



1

### Our Discussion

Commercial Insurance

Pre-Authorization

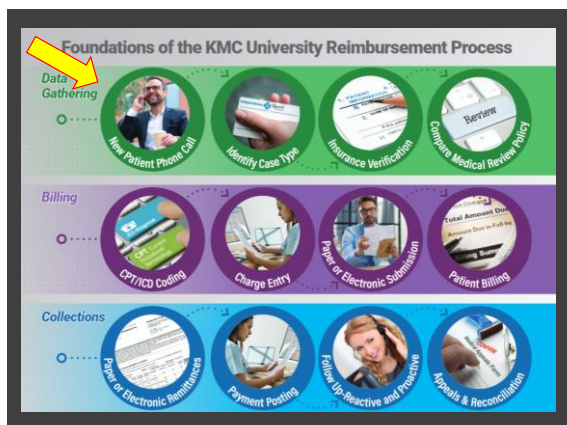
Medicare

Medicare Advantage

Importance of Payer Relationships



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### How Does a Patient Obtain Health Insurance?

5

### Major Players



6



# The Patient's Insurance Card



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## Provider Network Status

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



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## Doctor Insurance Company



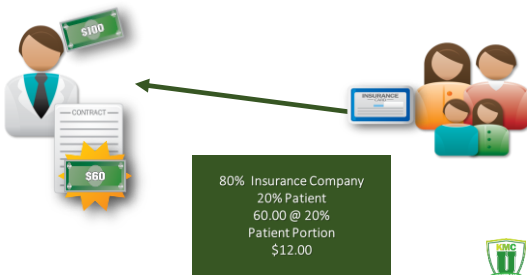
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## Insurance Company Patient



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## Patient & Doctor



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## 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**



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### 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



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### Co-Insurance

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



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### Health Insurance Deductible

The minimum balance you pay before your insurance company starts to cover medical costs.

Source: HealthCare.gov



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### DEDUCTIBLE

You pay full costs

You share costs with your insurance



before deductible

after deductible

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### Benefit Maximums

Maximum number of visits covered per year

Maximum amount of charges covered per year



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### Benefit Period

### Calendar

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



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### Out of Pocket Maximum

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

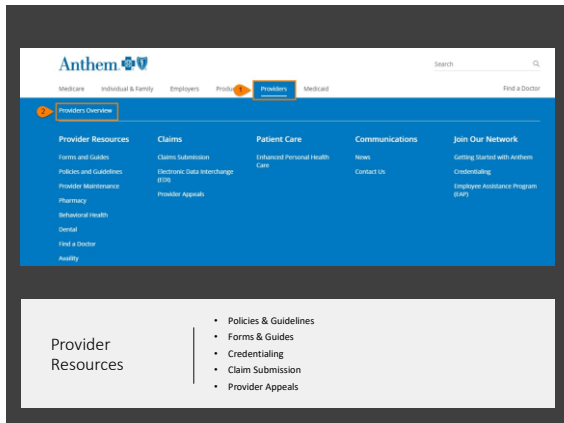
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### Payer Relationships



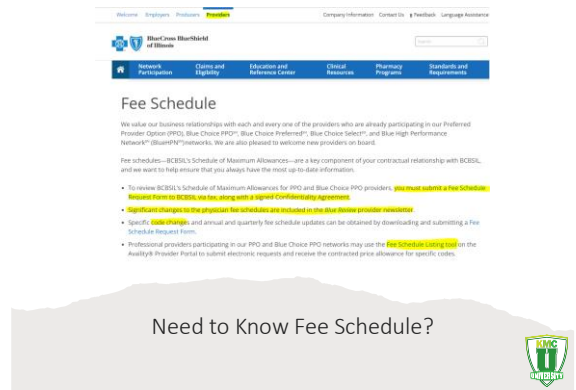
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### Provider Resources

- Policies & Guidelines
- Forms & Guides
- Credentialing
- Claim Submission
- Provider Appeals

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### Need to Know Fee Schedule?



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### Need to Know What is Covered?

**BlueCross BlueShield of North Carolina**  
Corporate Medical Policy

**Chiropractic Services**

**File Name:** chiropractic\_services  
**Organization:** 9/2065  
**Last C-AP Review:** 9/2021  
**Next C-AP Review:** 9/2022  
**Last Review:** 9/2021

**Description of Procedure or Service**

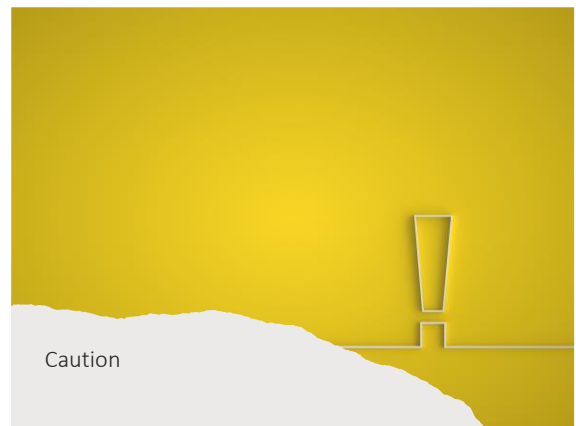
Chiropractic medicine is a system which is based on the relationship between the structure and function of the human body. Services rendered are intended to support the spinal column and nervous system functions.

Whereas Chiropractic Association published the following definitions: chiropractic care is a health care profession that focuses on diagnosis of the musculoskeletal system and the effects of those disorders on general health. Chiropractic care is used most often to treat musculoskeletal complaints, including but not limited to back pain, neck pain, pain in the arm or leg, and headaches. Spinal manipulations and other treatment modalities provided manually or with the assistance of mechanical or electrical devices.

**Cigna Medical Coverage Policy - Therapy Services Physical Therapy**  
Effective Date: 1/1/2022  
Next Review Date: 1/1/2024

**Cigna** American Specialty Health

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Caution

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## 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)

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**Use of any of the following treatments is considered experimental, investigational**

- Intensive Model of constant volume movement therapy (CMT)
- Intensive Model of Therapy (IMOT) programs
- Dry hydrotherapy (paraffin/paraffin wax)
- Non-invasive interactive neuromodulation (e.g., InteraX)
- Measurement Based Approach (MBA)
- HVAIVE
- Spinal Manipulation
  - Moire Contourgraphic Analysis
  - Network Technique
  - Neural Organizational Technique
  - Neuro Emotional Technique
- NUCCA (National Upper Cervical Chiropractic Association) procedure
- Origin insertion release technique
- Positional release therapy
- Sacro-Occipital Technique
- Spinal Adjusting Devices (ProAdjuster, PulStarFRAS, Activator)
- Therapeutic (Wobble) Chair
- Upledger Technique and Cranio-Sacral Therapy
- Webster Technique (for breech babies)
- Whitcomb Technique (see CPB 0388 - Complementary and Alternative Medicine)

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## What Must Be Documented?

