Insurance and Medicare

Deductibles, Coinsurance and Copays

RTS accepts many medical insurance plans from major carriers to Medicare. For a complete list and full understanding of your insurance benefits for the treatment you will receive at Respiratory Therapy Services, call our office today at **215.953.1217.**

Both Medicare and private health insurance plans pay for a large portion or sometimes even all costs associated with many types of medical equipment used in the home for sleep apnea. This type of equipment is referred to as durable medical equipment (DME) or home medical equipment. Most health insurance plans have similar rules to Medicare, but you should know that all private health insurance plans vary and the specific rules of your plan may differ.

We will submit all medical claims for you to your carrier for benefits. Most insurance companies will give authorization for equipment within 48-72 hours.

The following pages give a summary of insurance, deductibles, co-insurance, copays and another section solely on Medicare. Any questions please contact our office at **215.953.3807.**

Respiratory THERAPY Services

Understanding your insurance

Deductibles, Coinsurance and Copays

Deductibles

A deductible is an amount of money, set by the insurance policy that the ***patient will pay before the insurance company pays benefits***.

- Runs per calendar year, so on January 1st each year, your deductible will begin again.
- Deductibles must be met **before** benefits are paid by the insurance company
- Deductibles can range anywhere from $100 to several thousand dollars.
- Make sure that you stay with a provider contracted with you insurer, called in-network. Otherwise you may be charged an out-of-network rate. Ask RTS for eligibility.

Example:

If your deductible is $500 annually, you will pay the first $500 of medical bills, no matter what services you need. Once the deductible is met, the insurance company will pay your bills based on the policy terms. Many traditional policies offer an 80/**20** co-insurance, meaning that the insurance will pay 80% of medical bills and the patient will be responsible for the remaining 20%. With this scenario, if you incur a $5,000 medical bill, your costs would be:

•$500 for your deductible and •20% co-insurance of the remaining $4,500 or $900 = Total out of pocket expense - $1,400.

Co-insurance (Don't Confuse Co-insurance and Co-Payment)

Co-insurance is a percentage of a provider's charge that you may be required to pay after you've met the deductible.

- Co-insurance can range from a low of 10% to as high as 50

Example:

Using the above medical bill of $5,000 and a $500 deductible and **50% co-insurance**, your cost:

•$500 for your deductible and •50% co-insurance of the remaining $4,500 or $2,250 = Total out of pocket expense - $2,750.

Co-Payment

The co-payment or copay is a payment defined in the insurance policy and paid by the insured person each time a medical service is accessed.

- Co-payments are a fixed dollar amount.
- If your policy has a ***$25.00 copay for Doctor visits***/ ***$35.00 for specialist visits*** / ***$25.00 DME copay*** (durable medical equipment).

Example:

Doctors visit $ 75.00 - Insurance payment $50.00 *Co-payment* $25.00 – Total out of pocket - $25.00

Note: For medical equipment costing over $500, insurance companies will lease purchase the equipment by making ten equal payments over 10 months. Upon receiving the 10 payments from the insurer as well as the ten co-insurance or co-payments from the patient, title transfers to the patient.

Understanding Medicare

Deductibles, Coinsurance and Copays

Who qualifies for Medicare benefits?

- Individuals 65 years of age or older
- Individuals under 65 with permanent kidney failure (beginning three months after dialysis begins), or
- Individuals under 65, permanently disabled and entitled to Social Security benefits (beginning 24 months after the start of disability benefits)

The Different Benefits of Traditional Medicare

- Medicare Part A benefits cover hospital stays, home health care and hospice services
- Medicare Part B benefits cover physician visits, laboratory tests, ambulance services and home medical equipment
- While oftentimes you do not have to pay a monthly fee to have Part A benefits, the Part B program requires a monthly premium to stay enrolled. In 2011 that premium will range between $96.40- $353.60 per month depending on your income. Typically, this amount will be taken from your Social Security check.

What Can You Expect to Pay?

Every year, in addition to your monthly premium, you will have to pay the first $162 of covered expenses out of pocket and then 20 percent of all approved charges if the provider agrees to accept Medicare payments.

Unfortunately, your medical equipment provider cannot automatically waive this 20 percent or your deductible without suffering penalties from Medicare. They must attempt to collect the coinsurance and deductible if those charges are not covered by another insurance plan; however, certain exceptions can be made if you suffer from qualifying financial hardships.

