropractic
Address:		Authorizatio
Phone Number:	DOB:	
Fax Number: not available	SSN:	Valid Dates:
Specialty:	Phone:	Nov 03, 2019
NPI:		Subject to ch appointment
* To update incorrect provider information, please email providerservices@triwest.com.		

Verification Starts with the Referral

The VA Medical Center (VAMC) will send the Veteran's selected community provider a referral.

99

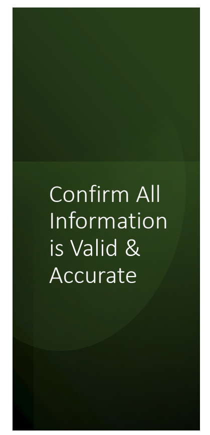
VA Member Card

Confirm Card Information with Referral Data

- Member ID
- Status- Service Connected (if applicable)

Validate patient's identity using photo on the card.

100



VA U.S. Department of Veterans Affairs

VA Form 10-7080 - Approved Referral for Medical Care

Veteran Name: ONE, Veteran
Veteran Date of Birth: 1900-01-01
Veteran Address: 515 Alpha St, DAYTON, OH 45404

Referral Number: VA0000001171
Priority: Routine
Referral Issue Date: 2019-05-31
Expiration Date: 2020-06-12
First Appointment Date: 2019-06-20

Referring VA Facility: Canandaigua VA Medical Center

Initial Community Care Provider/Facility: ACUTE & WELLNESS CHIROPRACTIC CLINIC
Initial Provider Location: ACUTE & WELLNESS CHIROPRACTIC CLINIC
Provider Name (if known): ACUTE & WELLNESS CHIROPRACTIC CLINIC

Any claim related to this episode of care MUST INCLUDE THE APPROVED REFERRAL NUMBER as the Referral Number or Prior Authorization number.

Please see below for Additional VA Referring Facility Information and Billing Information

101

- Decreased utilization of pain-related medications

dditional Information:

- Additional therapeutic modalities, including heat/cold and massage therapy require VA ap
- Additional consultations relevant to the condition require VA approval.
- Durable Medical Equipment (DME), prosthetics and orthotics requests should be faxed to t urgent or emergent.

OCEDURE	CODE RANGE	QTY	TYPE
ice/Outpatient Visit New	99201 - 99205	1	Visit
ice/Outpatient Visit Est	99211 - 99215	25	Visits

clinically necessary covered services for CHIROPRACTIC in the office, outpatient setting and ir ticipating facilities.

utine diagnostic radiology: CXR, extremity, abdomen, spine, joints and bones

ered services include the following procedure codes: 97124, 97140, 98925-98929, 98940-98943,

Look Closely For Covered Services

- Take note of visit limits
- Locate the procedure codes included in referral

102

	CODE RANGE	QTY	TYPE
sit New	99201 - 99205	1	Visit
sit Est	99211 - 99215	25	Visits
Regions	98940 - 98943	25	Visits
s	97110 - 97110	25	Visits
Therapy	97012 - 97012	25	Visits
Regions	97140 - 97140	25	Visits
ce Therapy	97016 - 97035	25	Visits
n Wound	G0283 - G0283	25	Visits
idiology: CXR, extremity, abdomen, spine, joints and bones			
Therapy	97014 - 97014		

Procedure Codes & Limitations

- The referral more likely will list the items line by line with the quantity
- Make note of this in your practice management software and set alerts to maintain the authorized treatment p

103

TriWest Healthcare Alliance

Chiropractic and Acupuncture Services

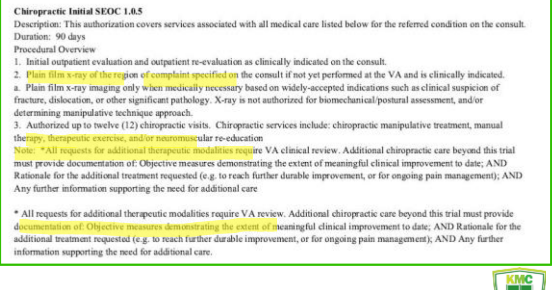
Quick Reference Guide – All Regions

included.

- If VA is appointing, submit the Request for Services (RFS) directly to the authorizing VA Medical Center (VAMC). VA will review the included clinical documentation supporting your request. If approved, you will be notified.
- No payment will be made for services rendered **without** a prior authorization.
  - Chiropractors should follow the same appointing and authorization process as other Community Care providers. Refer to the Appointment Scheduling Quick Reference Guide for more information.

Follow the Rules

104


Chiropractic Initial SEOC 1.0.5

Description: This authorization covers services associated with all medical care listed below for the referred condition on the consult.

Duration: 90 days

Procedural Overview

1. Initial outpatient evaluation and outpatient re-evaluation as clinically indicated on the consult.
2. Plain film x-ray of the region of complaint specified on the consult if not yet performed at the VA and is clinically indicated.

a. Plain film x-ray imaging only when medically necessary based on widely-accepted indications such as clinical suspicion of fracture, dislocation, or other significant pathology. X-ray is not authorized for biomechanical/postural assessment, and/or determining manipulative technique approach.

3. Authorized up to twelve (12) chiropractic visits. Chiropractic services include: chiropractic manipulative treatment, manual therapy, therapeutic exercise, and/or neuromuscular re-education

Note: *All requests for additional therapeutic modalities require VA clinical review. Additional chiropractic care beyond this trial must provide documentation of: Objective measures demonstrating the extent of meaningful clinical improvement to date; AND Rationale for the additional treatment requested (e.g. to reach further durable improvement, or for ongoing pain management); AND Any further information supporting the need for additional care

* All requests for additional therapeutic modalities require VA review. Additional chiropractic care beyond this trial must provide documentation of: Objective measures demonstrating the extent of meaningful clinical improvement to date; AND Rationale for the additional treatment requested (e.g. to reach further durable improvement, or for ongoing pain management); AND Any further information supporting the need for additional care.

