Enhanced Benefit

The Blue Cross and Blue Shield of Nebraska Medicare Advantage plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross and Blue Shield of Nebraska to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for routine chiropractic care is provided to members under the BCBSNE Medicare Advantage plans. The scope of the benefit, reimbursement methodology, maximum payment amounts, and the member's cost–sharing are determined by Blue Cross and Blue Shield of Nebraska.

The Medicare Advantage plans offer the following coverage:

- Visits for routine care covered under this benefit have a $20 copay amount.
- One set of diagnostic x-rays (up to three views) performed by a chiropractor annually at no cost to the member are provided under this benefit,

Coverage for mechanical traction therapy or other physical therapy services, and spinal manipulation for conditions not listed under the conditions for payment is not provided under this benefit.

Emergency treatment of an acute spinal condition must be provided within 48 hours of the injury. The BCBSNE Medicare Advantage plans do not pay for follow-up services unless the injury for which services were provided results in an ongoing acute or chronic condition. In that case, payment may be made for follow-up services for chiropractic manipulative treatment.

Providers who choose to participate in the BCBSNE Medicare Advantage network are considered to be in network.

Conditions for payment

The table below specifies the payment conditions for chiropractic services.

Conditions for payment		
Eligible provider	Chiropractor	
Payable location	Office	
Frequency	Based on CPT codes billed	
CPT / HCPCS Codes	Diagnostic radiology	72010, 72020, 72040, 72050, 72052, 72069, 72070, 72072,72074, 72080, 72090, 72100, 72110, 72114, 72120, 72170, 72190, 72200, 72202, 72220 X-rays of the area of chief complaint may be taken at the start of treatment. Follow-up X-rays should be performed within 90 days for acute conditions and within 365 days for chronic conditions.
	Evaluation & management	New patient visits (99201, 99202, and 99203) payable once every 36 months per chiropractor. Established patient visits (99212, 99213 and 99214) payable once every 12 months per chiropractor.
	Spinal manipulation	Spinal manipulation services (98940, 98941 and 98942): modifier AT required – may be billed once per day.

Diagnosis restrictions	Diagnostic radiology	X-rays of areas other than that of the chief complaint must be supported by documentation showing medical necessity. No restrictions
	Evaluation & management	Must be medically necessary. No restrictions.
	Spinal manipulation	Must be medically necessary. Consistent with Original Medicare.
Age restrictions	No restrictions	

Reimbursement

BCBSNE Medicare Advantage plans' maximum payment amount for chiropractic care services is consistent with Original Medicare. The provider will be paid the lesser of the allowed amount or the provider's charge, minus the member's cost share. This represents payment in full and providers are not allowed to balance bill the member for the difference between the allowed amount and the charge.

Member cost–sharing

- BCBSNE Medicare Advantage providers should collect a $20 copay for the first annual office visit and a $20 copay for all subsequent visits covered under this benefit. Providers can only collect the appropriate BCBSNE Medicare Advantage cost–sharing amount from the member.
- If the member elects to receive a non–covered service, he or she is responsible for the entire charge associated with the non–covered service.

To verify benefits and cost–share, providers may call 888-505-2022.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form or the 837 equivalent claim.
2. Use the BCBSNE Medicare Advantage unique billing requirements.
3. Report HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local BCBS plan.

Revision History:

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