Insurance Policies

**PLEASE READ:**

This is for your benefit and for everyone’s sanity! *The more you know the less we both get frustrated down the road when insurance doesn’t do what you expected.*

Insurance doesn’t automatically give each patient their policies maximum number of visits. Insurance requires the doctor to submit reasoning for the care requested for insurance coverage. It is my job as your doctor to be as accurate as possible to describe the exam findings, your complaints, and to justify what I have prescribed for your treatment plan. However, the insurance company may not agree with my prescribed treatment plan, and may deny one or all the requested visits.

Below I have outlined some office policies and additional information that might help you better understand the process.

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**Office Insurance Policy Protocol & Philosophy:**

As a Business Owner and a Doctor I have to find the right balance of financial decisions with treatment time decisions. For this office, insurance isn’t the focus of the time spent with the patient on the first visit. I also want to make sure you understand what all the options and rules are. If you have questions please ask!

Definitions you need to know! Wellness care, Elective or maintenance care.

Wellness Care\*\*: Regular wide spread care intended to keep motion in the joints that will not significantly change pain levels. This kind of care is not caused from a traumatic injury, or a chronic condition with any chances of significant improvement from care.

Acute pain: pain caused by trauma (fall or impact, or sudden movement). Typically 4-6 visits to achieve resolution.

Chronic Pain: Something more than 12 weeks old. A complaint that did not resolve fully.

I want to make sure your care is the priority of the time we spend working together.

* I require the **collection of payment at the time of service.**  The copay amount will be charged based on your individual plan.
  + By agreeing to get treated in my office you are confirming: that you know you are agreeing to be responsible for the full agreed amount of services rendered, not just the copay amount, if insurance decides not to cover services.
* It can take up to 180 days’ past the initial service date to find out that your insurance will not cover some or all of the services. (the office will let you know if there are any problems they see as soon as they can, but sometimes it’s a long line of forms and waiting for responses).
  + Payment options in this office: Cash, Check, HSA Cards, Debit and Credit Cards.
    - bounced checks have a $25 fee

**Patient’s wanting to use their Insurance coverage**:

All insurance patients will be charged their contracted amount for the insurance agreement with chiropractic care. This means if you have a deductible you will owe the cost for the fees allowed by the insurance company (commonly less than normal cash prices). Copay’s are anywhere from 10% - 50% of cost or a set value per office visit no matter the services provided. There are a few things to know:

Medicare patients: Insurance will only cover adjustments! That means the first exam is not covered under your plan (unless your secondary covers it). You will owe your copay amount plus the exam for the first office visit. The initial visit cost between 30-75$ depending.

- Therapies like massage, Muscle work, heat, stretching, or other services are also not covered under Medicare, and will be up to you to decide to accept services and pay for them out of your own pocket. (Look at the ABN form).

-Supportive care\*: is rarely coverage for more than a few visits (up to 5), without showing updates a progress with a high potential for resolution quickly down the road.

-Wellness\*\*: not covered (see ABN form)

Youth: Any youth insured patient will required prior approval before insurance will accept a claim/billed service. This means a wait for you. The doctor must write up, send in and get a response to get the approval. You can decide to have only the exam done and get this approval process done and confirmed coverage before continuing with care (not recommended for healing timing but better financially if you are hoping for coverage.

**ASH PATIENTS:** if you have coverage that processes through **ASH (American Specialty Health: Cigna, Kaiser, Aetna, Anthem)**, Insurance requires the physician to send in supportive details as to why you should continue to be covered by them for your current condition. This means after 8 visits you may not be covered if your conditions are considered *wellness\*\**, or not showing any improvement. Office policy is to be as quick to turn in these documents (though running my own business means I might not get your paperwork in before your 9th visit if it’s too quick after the 8th**). Please understand you may be denied for care no matter what I send in, this means you might not be covered under your insurance plan on the 9th and future visits, and therefore that cost is then your full responsibility.** In 2016 more strict insurance allowances and rules with coverage and physician protocols.

* I will bill all services applicable to insurance in a timely fashion: Legally, I have up to 180 days to submit a claim to insurance. (It is my intention to submit claims within 30 days of services or less)
* Typically insurance responds to the submitted claims within 2-10 days, but they have up to 90 days to do so (with any or all of the following)
  + - With Payment to the doctor
    - With any errors to be corrected or the reimbursement of service charges
    - With denial of coverage for services rendered (with reasons why)
  + This means you and I might not know there’s a problem with coverage for at least 7 days - 2 months after the first visit.
    - Please be patient with this process, I will let you know if I have any concerns.
* I will be your advocate for *services needed*, and attempt to resolve any errors or confusion with a claim. If insurance still denies to pay for the services, you have already received care and you will be invoiced the balance amount.
* Let me continue to be open and honest. Many Chiropractors are no longer offering insurance participation, because of the extra work it takes to make sure they get paid. Being in-network with an insurance company means an agreement to a Fee Schedule with that company. The Fee Schedules are rarely equal to the typical service prices in the office. Most doctors that participate with insurance have to take more time to do the extra paperwork than the cash practice doctors. However, being In-network means patients find us, that is why most doctors continue to work with insurance.

**United Health Care (UHC) PATIENTS:**

Within 10 days of your initial visit the doctor will send in information for your reasons to get approved for coverage. This typically is done and known within 3-5 days after it’s submitted. And a specific number of visits or date range will be given to get the care completed before more information will be required if more care in needed (continuance of care or new condition).

