The Patient's Guide to Understanding Insurance for Physical Therapy

Insurance 101 for Physical Therapy Patients

If your insurance "covers" physical therapy this doesn't necessarily mean you are not responsible for payment. In many cases, you will still have to pay a deductible, co-insurance, or copayment.

To better understand the terms of your plan, you must first understand the terminology. Here are a few common questions regarding insurance terms:

What is a deductible?

This is the total amount you must pay out-of-pocket before your insurance starts to pay. For example, if your deductible is $1,000, then your insurance will not pay anything until you have paid $1,000 for services subject to the deductible (keep in mind that the deductible may not apply to every service for which you have paid). Furthermore, even after you've met your deductible, you may still owe a copay or coinsurance for each visit.

What is a copay?

This is a fixed amount you must pay for a covered service, as defined by your health plan. Copays usually vary for different plans and types of services. Typically, you must pay this amount at the time of service. Copayments are fixed, regardless of the visit length, which means you will always pay the same amount. In most cases, copayments go toward your deductible.

What is a coinsurance?

This type of out-of-pocket payment is calculated as a percent of the total allowed amount for a particular service. In other words, it's your share of the total cost. For example:

- Your insurance plan's allowed amount for an office visit is $100.
- You've already met your deductible.
- You're responsible for a 20% coinsurance.

In this situation, you would pay $20 at the point of service. The insurance company would pay the rest of the allowed amount for that visit. Keep in mind that the coinsurance amount may vary from visit to visit depending on what services you receive.

What is Coinsurance for Medicare Part B?

Medicare Part B patients are responsible for a 20% coinsurance, after the deductible has been met, which typically amounts to $11-25 per visit. If you have Medicare as your primary insurance, but you also have a secondary insurance, the secondary payer becomes responsible for the 20%. In some cases, the secondary insurance also charges a copay, coinsurance, or deductible. We recommend contacting your secondary insurance carrier to find out.

How much will I owe for each visit?

If you have not met your annual deductible, then you will pay 100% of the negotiated rate per visit (approximately $100). If your deductible has been met, Medicare will pay the 80% ($80), and the remaining 20% will be forwarded to your supplemental insurance provider. If you do not have supplemental insurance, you will be responsible for the remaining 20% coinsurance (approximately $20/visit).

What if I can't afford to pay these amounts as frequently as I need care?

Your health is our number-one priority. We are happy to arrange a payment plan that works with your budget, and you can pay for your care over a timeframe that works for you. Simply ask to speak with our office manager.

A Few Handy Insurance Definitions

Date of Service: The date of your visit.

CPT Code: The code denoting each service provided to you during your visit (i.e., manual therapy, therapeutic exercise, home exercise instruction, etc.). You can request a list of these codes, along with their explanations, from your insurance company.

Billed Amount: This is the amount we billed the insurance company for that particular service. The billed amount may vary depending on the duration of the service, the services provided, and the state in which the facility is located.

Adjusted Amount: This amount is not a payment, but rather a write-off or "reduction." It is based on the contract in place between your provider and your insurance company. Neither you nor the insurance company pays this amount. The provider essentially writes it off (which is why it is sometimes called the provider's responsibility).

Patient Responsibility: This column may be labeled "Deductible," "Copay," "Coinsurance," or "Patient Responsibility (PR Amount)." It is the amount that you are responsible for paying. If a secondary insurance is on file, we will forward this amount to that insurance for payment. Once the secondary EOB comes back, you will receive a bill for any outstanding balances in the patient responsibility column.

Insurance Paid: This is the amount the insurance company paid us for the services you received on that date of service.

A Couple of Notes

- Most insurance companies offer several different plans or subsidiaries. Thus, two patients with Blue Cross Blue Shield, for instance, may have completely different benefits, and therefore, completely different financial responsibilities. Some plans have no copays or deductibles while others may. Furthermore, some providers may not accept all plans from a particular insurance. This is why it is crucial that you investigate the details of your specific plan.
- If your insurance offers an online patient portal, sign up for it! These resources typically enable you to:
    - check your benefits,
    - track your deductible,
    - see which providers in your area accept your particular plan,
    - track your claims, and
    - compare claims to your receipts from the doctor's office (if they don't match up, you can then follow up on any discrepancies).

Tips for Choosing an Insurance Plan

Whether you're shopping for your own insurance or going through the benefits selection process with your employer, choosing the right plan can seem like an overwhelming task. While we can't tell you which specific plan to choose, the following questions should help you with the selection process.

Questions to Ask Potential Insurance Carriers

What is my premium?

This is the monthly amount you pay for coverage. The lower it is, the higher your deductible will typically be. Plans with low premiums and high deductibles are often called "catastrophic" plans. Conversely, higher premium plans often feature lower deductibles, copays, and coinsurances.

What is my deductible and how is it applied?

This is the total amount you must pay each year before your insurance begins to pay. For example, if your deductible is $4,000, then you must pay $4,000 toward deductible-applicable services before your insurance will pay anything. Once you reach your deductible, your copay or coinsurance will apply.

What is my copay?

High copays are another common drawback to low-premium plans. Remember, the copay applies even after you have met your deductible, and the copay for specialist visits—including PT visits—can be as high as $80. So, if you anticipate a lot of office visits during this plan year, you will definitely want to factor the copay into your decision process.

What is my coinsurance?

As previously noted in this document, coinsurance is another version of cost-sharing. While copays are fixed amounts, and more predictable, coinsurances are percentages. Therefore, your financial responsibility varies based on how much your provider charges for the services rendered.

Are there any restrictions on the types of providers I can see?

Some insurance plans are limited to a certain network of providers. So, make sure you have a good selection of covered providers and facilities in your area. If you travel frequently or live in a rural area, you may want to choose a plan that has no network restrictions.

Do I have to get a referral to see a specialist?

If your insurance plan requires you to obtain a referral before seeing a specialist (i.e. physical therapist) and you fail to do so, the insurance company may deny coverage for services rendered. If you do not want to go through a primary care provider each time you want to see a specialist, make sure your plan does not require a referral for specialist services.

How many visits of Physical Therapy am I allowed each year?

Some plans place a limit on the number of covered visits per year, while others allow for unlimited visits. If you're athletic, have chronic joint pain, or anticipate needing a joint replacement in the near future, you may not want any restrictions on the number of rehabilitative visits allowed.

For Medicare Secondary Payers: Will this plan cover the entire 20% not covered by Medicare?

Medicare only pays 80% of the cost of care, so many Medicare beneficiaries seek supplemental insurances to pay the remaining 20%. However, even those plans often feature deductibles, copays, co-insurances, or visit limitations. Thus, we recommend posing all of the above-listed questions to any secondary insurances you are considering.

The Bottom Line

Higher-premium plans are generally better for individuals who expect to receive medical care on a regular basis. Lower-premium plans will save those individuals money monthly, but those savings won't make up for the cost-sharing portion.

The Self-Pay Option

If Dynamic Edge Physiotherapy is not an in-network provider with your insurance company, or you have exhausted your benefits for the year, then you have the option to receive services on a self-pay basis. Please speak with our office manager about self-pay rates and services.