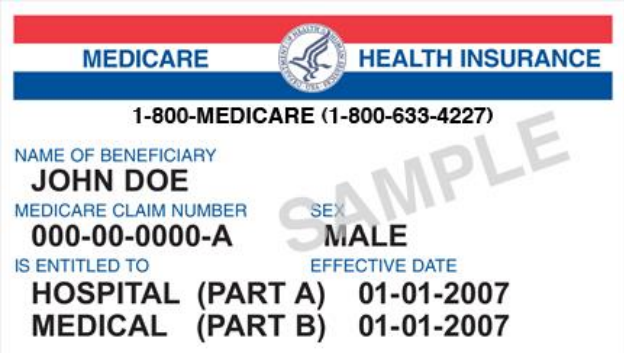
Performance Chiropractic, LLC

State of the Art, With a Caring Touch

"What will Medicare pay?" (updated 04.2018)



This sounds like a simple enough question, and we get it often enough that we've put together this document for you. Please read it carefully.

It is your responsibility to understand your own coverage; however, as a courtesy, we'll verify your coverage to help you better understand what your policy or policies may cover. You may have coverage in addition to Medicare; or you may have a Medicare Advantage plan, or a Medicare Replacement Plan, or a Secondary Policy, or a Medicare Supplement, or a MediGap policy. Each may modify what's covered. You can read your policy, or call your insurance company or Medicare; but it's not unusual for lay people to misinterpret the information, or for a well-meaning customer service representative to give wrong information. Until you receive your EOB (Explanation of Benefits) from your insurance company and/or Medicare, our expectations of what will be covered are just our informed guesses based on the information they provide to us – and of course, we'll share that information with you.

For chiropractic care, Medicare will typically cover SOME but NOT ALL of your costs.

Medicare is a government program that covers a variety of services. For **M.D. (allopathic)** care and hospitalization, Medicare currently covers a remarkable percentage of the cost… sometimes even 100%, with ZERO out-of-pocket expense to you. For **dental** care, Medicare covers NOTHING. For **chiropractic** care, Medicare will typically cover SOME but NOT ALL of your costs. Read on.

Medicare will cover 80% of their allowable amount on spinal manipulation (CPT 98940, 98941, and/or 98942) ONLY. The program covers NOTHING else, when performed by a D.C. (Doctor of Chiropractic). Exams, therapy modalities (which some companies refer to as "physical therapy"), massage, acupuncture, therapeutic exercises (including stretching), and all other procedures are covered at ZERO percent under Medicare. Please note that we do not base our treatment protocols on your coverage. The doctor will prescribe what you need, not what's "covered." It wouldn't be fair for us to prescribe "a lot" for a patient with "great coverage," and "a little" for a patient with "poor coverage," if their clinical needs were the same.

We participate in Medicare's program, but we do not "accept assignment." You and all Medicare patients pay us, and then Medicare will reimburse you* for the portion they approve. If paying in full at time of service is stressful to your wallet or pocketbook, we offer 0% financing through our EZ Pay program. Just ask. We don't want finances to affect your ability to access the care you need.

Our billing company will file your claim with Medicare, and Medicare will determine what they'll pay. If Medicare rejects something that we believe they should have paid, we'll appeal. We want you to receive the full amount from Medicare that you're entitled to.

There are a few terms you need to know:

Secondary Policy: A policy you've purchased in addition to Medicare. This may be a Medicare Supplement, or a MediGap policy.

> **Medicare Supplement**: This sort of policy may cover some or all of a wide variety of services we perform, OR it may just cover the 20% "gap" that Medicare didn't pay on spinal manipulation (CPT 98940, 98941, and/or 98942). Which did you purchase? We can't know; though we'll know far more once we receive the EOB from your Supplemental insurance company (Cigna, Blue Cross, United Health, GEHA, etc.).
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> **MediGap policy**: This sort of policy cover ONLY the 20% "gap" that Medicare didn't pay on spinal manipulation (CPT 98940, 98941, and/or 98942). It does not cover any other service.

EOB: Explanation of Benefits. This is the form that outlines what an insurance company (Medicare, Blue Cross, etc.) pays and/or allows. They often mail this to you 4 weeks after the service is rendered, though it could be a longer or shorter time period. Please note that sometimes a service may be rejected as "medically unnecessary" when in fact it's just an uncovered service under your policy, as opposed to an "unnecessary" service performed without good reason.

Wellness Care (maintenance therapy): Wellness is our goal for you. We want you to live well. When you're on Active Care with an ache, pain, injury, or problem, we'll submit it to Medicare for a coverage determination which we hope and expect will be favorable. When you reach a plateau of expected therapeutic benefit, the doctor will release you from Active Care to Wellness Care. Medicare does not cover Wellness Care. "Maintenance therapy is defined 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." "Maintenance care [sometimes called "Wellness Care"] is not considered by Medicare to be medically reasonable and necessary [!!], and is not reimbursable by Medicare." [1]

* On very rare occasions in the past, Medicare made a mistake and paid us. In such cases, we'll refund any such payments to you, or leave those amounts as credits if you prefer.

[1] *Centers for Medicare and Medicaid Services, 2012* http://www.cms.gov/mlnproducts/downloads/chiropractors_fact_sheet.pdf