Active Seattle
CHIROPRACTIC • SPORTS THERAPY

INSURANCE BILLING INFORMATION

For patients with insurance coverage in which our practitioners are a contracted (In-Network) provider, we submit your claim to insurance directly, receive payment directly from insurance, and collect any patient responsibility charges from you. The patient is responsible for any and all co-payments, deductibles, coinsurances, and uncovered services. These amounts are determined by your medical benefits, not ASCST, and any disputes over coverage are to be directed to your insurance company.

TO BILL INSURANCE

You are required to have valid and eligible insurance on file at the time of your visit. If the insurance information you provide is delayed, out-of-date, invalid, expired, or incorrect, you will be responsible for payment in full on any services rendered, which will be charged to your credit card on file. For Personal Injury Protection claims, an open claim number must be supplied at the time of your visit; we do not accept liens or settlement payments, and will require an alternate form of payment if a claim has not yet been opened.

UNDERSTANDING YOUR INSURANCE

It is your responsibility to understand your insurance benefit plan. It is your responsibility to know what services are covered and if a written referral, authorization, or medical necessity review is required prior to treatment. It is your responsibility to know how many services are covered in a plan year and to track your use; ASCST is unable to track how many visits and which benefit grouping your insurance has drawn from.

PRE-AUTHORIZATION & MEDICAL NECESSITY REVIEW

- Pre-Auth (request for coverage PRIOR to seeking treatment) generally does not apply at ASCST
- Medical Necessity Review (often incorrectly referred to as pre-auth) frequently applies to treatment at ASCST. It is a request submitted AFTER an appointment to verify that the treatment you are seeking for your condition is medically necessary and appropriate. *MNRs are designed for short courses of acute and subacute care that reach resolution, ending the care plan.*
- MNRs dictate how many visits will be covered regardless of the listed benefits on your plan. It is your responsibility to track how many visits are allowed and when that authorization expires.

ASCST will make every effort to request your PA/MNR, but due to the time and labor involved in this process we will not appeal insurance decisions or request additional care within the initial time frame unless there is an acutely unique injury present. *For ongoing/maintenance treatment, we cannot qualify acute medical necessity, and if you choose to receive additional treatment it may be at our out-of-pocket rate.*

BILLING SPECIFICS

In the past few years, insurances have begun changing how they allocate service benefits. We aim to be transparent with *what* we bill, but we can't control *how* your insurance processes it:

- Chiropractic adjustments (mobilizations, activator, drop table) are billed by region with the codes 98940-3 and apply to your **Spinal Manipulation Therapy** benefit.
- Soft tissue work and rehab (ART, Graston, traction, postural exercises) are billed by time unit based on visit length with the code 97530 Therapeutic Activities and often apply to your **Outpatient Rehabilitation** benefit. These are pooled benefits utilized by physical therapists, chiropractors, acupuncturists, massage therapists, etc.
- Different benefit pools may have different coverages (copay vs co-insurance) and we recommend familiarizing yourself with both to best anticipate charges.
- Treatment at ASCST may **double-draw** benefits from both SMT and Outpatient Rehab. If you would like to retain or avoid utilizing your outpatient rehabilitation benefits, we may not able to provide a comprehensive appointment or you may strategically opt to pay out of pocket.