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

- Onset of symptoms
- Mechanism of injury (if known)
- Functional impairment
- Patient history and effectiveness
- Current and past treatments prescribed by the patient and provider
- The patient's compliance with the treatment plan and its effectiveness in relieving symptoms
- Specific physical therapy modalities being requested and expected measurable outcomes
- Complicating or extenuating circumstances requiring extended treatment
- Other providers involved in the care of the patient
- A plan of care may also be ordered. This plan of care should include:
  - specific statements of long- and short-term goals
  - measurable objectives
  - a reasonable estimate of when the goals will be reached
  - specific modalities and exercises to be used in treatment and
  - the frequency and duration of treatment
- 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.



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

### GUIDELINES

#### Medically Necessary

- A physical therapy evaluation is considered medically necessary for the assessment of a physical impairment.
- 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 or 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 ?

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## Must Have ALL the Components

**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:

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

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

**No improvement is documented within 30 days**, despite modification of chiropractic treatments, **ongoing chiropractic treatment is considered not medically necessary.**

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



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**Modifier 25 Tip Sheet**

Making It Easier for Physicians and Other Healthcare Providers

**Modifier 96 and 97 Tip Sheet**

Making It Easier for Physicians and Other Healthcare Providers

**THIS INFORMATION APPLIES TO PROFESSIONAL AND FACILITY CLAIMS IDENTIFIED BY HARBORVIEW AND INDEPENDENT SERVICES FOR YOUR INTENT TO COVER BY HUMANA COMMERCIAL PLANS WITH CERTAIN HEALTH BENEFITS.**

**Harbortree and Harborview**

**Harbortree and Harborview**

**Harbortree and Harborview**

**Harbortree and Harborview**

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Pay Attention to the Details

**Multiple 19 Reimbursement Policy**

| Policy Number | Annual Approval Date | Effective Date | By                                      |
|---------------|----------------------|----------------|---|
| 19000         | 03/2022              | 03/2022        | Optum Quality and Improvement Committee |

**IMPORTANT NOTE ABOUT THE REIMBURSEMENT POLICY**  
You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code in which the service is billed. This reimbursement policy is intended to ensure that you are reimbursed based on the code in which the service is billed. This reimbursement policy is intended to ensure that you are reimbursed based on the code in which the service is billed.

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.

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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



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**Network News Search**

Last modified: September 15, 2021

**Effective Sept. 1, 2022:** 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

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## 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 |

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## One Stop Shopping Resources

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Availity is where healthcare connects  
Payer-provider collaboration starts here!

One stop log in to access a variety of payer portals  
Payer Collaboration Sites

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**Information Center**  
Locate important policies, forms and educational resources.

- Eligibility and Benefits Inquiry
- Authorizations & Referrals
- View Essentials Plans
- Patient Care Summary Inquiry

**Code Edit Lookup Tools**  
Enter claim scenarios and check edits.

**Availity Payer Resources**

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**Professional Fee Schedule User Guide**  
via the Availity® Provider Portal  
Aug 2021

The Availity Fee Schedule tool allows professional providers participating with Blue Cross and Blue Shield of Illinois (BCBSIL) to electronically request a range of up to 20 procedure codes and immediately receive the contracted price allowance for the patient services you perform.

**Fee Schedule Listing**

- Log into Availity
- Locate the Claims Payments section
- Drop down box and select Fee Schedule Listing

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**Sender Info**  
Please review the information below and make any necessary changes:

Sender First Name, Sender Last Name, Email Address, Practice Location, Provider Identifier, Phone, Organization

I am contacting Avia about:

- A member claim?
- A Claim Explanation of Benefit (EOB)?
- Member eligibility or benefits?
- A member referral?
- A member precertification?

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**Availity** essentials Home Notifications My Favorites

My Top Applications:

- Payer List
- Eligibility and Benefits Inquiry (EB)
- Claim Status (CS)
- Authorizations & Referrals (A&R)

News and Announcements:

- Availity's Health Information Network Maintenance
- Availity's Health Information Network between 6:00am and 7:00am ET on Saturday, September 17, 2022
- Availity's Health Information Network between 6:00am and 7:00am ET on Saturday, September 17, 2022
- Availity's Health Information Network between 6:00am and 7:00am ET on Saturday, September 17, 2022

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**Availity**

**What's on tap for Essentials Training in September?**

Check out this quick menu to see what's coming for payer training—and more.

Psst... If a webinar is region-specific, those regions will be listed in each Availity Learning Center (ALC) webinar description.

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**Summary**

Commercial Insurance is administered by Nongovernmental agencies.

Most commercial insurance is provided by an employer.

Two of the most popular types of commercial health insurance plans are the preferred provider organization (PPO) and health maintenance organization (HMO).

Although not government administered, benefit limitations and types of coverage are often regulated and overseen by each state.

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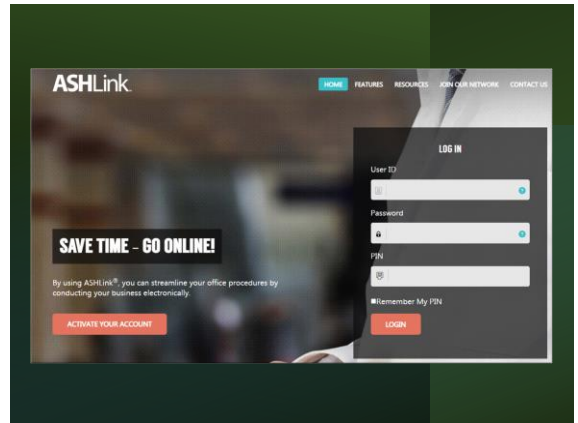
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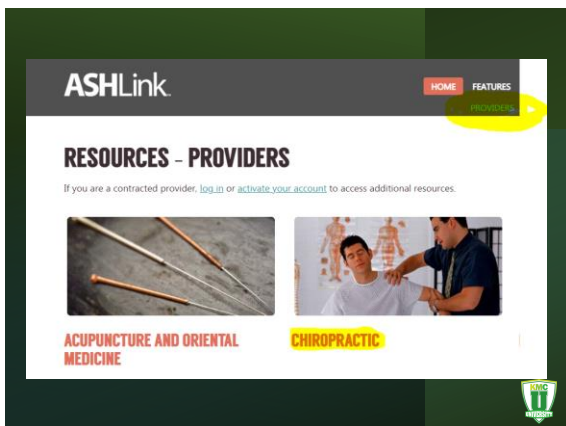
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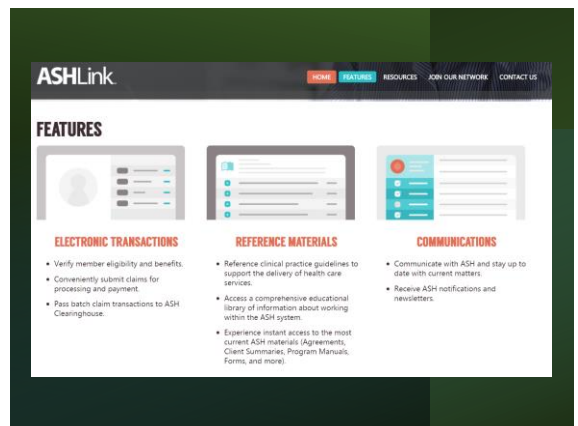
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Stay Up to Date