Insurance will only cover Up to $50/office visit. That means the first exam is covered under your plan, but if you are getting treated on that same date no more services will be covered by your insurance. **You have a choice** to just get the exam, and get treated the next day to get both covered, this means two copays for you because of the 2 dates of service. Or you can choose to get treatment on the same day as your initial exam and I will have you sign an ABN, saying you will pay your copay for the exam and pay for the cost of treatment (insurance agreed price to get care on the same day. An adjustment is $40-$50, other therapies cost between $5-$20. You get to decide what’s better for your health/healing/pain relief and /or better on your pocketbook.

**Reasons that insurance might not cover services rendered:**

* You have health insurance but no Chiropractic coverage (it may be a separate when applying for coverage).
* You may not have met and satisfied your deductible, yet, and therefore you are responsible for the full service fee at the time of service or within 30 days (from the date the denial has been identified to you from either the insurance EOB (explanation of Benefits) or through this office).
* Insurance is getting stricter on its coverage policies. The new policies have a lot more rules for proving why care is necessary, and the condition is being actively treated with productive results:
  + Must be an active complaint, with an objective sign (positive test) or evidence of subluxation (the term for any area in the body, a joint that has limited motion, and will warrant a chiropractic adjustment), for care to be approved.
  + There must be active care being done (meaning that we are working on a specific location towards a goal of improvement or maintaining without regression).
  + **\*\*Wellness care** (non-actively treating a condition care) is hard to prove necessary for many, if any visits/year. The average insurance company allows 8 visits without added proof of necessity, per fiscal year.
  + **Supportive Care:** Care that is covered by insurance.
    - For Example: If you have chronic low back pain and adjustments are keeping the pain bearable but not “curing the problem,” insurance will (at some point) want us to resend care for a period of time, to see if the intermission will show regression and increased symptoms. If this break in care created increase symptoms it is better evidence, thus proving long term care is still warranted.

**Here are 3 different approaches to your choices for treatment options keeping insurance coverage in mind.**

Any new complaint is likely to get treatment as long as it can be positively influenced with Chiropractic care will be likely to get coverage approved. Though, Wellness care is less likely to be covered. An example: If you come in with Neck and Back pain at the same time:

* + - * Option 1: We treat the whole body knowing it’ll reduce more overall pain in the entire body sooner, and bill for both areas at the same time, this will give us (commonly) 2-6 visits for the neck and 4-8 visits for the Low back, but that means that you as a patient only get 6-8 visits allowed. We will then have to send in further supporting facts justifying need more care for any active complaint.
      * Option 1, and extended Wellness care: Complete care with Option 1 and follow through with as much as we can to prove further necessary care. When insurance denies more care. We will then conclude care through insurance coverage (unless a new active complaint arises in the future). As a result, any maintenance or wellness care would be only charged to you personally as a cash plan, and collected at the time of service. None of these, wellness services would be submitted to your insurance (because they would be denied).
    - With Wellness Care: This means a cash plan for this situation needs to be set and understood. You, the patient will be solely responsible for paying the service charges:
      * Adjustments only: $30 (Walk-in price is $45)
      * Adjustments and therapies: $40 (Walk-in Price would be between $55-70)
      * Option 2: Work on the most important complaint (ie, the Low back first until it is resolved, while not working on your neck at that time), receiving 4-8 visits for this care, and more if we can prove more care is required for resolution. Then turn our focus to work on the Neck as a completely separate complaint and case, to then get the 2-6 visits approved for the Neck… Thus getting minimally 6-14 visits total for the two complaints.

Doing option two mean you will have neck pain for those few weeks+ until the first case is completed, but it would be done legally.

Thank you for reading through this. It helps to know all of the potential problems that could arise. Please let me know if you are still unsure of anything and I will try to clarify any questions. If you have questions about your coverage please call your insurance and they can fairly quickly let you know what is and is not covered and why.

**During Open Enrollment (Things to consider):**

All insurance companies have different plans with many options:

* Health Care package (annual physicals, MD visits, OBGYN, Rx)
* Dental
* Vision

Chiropractic (possibly bundled with Physiotherapy and Acupuncture)

Then you have options of Deductibles vs. Monthly costs vs. HSA cards (Health Savings Account)

* Deductibles are great when you are healthy and do not anticipate office visits to the doctor’s office for the year, but they can be harmful in the first few months of the year if the $1000-$5000 deductibles are your responsibility to pay for the full amount of the office visits until it is satisfied.
  + More recently there some are plans that don’t include the deductible with Chiropractic coverage (meaning you will not owe a deductible amount when only getting treated in a Chiropractor’s office. You will be responsible for it in other Medical Facilities like normal though, (MD, Dental, Vision)).
* Monthly Cost of Health insurance Varies, mostly on the amount of coverage and the amount of the deductible. You will have to find the best fit for your needs, and financial ability.
* HSA Cards: it is a set amount of your income paycheck you can choose to put into an account for you to use for health care needs.
  + This means us can use it for: Deductibles, Copays, or any non-insurance service you need to better your health (this includes Chiropractic, body supports, Massage, and PT).
    - You will need to clarify how to record/report your spending. Sometimes all they ask for is a receipt from the office (with the letter head saying the type of office or services), or a superbill of itemized services or items. Rarely do they require a written report from the provider stating the care given.
  + Your contribution to your HSA card is from your income, on a pre-taxed basis. For more information: <https://www.humana.com/health-care-reform/hsa>
  + HSA cards have an expiration date. Typically you can add a predicted spending amount of money into the account when you enroll, then choose to add more money in to the account as you need.