If you have a supplemental insurance policy, that plan may pick up this portion of your responsibility after your supplemental plan's deductible has been satisfied.

If your medical equipment provider does not accept assignment with Medicare you may be asked to pay the full price up front, but they will file a claim on your behalf to Medicare. In turn, Medicare will process the claim and mail you a check to cover a portion of your expenses if the charges are approved.

Other possible costs:

Medicare will pay only for items that meet your basic needs. Oftentimes you will find that your provider offers a wide selection of products that vary slightly in appearance or features. You may decide that you prefer the products that offer these additional features. Your provider should give you the option to allow you to privately pay a little extra money to get the product that you really want.

To take advantage of this opportunity, a new form has been approved by the Centers for Medicare and Medicaid Services (CMS) that allows patients to upgrade to a piece of equipment that they like better than other standard options they may otherwise qualify for.

The Advance Beneficiary Notice of Non Coverage, or ABN, must detail how the products differ, and requires a signature to indicate that you agree to pay the difference in the retail costs between two similar items. Your provider will typically accept assignment on the standard product and apply that cost toward the purchase of the fancier item, thus requiring less money out of your pocket.

Purpose of ABN

The Advance Beneficiary Notice of Non Coverage also will be used to notify you ahead of time that Medicare will probably not pay for a certain item or service in a specific situation, even if Medicare might pay under different circumstances. The form should be detailed enough that you understand why Medicare will probably not pay for the item you are requesting.

The purpose of the form is to allow you to make an informed decision about whether or not to receive the item or service knowing that you may have additional out-of-pocket expenses.

Understanding Assignment (a claim-by-claim contract)

When a provider accepts assignment, they are agreeing to accept Medicare's approved amount as payment in full.

- You will be responsible for 20 percent of that approved amount. This is called your coinsurance.
- You also will be responsible for the annual deductible, which is $162.00 for 2011.
- If a provider does not accept assignment with Medicare, you will be responsible for paying the full amount upfront. The provider will still file a claim on your behalf and any reimbursement made by Medicare will be paid to you directly. (Providers must still notify you in advance, using the Advance Beneficiary Notice, if they do not believe Medicare will pay for your claim.)

Mandatory Submission of Claims

Every provider is required to submit a claim for covered services within one year from the date of service.

The role of the physician with respect to home medical equipment:

- Every item billed to Medicare requires a physician's order or a special form called a Certificate of Medical Necessity (CMN), and some times additional documentation will be required.
- All physicians have the right to refuse to complete documentation for equipment they did not order, so make sure you consult with your physician before requesting an item from a provider.

How does Medicare pay for and allow you to use the equipment?

Typically there are four ways Medicare will pay for a covered item:

- Purchase it outright, then the equipment belongs to you,
- Rent it continuously until it is no longer needed, or
- Consider it a "capped" rental in which Medicare will rent the item for a total of 13 months and consider the item purchased after having made 13 payments.
- Medicare will not allow you to purchase these items outright (even if you think you will need it for a long period of time).
- This is to allow you to spread out your coinsurance instead of paying in one lump sum.
- It also protects the Medicare program from paying too much should your needs change earlier than expected.

If you have oxygen therapy, Medicare will make rental payments for a total of 36 months during which time this fee covers all service and accessories.

- Beyond the 36 months (for a period of 2 additional years), Medicare will limit payments to a small fee for monthly gas contents and a limited service fee to check the equipment every six months for equipment that is not covered under warranty.

After an item has been purchased for you, you will be responsible for calling your provider anytime that item needs to be serviced or repaired. In cases where you own the equipment and Medicare considers it necessary, Medicare may pay for a portion of repairs, labor, replacement parts and for temporary loaner equipment to use during the time your product is in for servicing. All of this is contingent on the fact that you still need the item at the time of repair and continue to meet Medicare's coverage criteria for the item being repaired.

BiLevel Devices/Respiratory Assist Devices

For a respiratory assist device to be covered, the treating physician must fully document in your medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headaches, cognitive dysfunction, dyspnea, etc.

A respiratory assist device is covered for those patients with clinical disorder groups characterized as (I) restrictive thoracic disorders (i.e., neuromuscular diseases or severe thoracic cage abnormalities), (II) severe chronic obstructive pulmonary disease (COPD), (III) central sleep apnea (CSA) or Complex Sleep Apnea (CompSA), or (IV) hypoventilation syndrome.