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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 **Local Submission 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 see box 1 or 2 to obtain the Medical Records Cover Sheet and be sure to:

Out-of-Network Provider Options

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| Procedure      | Units      | Unit of Measure | Procedure | Units                      | Unit of Measure | Opt Code |
|----------------|------------|-----------------|-----------|----------------------------|-----------------|----------|
| New Pt. Exam   | 0          | 0               | W/A       | DME                        | 0               | 0        |
| Sp. Rx Exam    | 0          | 0               | W/A       | Cardinal X-Ray             | 0               | 0        |
| Adjustment     | 3          | 3               | 1         | Lumbar X-Ray               | 0               | 0        |
| Therapy        | 3          | 3               | 1         | Thoracic X-Ray             | 0               | 0        |
| Consultation / | 0          | 0               | W/A       | Other                      | 0               | 0        |
| Preventive Svc | 0          | 0               | W/A       | Package / Special Services | 0               | 0        |
| Submitted      | 09/12/2021 | 09/02/2021      |           | Unit                       | 0               | 0        |
| Approved:      | 09/12/2021 | 09/02/2021      |           |                            |                 |          |

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UHC Prior Authorization Resources

Enter Procedure Code and Plan Type with the Prior Authorization Tool

A Better Way to Do Your Work

Use the Prior Authorization and Notification tool to check prior authorization requirements, submit new medical prior authorizations and applicant admission notifications, check the status of a request, and submit case updates such as uploading required clinical documentation.

Self-Paced User Guide

Register for Live Training

Benefits and Features

- Determine if notification or prior authorization is required using just the procedure code and plan type, or based on a patient's plan and detailed case information.
- Submit a new request for medical prior authorization or to notify Unltd-Healthcare of an inpatient admission.
- Check the status or update a previously submitted request for prior authorization or notification using the reference number or member or provider information. You can also request a case be canceled without having to call.
- Upload clinical notes or attach medical records and images to a request.
- Provide pertinent clinical information as requested at the time of your initial submission, which may allow for quicker decisions and improved efficiency for online submissions.



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Confirm Utilization Management

- Identify the plan type
- Confirm if Optum Care Network manages services provided by the DC
- Know Your Tier Status (if applicable)

| Health Plan   | UM Managed by? | Contact Information                   |
|---|----------------|---------------------------------------|
| UHC - Medicare Advantage (HMO) + ASHP Medicare Complete Plan 1 Plan 2 Plan 3  | OCN            | Phone: 877-836-6906 Fax: 855-402-1684 |
| UHC - Medicare Advantage (Dual) + Medicare Solutions Dual Complete + Gold Plus HMO-MAPD Plan  | UHC            | Phone: 877-842-3210                   |
| Humana - Medicare Advantage (HMO) + HumanaChoice PPO  | OCN            | Phone: 877-836-6906 Fax: 855-402-1684 |
| Humana - Medicare Advantage (PPO) + HumanaChoice PPO  | Humana         | Phone: 855-457-4708                   |
| Humana - Medicare Advantage (MAP) + Gold Plus - SPP-DC  | OCN            | Phone: 855-457-4708                   |
| Premiera - Medicare Advantage (HMO) + Medicare Advantage (HMO-MAPD Plan) + Medicare Advantage Classic (HMO-MAPD Plan) + Medicare Advantage Classic Plus (HMO-MAPD Plan) | OCN            | Phone: 877-836-6906 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.

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### 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 Provider

If you choose to use a non-participating provider, 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 provider, OptumHealth typically reviews the associated claims on behalf of UnitedHealthcare. For certain services, a request for medical records may be required. The request is reviewed. This is referred to as a Retrospective Review. If a service is deemed to be medically necessary or not covered benefit you will be responsible for the costs in full.

- You or your chiropractor submit claims to OptumHealth, P.O. Box 5888, Kingston, NY 12458 8888.
- OptumHealth will review the claim along with your chiropractor's documentation for medical necessity. After the treatment is rendered.
- If medical notes are not submitted along with the claim, OptumHealth will send a request to you and your chiropractor asking that medical notes will need to be provided to support medical necessity. If medical notes are not received, you will be responsible for the cost of the service.
- If the service is determined to be medically necessary and you have not obtained benefits, services will be reimbursed subject to applicable coinsurance and deductible. If 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 entering continuing services, to find the situation where you have to pay 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. Follow-up Patient Coverage Process are not available for continuing care services beyond the initial approval. The services will be reviewed retroactively as described above. To avoid this, please ensure that your chiropractor submits Patient MS-06-016.