105

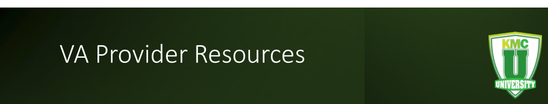
OPTUM Serve

Home News Webinars Training & Guides Forms & Resources Formulary & Pharmacy Search COVID-19 Contact

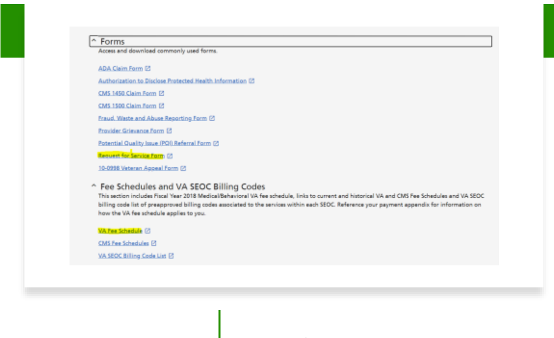
VA Community Care

Provider Portal

NEW: Provider Manual Updates



106



Optum VA Portal

- Request for Service Form
- Fee Schedule

107

Community Care Network Resources

CCN Secure Login (Availity)

Access Access VA's Referral Network

Search Multiple Claims

Check Claims Status Online Anytime

Take CCN Training

Join Our Network

Corporate Philosophy

Read Our Newsletter

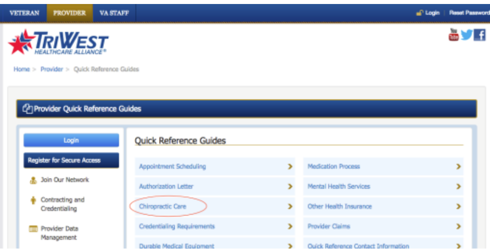
TriWest Provider Resources

- Referrals
- Trainings
- Claim Status

108

Benefits

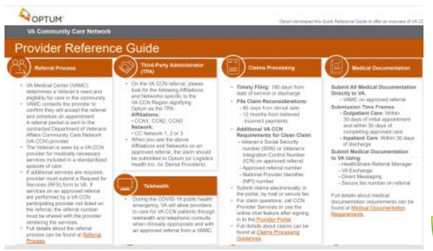
- Locate the Reference Guides on the TPA Portal or website for your region
- Select Chiropractic Care
- Review the Coverage Options, Documentation Requirements, and authorization process



109

Optum Reference Guide

- Requirements for a Clean Claim
- Include Referral Number
- Where to submit Medical Documentation to VA



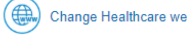
110

Know Where to Send Documentation

VA must maintain a record of all treatment rendered by a Community Provider in their database. VA will provide direction on how and where to send all treatment notes, exams and test results. DO NOT OVERLOOK THIS IMPORTANT REQUIREMENT!

Claims and supporting documentation submitted to the above address will be scann ctions and submitted electronically to VA.

PLEASE NOTE: VA strongly encourages community providers to submit claims and electronically through VA's clearinghouse, Change Healthcare. Doing so can improv reduce the amount of time for claims processing determinations.



111

Department of Veterans Affairs (VA)	Veterans	Benefit covering those who once served in the military, but have now separated or retired and become Veterans (no longer active duty). They also meet certain eligibility and health criteria. VA benefits fall under the umbrella of the Department of Veterans Affairs, which is separate from the Department of Defense.
TRICARE	Active Duty Service Members, National Guard/ Reserve, and Their Families and Retirees and their families	Civilian network providing health care benefits for active duty Service members, National Guard/Reserve members, and their families when services cannot be provided at a Military Treatment Facility. Military retirees and their families are also TRICARE eligible. TRICARE falls under the Department of Defense and receives its funding through the defense budget.
Medicare	Civilians Ages 65 Years and Older or Disabled	Federal health care benefit available to U.S. civilians who are age 65 and older. Many Veterans may have both Medicare and VA benefits.
Medicaid	Financially Disadvantaged	Federal health care program for civilians living at or under the poverty line. The threshold for eligibility varies from state to state. Veterans may have Medicaid in addition to their VA benefits.
TriWest Healthcare Alliance	Veterans Using VA Community Care Programs	Third Party Administrator contracted with VA to administer VA community care programs across all or parts of 28 states when VA cannot meet a Veteran's health care needs.

112

VA & Medicare

Medicare – Civilians Ages 65 Years and Older or Disabled

Veterans may have both Medicare and VA benefits

If you have an authorization from TriWest, **always bill TriWest – not Medicare**

113

VA & Medicaid

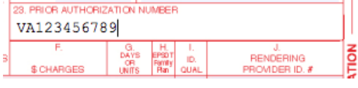
Medicaid – Medical Insurance for Financially Disadvantaged; Federal health care program for individuals living at or under the poverty line; Threshold for eligibility varies from state to state

- Veterans may have Medicaid and VA benefits
- If you have an authorization from TriWest, **always bill TriWest – not Medicaid**

114

Authorize! Authorize!

- Obtain Authorization
- Follow Authorization
- Set authorization # and limits in billing software
- Bill with Auth # on claim



115

- VA Provider must be enrolled in the Community Care Network (CCN)
- Providers must work directly with the assigned TPA
- Providers must wait for referral from VA
- Providers must follow the referral authorization
- Providers bill the TPA directly, never bill the patient, and send ALL medical records to VA.

116

117

118

119