If you are diagnosed with Obstructive Sleep Apnea, see the coverage criteria for Positive Airway Pressure Devices below.

Various tests may need to be performed to establish one of the above diagnosis groups. Three months after starting your therapy, your physician will be required to respond in writing to questions regarding your continued use, along with how well the machine is treating your condition.

Positive Airway Pressure Devices (CPAPs and Bi-Level Devices for Obstructive Sleep Apnea) Continuous Positive Airway Pressure (CPAP) Devices are covered only for patients with obstructive sleep apnea (OSA).

You must have an overnight sleep study performed in a sleep laboratory to establish a qualifying diagnosis of Obstructive Sleep Apnea. In March of 2008, home sleep testing was approved as an acceptable means of diagnosing this condition when your physician deems this testing is appropriate.

- Medicare will also pay for replacement masks, tubing and other necessary supplies.
- After the first three months of use, you will be required to verify if you are benefiting from using the device and how many hours a day you are using the machine. Per Medicare and Private Insurance guidelines, a face-to-face visit with your physician that documents an improvement of your symptoms is required no sooner than 31 days and no later than 91 days from the set-up date. A data report from your sleep equipment which documents that the PAP has been used for at least 4 hours per night on 70% of nights during a 30-day consecutive period is required.
- If the CPAP device is not working, or if you cannot tolerate the CPAP machine, your doctor may also try to use a different device called a Bi-Level or a Respiratory Assist Device (RAD), and Medicare can consider this for coverage as well. To switch to a RAD, the physician must document the following 4 items in the patient's chart:
- The patient tried but was unsuccessful with attempts to use the CPAP device; and,
- Multiple interface (mask) options have been tried and the current interface (mask) is most comfortable to the patient; and,
- The work of exhalation with the current pressure setting of the CPAP prevents the patent from tolerating the therapy; and,
- Lower pressure settings of the CPAP fail to adequately control the symptoms of Obstructive Sleep Apnea or reduce the AHI/RDI (apneas and hypopneas) to acceptable levels.
- Talk with your provider if you are having problems adjusting to the therapy. There are a lot of variations that can make the therapy more comfortable for you.

Oxygen

Covered for patients with significant hypoxemia in the chronic stable state when:

- patient has a chronic lung condition or disease or hypoxemia that might be expected to improve with oxygen therapy, and
- patient's blood gas levels or oxygen saturation levels indicate the need for oxygen therapy, and
- alternative treatments have been tried or deemed clinically ineffective.

Categories/Groups are based on the test results to measure your oxygen:

- Group I Criteria: mmHG = 55, or saturation = 88%
- For these results you must return to your physician 12 months after the initial visit to continue therapy for lifetime or until the need is expected to end. Typically, you will not have to be retested when you return to your physician for the follow-up visit.
- Group II Criteria: 56-59 mmHg, or 89% saturation
- For these results, you must be retested within 3 months of the first test to continue therapy for lifetime or until the need is expected to end.
- Group III Criteria: mmHg=60 or saturation =90% not medically necessary.

Oxygen will be paid as a rental for the first 36 months. After that time, if you still need the equipment, you may keep it for up to two additional years, although your provider still owns the equipment. There are no rental payments during the two-year service period. Medicare will no longer make rental payments on the equipment during the two-year service period. During the service period, Medicare will pay for refilling your oxygen cylinders and for a semi-annual maintenance fee if your equipment is not otherwise covered by a manufacturer warranty.

After 60 months of service through Medicare you may choose to receive new equipment.

Medicare Supplier Standards—Medicare Beneficiary Information 1-800-633-4227

RTS Inc., is obligated to inform you of Medicare's expectations of a Home Medical Equipment supplier.

1. A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment.
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier must agree not to initiate telephone contact with beneficiaries, with a few exceptions allowed. This standard prohibits suppliers from contacting a Medicare beneficiary based on a physician's oral order unless an exception applies.
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery.
13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries.
15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item.
17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number.
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals). *Implementation Date – October 1, 2009*
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57(c). *Implementation date – May 4, 2009*
27. A supplier must obtain oxygen from a state-licensed oxygen supplier.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers.
30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.