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**OPTUM Care** PRIOR AUTHORIZATION FORM  
Phone: (877) 576-5445 ext 2 Fax: (888) 863-0828

PLEASE MARK ONE OF THE FOLLOWING:  
 ROUTINE (routine, no request required)  
 LIMIT (LIMITED/limited services is defined as an upcoming date of service)  
 LIMITED (LIMITED/limited services is defined as a specified range of health care services that is completed within 21 hours)

**PATIENT INFORMATION:**  
 LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ JOB: \_\_\_\_\_  
 PHONE: \_\_\_\_\_ INSURED ID: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**REQUESTING PROVIDER INFORMATION:**  
 PROVIDER NAME: \_\_\_\_\_ PLACE OF SERVICE INFORMATION:  
 GROUP/PRACTICE: \_\_\_\_\_ GROUP NAME: \_\_\_\_\_  
 SPECIALTY: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_  
 TAX ID # \_\_\_\_\_ TAX ID # \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
 CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ STATE: \_\_\_\_\_  
 CONTACT NAME: \_\_\_\_\_ CONTACT NAME: \_\_\_\_\_  
 PHONE: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 FAX: \_\_\_\_\_ FAX: \_\_\_\_\_

**SERVICES:** DOI: \_\_\_\_\_ (ONE TIME CHECK ONLY) - MENTAL - PURCHASE  
 TYPE OF SERVICE:  SUPPLY  SUPPLY  OTHER  SUPPLY  SUPPLY  SUPPLY  SUPPLY  SUPPLY  
 DIAGNOSIS CODE(S): \_\_\_\_\_  
 CPT/PCS CODE(S) INCLUDES ICD-9-CM ICD-10-CM ICD-10-PCS

\*PLEASE ATTACH SUPPORTING CLINICAL INFORMATION (E.G., PLAN OF CARE, MEDICAL RECORDS, LAB REPORTS, LETTERS OF MEDICAL NECESSITY/PROGRESS NOTES, ETC.)

\*ALL SECTIONS OF THIS FORM MUST BE COMPLETED.

\*AN ADVANCE ESTIMATION, A RECONSIDERATION/REVISED APPEAL MAY BE REQUESTED.

This information is not a guarantee of payment. Payment is contingent upon eligible benefits available at the time the service is rendered. Coverage, amounts, conditions, exclusions, and coordination of benefits are subject to the plan as shown in the member's Summary of Coverage.

The information contained on this form, including attachments, is provided for informational purposes only. It is not intended to constitute an offer of insurance or to be used for the individual or entity covered on this form. If the member of the form is not the individual covered by the insurance, the member responsible for the medical benefits, the member is hereby notified that any dissemination, distribution, or reuse of this information is strictly prohibited. If this communication has been received in error, the member shall notify the member immediately and shall destroy all electronic copies.



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#### Physical Medicine Services Requiring Prior Authorization

| ICD Code | Description                       | CPT Code | Description                               |
|----------|-----------------------------------|----------|---|
| 97.03    | Mechanical Traction Therapy       | 97122    | Cognitive Skills Development              |
| 97.04    | Electric Stimulation Therapy      | 60635    | Cognitive Skills Development              |
| 97.05    | Thermotherapy (Heat Therapy)      | 97123    | Memory Rehabilitation                     |
| 97.06    | Paraffin Bath Therapy             | 97135    | Self-Care Management Training             |
| 97.07    | Massage Therapy                   | 97140    | Wound Management                          |
| 97.08    | Chiropractic Treatment            | 97142    | Physical Performance Test                 |
| 97.09    | Behavioral Therapy                | 97148    | Behavioral Management, Initial Assessment |
| 97.10    | Ultrasound Therapy                | 97160    | Physical Therapy, Initial Assessment      |
| 97.11    | Electrical Stimulation            | 97161    | Physical Therapy, Initial Assessment      |
| 97.12    | Electrical Stimulation            | 97162    | Physical Therapy, Subsequent Assessment   |
| 97.13    | Electric Current Therapy          | 97163    | Physical Therapy, Subsequent Assessment   |
| 97.14    | Controlled Bath Therapy           | 97164    | Physical Therapy, Subsequent Assessment   |
| 97.15    | Ultrasound Therapy                | 97165    | Physical Therapy, Subsequent Assessment   |
| 97.16    | Neurostimulation                  | 97166    | Physical Therapy, Subsequent Assessment   |
| 97.17    | Vibrotactile Modality (VibePac)   | 97167    | Physical Therapy, Subsequent Assessment   |
| 97.18    | Therapeutic Exercise              | 97168    | Physical Therapy, Subsequent Assessment   |
| 97.19    | Neuromuscular Reeducation         | 97169    | Physical Therapy, Subsequent Assessment   |
| 97.20    | Speech Therapy/Services           | 97201    | Speech Therapy/Services                   |
| 97.21    | Group Training Therapy            | 97202    | Speech Therapy/Services                   |
| 97.22    | Ultrasound, Therapeutic Procedure | 97203    | Speech Therapy/Services                   |
| 97.23    | Massage Therapy                   | 97204    | Speech Therapy/Services                   |
| 97.24    | Group Therapeutic Procedures      | 97205    | Speech Therapy/Services                   |
| 97.25    | Therapeutic Activities            | 97206    | Speech Therapy/Services                   |

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

Do Not Assume



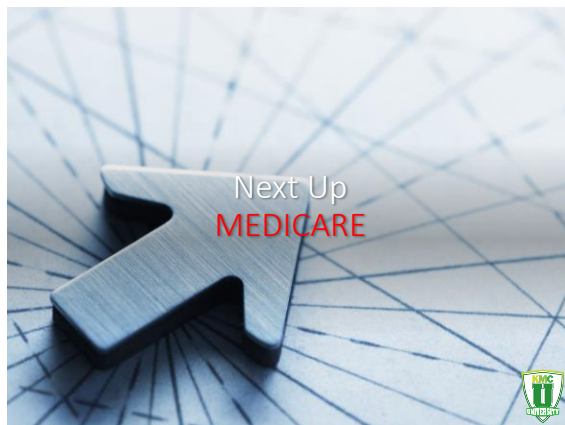
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## Summary

- 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



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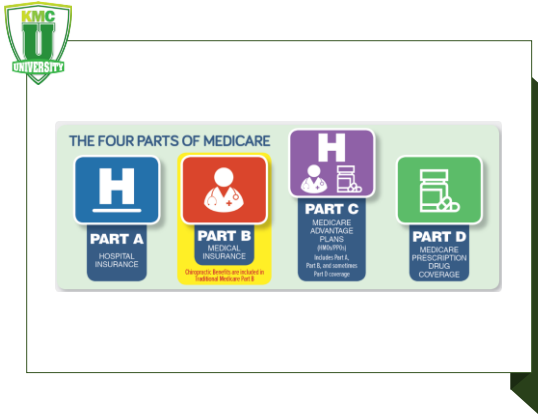


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# MEDICARE

Chiropractic Coverage

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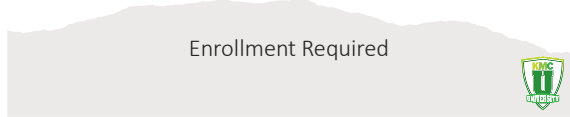
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**Things to do:**

