



Supplemental/Routine Chiropractic Services

Policy Number	0069	Annual Approval Date	04/2020	Approved By	Optum Reimbursement and Technology Committee Optum Quality and Improvement Committee
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IMPORTANT NOTE ABOUT THIS 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 or codes that correctly describe the health care services provided. Optum reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. Coding methodology, clinical rationale, industry-standard reimbursement logic, regulatory issues, business issues and other input is considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding Optum's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to Client enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This policy applies to all Medicare plans, all network and non-network rehabilitation providers that offer **Supplemental/Routine Chiropractic** benefits managed by Optum. This includes non-network authorized, and percent of charge contract providers.

Fee schedule/provider contract/client contract may supersede

Policy

Overview

This policy describes Optum requirements for the reimbursement of claims for Supplemental/Routine Chiropractic services

Description: Supplemental/Routine chiropractic claims need to be submitted differently than standard Medicare claims.

Optum Physical Health Guidelines: Claims for Supplemental/Routine chiropractic services **will be denied** if submitted with –AT modifier. This differs from standard Medicare which requires the –AT (active treatment modifier) be appended to consider the service for payment.



Examples/Scenarios

Use of the Routine Benefit vs. the standard Medicare benefit: In the event you have a Medicare patient who has both the standard Medicare benefit as well as the routine chiropractic benefit available to them, the way you bill the claim will determine which of these benefits the claim date of services will be counted toward. (Routine services cannot be combined with original Medicare services at any single date of service)

Scenario 1) A chiropractor bills 98940, 98941, or 98942 with an AT modifier. The AT modifier indicates this is active treatment, the entire date of services, including any additional services such as exams, therapies, and x-ray, will be subject to standard Medicare payment coverage. Please consult CMS.gov for review of the proper use of the AT modifier as well as appropriate use of the Advanced Beneficiary Notice (ABN).

Scenario 2) A chiropractor bills a date of services that does not contain 98940AT, 98941AT, 98942AT within the billing. The absence of the _AT modifier indicates this date of service is not active treatment and would count toward the routine benefit. Please note that the routine benefit was meant to allow for coverage of patients presenting with pain, neuromusculoskeletal disorders and nausea. Please consult CMS.gov for review of the proper use of the AT modifier as well as appropriate use of the Advanced Beneficiary Notice (ABN).

Additional Information

What are Supplemental/Routine chiropractic care services?

- These are supplemental benefits that are offered on some Medicare Advantage plans including:
 - AARP®, UnitedHealthcare®, MedicareComplete®
 - Group Medicare Advantage
 - Dual Complete® Medicare Advantage plans
- These benefits cover additional services that are not covered by original Medicare.
- No referral is required.
- There is no utilization management (UM) requirement, member's benefit packages have a set number of annual visits.
- Routine services do not count towards the member's maximum out-of-pocket amount.
- Routine benefit claims may be required to be submitted to a different clearing house or mailing address. Please refer to Plan Summary for specific claim submission requirements.
- For full benefit summary and covered services, please refer to the member's Evidence of Coverage (EOC).

Resources

- American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
- Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services

History / Updates

6/20/2018	New
4/2019	Annual review and update
04/2020	Annual review and update

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