

Particularly important information for patients with Medicare, Tufts and United Plans

Non-Reimbursed Fees

We charge a fee for services that are not covered by your health insurance plan. Examples of procedures that may not be covered include:

- Exercise instruction
- Doctor assisted stretching and exercise monitoring
- Soft tissue therapies (i.e., massage and Graston Technique)
- Therapy modalities (i.e., ultrasound and electrical muscle stimulation)
- Medicare patient examinations

Fees for non-reimbursed services are not applicable to your annual deductible. Payments may range from \$10.00-25.00.

You may consider going to another health care professional for these services, such as physical therapy, but keep in mind that there will be an additional co-payment incurred. Often, it is more economical to receive all treatments at one facility.

Diagnostic Testing and Imaging

Many insurance companies **do not cover** the cost of diagnostic tests and procedures if performed or ordered by a chiropractor's office. If you are unsure if your insurance company will pay for tests and procedures that are ordered by your chiropractor, be sure to verify coverage with your insurance company.

Medicare Beneficiaries

There is a fee for an initial and recheck examinations. Recheck examinations are billed when a patient has been out of care for longer than six months or presents with a new problem. There is also a fee for other non-covered services that may be necessary during your care (i.e., ultrasound, electrical muscle stimulation, exercise instruction, etc.). Medicare does not allow for payment for these services to be applied to the annual deductible.

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Why DOESN'T MY INSURANCE pay for all of my care?



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If you have questions regarding your chiropractic insurance plan, or a problem with reimbursement, please contact your employer or insurance company.

Some Background Information

Health insurance is not intended to be the exclusive payer for chiropractic care; rather, it serves as a supplement.

Most health insurance companies will reimburse for a portion of chiropractic treatment. The amount of coverage is determined by the policy limits that were negotiated by the policy holder's employer group. Unfortunately, we have no control over the terms of your policy.

When selecting a health insurance carrier and benefits plan, it is important to consider the health services that you use. If you, or the policy beneficiaries, wish to receive chiropractic care as part of the plan, pay close attention to the benefits that you will receive.

“Usual and Customary Fees”

Most health insurance companies will pay a set amount for a given chiropractic procedure. They refer to this as their “Usual and Customary” or “Reasonable and Customary” fee. This “discounted fee” will be reflected on the insurance company Explanation of Benefits (EOB) that you receive. Although the fees that we submit to the insurance company are higher than the paid amount, it does not mean that your insurance company has been over charged, nor does it reflect the cost of delivering a given service. The “allowed” amount simply reflects the amount that the insurance company is willing to pay.

Important Terms to Know

Deductible—the annual amount that must be paid by the patient before health insurance benefits begin. Many health insurance carriers have deductibles for each family member.

Benefit period, annual versus rolling—most insurance companies reset their treatment deductible allotments via calendar year, whereas others use a rolling calendar date that begins upon the date of initial treatment.

Co-payment—payment made by the patient that represents partial payment toward services rendered. Co-payments commonly range from \$0.00 to \$50.00 and must be paid at the time that the service is rendered.

Co-insurance—payment that is made toward services rendered, in addition to any co-payments. It is becoming more common to see policies that have BOTH co-payments and co-insurance.

Annual Limits

Health insurance carriers typically have an annual policy limit for chiropractic services. These limits may be set by a dollar amount, or by a number of treatments. For example, some plans have a \$1000.00 annual maximum benefit, while others allow for a set number of treatments. A commonly encountered treatment number is 12.

Procedure Exclusions

Some health insurance companies will reimburse for spinal manipulative therapy only. Other services that are provided in the best interest of restoring your health may not be covered. We will not compromise the quality of our patient's care and it is our policy to offer these services to our patients. A fee does, however, apply.

When an insurance plan does not cover certain procedures, it does not mean that these services are not necessary. Your doctor can assist you with determining the best course of treatment for you.

Making Out of Pocket Payments More Manageable

Out of pocket chiropractic expenses are applicable to your Medical Savings Account (MSA) or Health Savings Account (HSA). This will allow you to pay for your chiropractic expenses through pre-tax dollars.

We also have payment plans available upon request.

For a “Patient's Guide to Insurance Verification”, please go to www.NESpineInstitute.com and click “For the Patient” and “Insurance Coverage”.