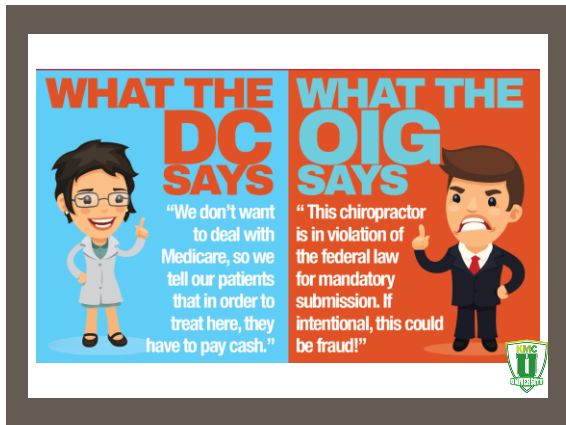
- ★ Apply for a National Provider Identification number (NPI)
- ★ Every provider must enroll in Medicare to treat a Medicare patient. **There is NO Opt-Out for chiropractors.**

**PART B**

- ★ Providers must enroll their corporate business entity in Medicare and attach individual provider numbers by reassigning benefits.



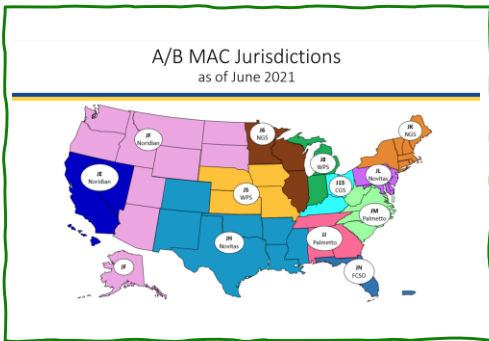
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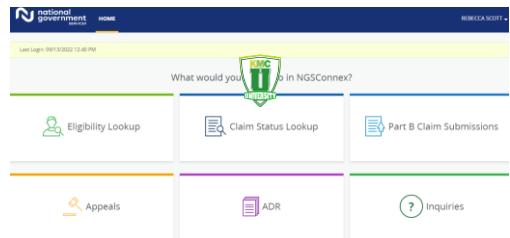
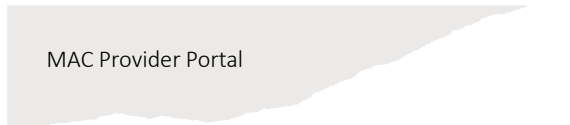
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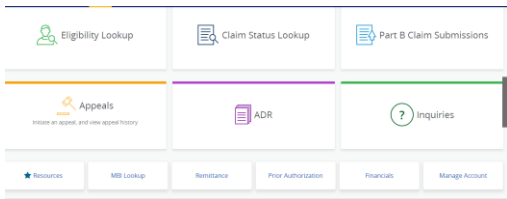
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### Available Information

- MBI Look Up
- Remittance Advice
- QMB Status



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### CHIROPRACTIC MEDICARE BENEFITS AND LIMITATIONS

Recognize the Fundamentals of Medicare Coverage for Chiropractic Services

|  |   |
|--|---|
| <b>Covered and Payable</b>                                     | Active Treatment (AT) Spinal Chiropractic Manipulative TX (CMT) CPT Codes 98940, 98941, 98942   |
| <b>Covered but Not Payable</b>                                 | Spinal CMT codes are deemed Covered but Not Payable when performed for: <ul style="list-style-type: none"> <li>• Chiropractic maintenance treatment</li> <li>• More than one spinal manipulation per day</li> </ul>   |
| <b>Statutorily Excluded from Medicare Chiropractic Benefit</b> | All services/supplies ordered or provided by a chiropractor, other than those defined above, are excluded from the Medicare benefit, and therefore the patient is responsible for payment. This includes but is not limited to: <ul style="list-style-type: none"> <li>• *ABN is not required for these services. Office Financial Policy is recommended to communicate these limitations of Medicare coverage.</li> <li>• Extremely CMT 98943</li> <li>• X-rays</li> <li>• Products/supplies</li> <li>• Therapies</li> <li>• Exams</li> <li>• Alternative treatment protocols</li> </ul> |

Chiropractic is Different In Medicare Know the Difference

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### 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)

### FACTS

Chiropractors are one of those service providers that are not permitted to opt-out of Medicare along with independent PTs and OTs.

DCs must submit bills on behalf of all Medicare patients for all CMT codes unless otherwise directed by Option Two on the Mandatory ABN.

Medicare's mandatory submission rule states that all covered services (except CMT) MUST be billed to Medicare by the provider.

Participation in the Medicare program has nothing to do with Medicare Enrollment. DCs must be enrolled to treat Medicare patients, even for excluded services.

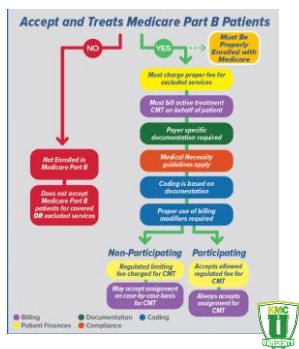
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### KMC University's Guide to PARTICIPATING (PAR) VS. NON-PARTICIPATING (NON-PAR) MEDICARE PROVIDER

| 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   |

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



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### Medical Necessity Definitions

The definition of Medical Necessity, per Medicare, is: The patient must have a significant health problem in the form of a neuromusculoskeletal condition mandating treatment, 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.

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AT = Active Treatment

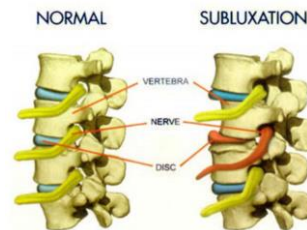
- Meets medical necessity
- Billed and expected to be paid
- Should not be automatic



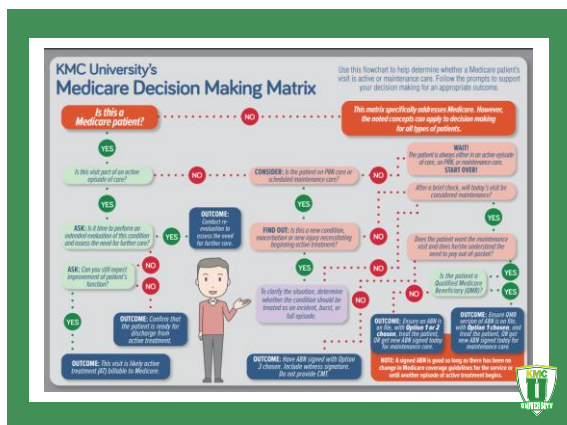
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The Opposite of Active Treatment

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.



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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

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**How to Subscribe to the MLN Matters® Electronic Mailing List**

MLN Matters Articles explain national Medicare policy in an easy-to-understand format.

To subscribe to the free MLN Matters electronic mailing list:

1. Go to <https://list.nih.gov/opt-bin/vsa.exe?AD=mlnmatters>. On the right side of the page, under the "Options" tab, select "Subscribe or Unsubscribe".
2. Set up an account and get an email when we release new and revised MLN Matters articles. It's that easy!

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Summary

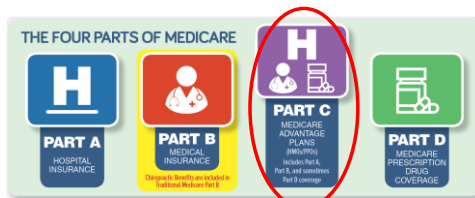
- As a Chiropractor you MUST be enrolled in Medicare to see a Medicare patient in ANY capacity for any type of service.
- You MUST bill Medicare for all covered service classified as active treatment.
- You MUST bill Maintenance CMT if the patient selects Option 1 on the ABN form.
- You MUST collect for covered and statutorily excluded services according to the Medicare Explanation of Benefits.
- Know your MAC- Medicare Administrative Contractor



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Part C Medicare

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

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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.

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| Original Medicare   | Medicare Advantage (also known as Part C)   |
|---|---|
| <ul style="list-style-type: none"> <li>• Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).</li> <li>• You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).</li> <li>• You can use any doctor or hospital that takes Medicare, anywhere in the US.</li> <li>• To help pay your out-of-pocket costs in Original Medicare (like your 20% coinsurance), you can also shop for and buy supplemental coverage.</li> </ul> | <ul style="list-style-type: none"> <li>• 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.</li> <li>• In most cases, you can only use doctors who are in the plan's network.</li> <li>• In many cases, you may need to get approval from your plan before it covers certain drugs or services.</li> <li>• Plans may have lower out-of-pocket costs than Original Medicare.</li> <li>• Plans may offer some extra benefits that Original Medicare doesn't cover—like vision, hearing, and dental services.</li> </ul> |
| <p><b>You can add:</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Part A</li> <li><input checked="" type="checkbox"/> Part B</li> </ul>   | <p><b>Part A</b></p> <p><b>Part B</b></p>   |
| <p><b>You can also add:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Part D</li> <li><input type="checkbox"/> Supplemental coverage</li> </ul> <p>This includes Medicare Supplement Insurance (Medigap). Or, you can use coverage from a former employer or union, or Medicaid.</p>  | <p><b>Most plans include:</b></p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Part D</li> <li><input checked="" type="checkbox"/> Some extra benefits</li> </ul> <p><b>Some plans also include:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lower out-of-pocket costs</li> </ul>   |

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### Different Plan Types

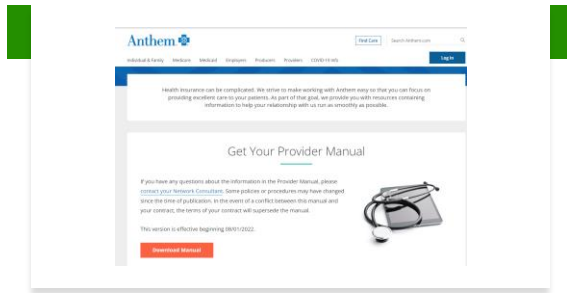
- 2022 Humana Medicare Advantage Health Maintenance Organization (HMO) plan
- 2022 Humana Medicare Advantage Preferred Provider Organization (PPO) Plan
- 2022 Humana Medicare Advantage full and partial networks private-fee-for-service (PFFS) plans

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Identify the Plan Type & Your Network Status



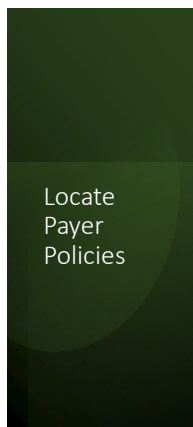
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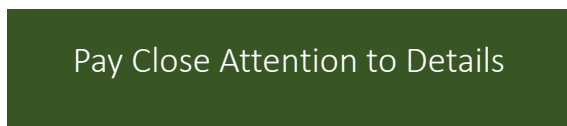
Find the Specific Provider Manual

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

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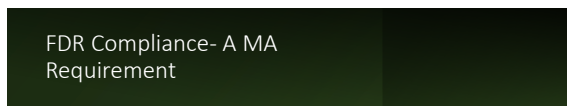


Medicare coverage of chiropractic service is specifically **limited to treatment by means of manual manipulation** of the spine to **correct a subluxation** (that is, by use of the hands). The patient must require treatment by means of manual manipulation of the spine to correct a subluxation and the 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 handled 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.

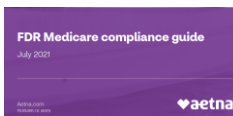
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A provider is not required to agree to accept a PFFS plan's terms and conditions of payment or agree to treat a PFFS plan member. If a provider does not agree to accept the plan's terms and conditions of payment or refuses to treat the member, then 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

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**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

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## Resources

### How to Avoid Medicare Part C Pitfalls

Working directly with providers in assisting them with Medicare compliance requirements, we have found areas of great concern in the billing process.

### OIG Compliance


This course outlines why an OIG Compliance program is critical for practice in today's healthcare environment.



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## Summary

- Confirm your Medicare participation status
- Identify your network status with all Medicare Advantage Plans
- Locate Payer Policies & Agreements
- Make a list of network plans and plan types
- Locate the FDR Requirements for each plan
- Establish a Notification & Consent Process for out-of-network services




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## VA Community Care Network

In the Chiropractic Clinic



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## Regional Networks

**NOTE:** VA awarded a contract to Optum Public Sector Solutions, Inc. (Optum), part of UnitedHealth Group, Inc. to serve as a Third Party Administrator (TPA) for CCN Regions 1, 2, and 3. In addition, VA has awarded a contract to TriWest Health Care Alliance (TriWest) to manage CCN Regions 4 and 5.

**News Releases:**  
 VA awards Community Care Network contracts to increase health care access  
 VA awards contract for Region 4 of CCN to increase Veteran access to health care  
 VA awards contract for Region 5 of Community Care Network to increase Veteran access to health care in Alaska

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## First Step


**Join CCN**

If you are a community provider located in Regions 1, 5, and are ready to partner with VA to care for Veterans, sign up to join CCN today!

|  |   |
|--|---|
| <b>Regions 1, 2 and 3-Contract Optum</b><br>Region 1: 888-901-7427<br>Region 2: 844-638-8108<br>Region 3: 888-901-6913<br>Optum provider website | <b>Regions 4 and 5-Contract TriWest</b><br>Provider Contract Request website (preferred)<br>ProviderServices@TriWest.com<br>877-CCN-TRWV (877-226-8746) |
|--|---|

**CCN Frequently Asked Questions**


- What is the Community Care Network (CCN)?
- What is the role of TriWest during the transition to the new Community Care Network?
- Why is VA hiring new Third Party Administrators (TPAs)?
- What happens if a Veteran needs a referral for additional health care services?
- Who is responsible for handling customer service for Veterans?



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## VA Optum Regions

| Region 1  | Region 2  | Region 3  |
|---|---|---|
| Connecticut<br>Delaware<br>District of Columbia<br>Florida<br>Georgia<br>Hawaii<br>Illinois<br>Indiana<br>Iowa<br>Kansas<br>Kentucky<br>Louisiana<br>Maine<br>Maryland<br>Massachusetts<br>Michigan<br>Minnesota<br>Mississippi<br>Montana<br>Nebraska<br>Nevada<br>New Hampshire<br>New Jersey<br>New Mexico<br>New York<br>North Carolina<br>North Dakota<br>Ohio<br>Oklahoma<br>Oregon<br>Pennsylvania<br>Rhode Island<br>South Carolina<br>South Dakota<br>Tennessee<br>Texas<br>Utah<br>Vermont<br>Virginia<br>West Virginia | Alabama<br>Arizona<br>Arkansas<br>California<br>Colorado<br>Connecticut<br>Delaware<br>Florida<br>Georgia<br>Hawaii<br>Illinois<br>Indiana<br>Iowa<br>Kansas<br>Kentucky<br>Louisiana<br>Maine<br>Maryland<br>Massachusetts<br>Michigan<br>Minnesota<br>Mississippi<br>Montana<br>Nebraska<br>Nevada<br>New Hampshire<br>New Jersey<br>New Mexico<br>New York<br>North Carolina<br>North Dakota<br>Ohio<br>Oklahoma<br>Oregon<br>Pennsylvania<br>Rhode Island<br>South Carolina<br>South Dakota<br>Tennessee<br>Texas<br>Utah<br>Vermont<br>Virginia<br>West Virginia | Alabama<br>Arizona<br>Arkansas<br>California<br>Colorado<br>Connecticut<br>Delaware<br>Florida<br>Georgia<br>Hawaii<br>Illinois<br>Indiana<br>Iowa<br>Kansas<br>Kentucky<br>Louisiana<br>Maine<br>Maryland<br>Massachusetts<br>Michigan<br>Minnesota<br>Mississippi<br>Montana<br>Nebraska<br>Nevada<br>New Hampshire<br>New Jersey<br>New Mexico<br>New York<br>North Carolina<br>North Dakota<br>Ohio<br>Oklahoma<br>Oregon<br>Pennsylvania<br>Rhode Island<br>South Carolina<br>South Dakota<br>Tennessee<br>Texas<br>Utah<br>Vermont<br>Virginia<br>West Virginia |



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## The Network Journey

- Example of a Veteran's journey through the VA Community Care Network**
1. Veteran seeks care from VA.
  2. VA determines, based on eligibility criteria, whether medical care from a community provider is appropriate. Veterans agree.
  3. VA assigns community provider to accept referral and medical of delivery. Referral packet includes medical records.
  4. VA schedules appointment with community provider and sends referral packet.
  5. Veteran self-schedules his or her appointment with community provider.
  6. Veteran receives care from community provider.
  7. Provider sends medical record to VA.
  8. Provider bills. Option for this care.

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



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- What is Covered?**
- E/M
  - CMT
  - X-RAYS
  - Physical Therapy Modalities and Services
- Prior- Authorization Required for ALL services**

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### TriWest Healthcare Alliance Provider Pre-Appointing Request

THIS IS NOT AN AUTHORIZATION TO START DELIVERY OF CARE

| PROVIDER INFORMATION *    | VETERAN INFORMATION | AUTHLINE AUTHORIZED CHIROPRACTIC AUTHORIZATION |
|---------------------------|---------------------|--|
| Name: [REDACTED]          | Name: [REDACTED]    | Valid Dates: Nov 03, 2015                      |
| Group name: [REDACTED]    | Address: [REDACTED] | Subject to ch appointment.                     |
| Address: [REDACTED]       | DOB: [REDACTED]     |  |
| Phone Number: [REDACTED]  | SSN: [REDACTED]     |  |
| Fax Number: not available | Phone: [REDACTED]   |  |
| Specialty: [REDACTED]     |                     |  |
| NPI: [REDACTED]           |                     |  |

\* To update incorrect provider information, please email [providerservices@triwest.com](mailto:providerservices@triwest.com)

### 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.

**Verification Starts with the Referral**

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

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**Confirm All Information is Valid & Accurate**

**VA U.S. Department of Veterans Affairs VA Form 10-7880 - Approved Referral Medical Care**

Veteran Name: [REDACTED] Referral Number: 140220011771  
 Veteran ICR: 10121518V059909 Priority: Routine  
 Veteran EDPI: 101208 Referral Issue Date: 2019-05-21  
 Veteran Date of Birth: 1950-01-01 Expiration Date: 2020-05-12  
 Veteran Address: 110 Alpha St. First Appointment Date: 2019-06-20  
 City/State: DMV/TX, 0914624

Veteran Phone Number:  
 Referring VA Facility: Carmanigan VA Medical Center  
 VA Telephone Number: 800-538-2389  
 VA Fax Number: 800-563-8328

Initial Community Care Provider/Facility: ACUTE & WELLNESS CHIROPRACTIC CLINIC  
 Initial Provider Location: ACUTE & WELLNESS CHIROPRACTIC CLINIC  
 Provider Name (if Assent): ACUTE & WELLNESS CHIROPRACTIC CLINIC  
 Community Provider NPI: 158745320

Any claim related to this copy 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

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**Additional Information:**

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

| PROCEDURE                   | CODE RANGE    | QTY | TYPE   |
|-----------------------------|---------------|-----|--------|
| Office/Outpatient Visit New | 99201 - 99205 | 1   | Visit  |
| Office/Outpatient Visit Est | 99211 - 99215 | 25  | Visits |

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

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

covered 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

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|           | CODE RANGE    | QTY | TYPE   |
|-----------|---------------|-----|--------|
| Visit New | 99201 - 99205 | 1   | Visit  |
| Visit Est | 99211 - 99215 | 25  | Visits |
| Regions   | 98940 - 98943 | 25  | Visits |
| s         | 97110 - 97110 | 25  | Visits |
| Thomy     | 97012 - 97012 | 25  | Visits |
| Regions   | 97140 - 97140 | 25  | Visits |
| cc Thomy  | 97016 - 97035 | 25  | Visits |
| n Wound   | G0283 - G0283 | 25  | Visits |
| Therapy   | 97014 - 97014 | 25  | Visits |

### 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 plan



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### 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**

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#### 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:

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



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VA Community Care Provider Portal

NEW: Provider Manual Updates

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### VA Provider Resources



#### Forms

Access and download commonly used forms.

- ADA Claims Form
- Authorization to Disclose Protected Health Information
- CMS 1002 Claims Form
- CMS 1003 Claims Form
- Facial, Wrist and Ankle Reading Form
- Provider Grievance Form
- Potential Quality Issue (PQI) Referral Form
- 30-0988 Network Appeal Form

\* Fee Schedules and VA SEOC Billing Codes

This section includes Fiscal Year 2018 Medicare/Partial VA fee schedule, links to current and historical VA and CMS Fee Schedules and VA SEOC billing codes and an appointment billing code associated to the services within each SEOC. Reference your payment appenda for information on how the VA fee schedule applies to you.

- VA Fee Schedules
- CMS Fee Schedules
- VA SEOC Billing Code List

#### Optum VA Portal

- Request for Service Form
- Fee Schedule

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#### Community Care Network Resources

- CCN Access Login (Web/pt)
- 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

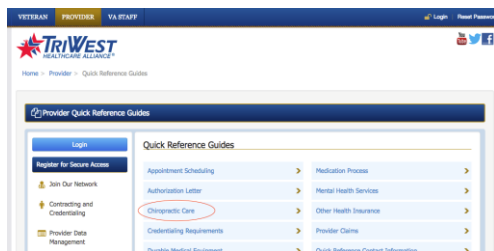
- Referrals
- Trainings
- Claim Status

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## Benefits

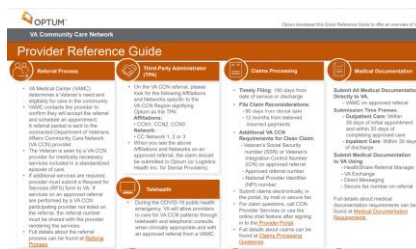
- Locate the Reference Guides on the TPA Portal or website for your region
- Select Chiropractic Care
- Review the Coverage Options, Documentation Requirements, and authorization process



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## Optum Reference Guide

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



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## 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 scanned 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 improve the amount of time for claims processing determinations.

[Change Healthcare website](#)



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| 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 | Custom 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.   |



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## 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**

## VA & Medicaid

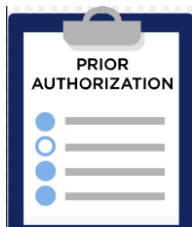
Medicaid – Medical Insurance for Financially Disadvantaged; Federal health care program for individuals living at or under the poverty line; Threshold for eligibility varies from state to state

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



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# Authorize! Authorize!

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

| 23. PRIOR AUTHORIZATION NUMBER |               |          |          |                          |        |
|--------------------------------|---------------|----------|----------|--------------------------|--------|
| VA123456789                    |               |          |          |                          |        |
| P                              | Q             | M        | I        | J                        | ACTION |
| \$ CHARGES                     | DAYS OR UNITS | IND T PA | ID. QUAL | RENDERING PROVIDER ID. # |        |

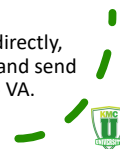


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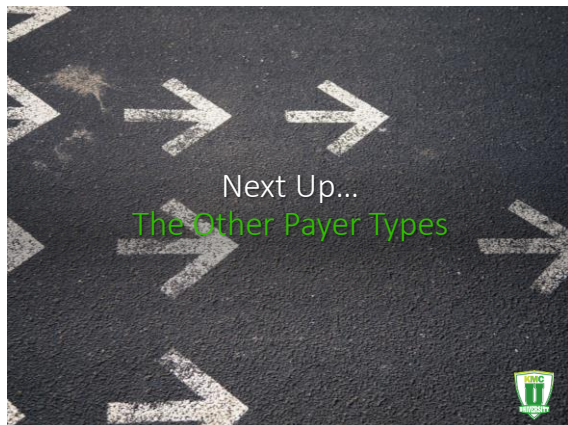


## Summary

- 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.



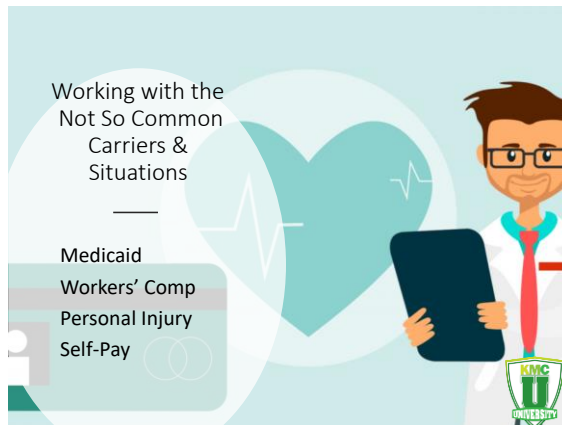
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## Next Up... The Other Payer Types



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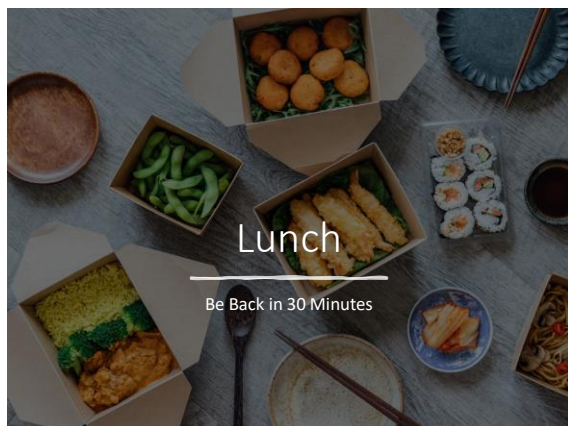


## Working with the Not So Common Carriers & Situations

- Medicaid
- Workers' Comp
- Personal Injury
- Self-Pay



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## Lunch

Be Back in 30 Minutes

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