vitalcare INFUSION SERVICES

Understanding Your Infusion Bills

Introduction

Medical bills can be very confusing. Each type of insurance plan provides different coverage and has different requirements for billing procedures.

This booklet is intended to give you general information about coverage for home infusion; however, your individual plan may differ. You can receive the most specific information by contacting our pharmacy's billing office.

General Information (Typical for Most Payers)

- Every payer has different coverage for infusion therapy. We make every effort, by communicating with your payer, to understand from the start what your coverages are.
- Many payers use "case managers", who negotiate the rate for your therapy. The amount agreed upon is typically lower than our standard rate.
- We will estimate for you what your co-payment and deductible amount will be. We base this on information provided to us by your insurance company, and based on the current prescription. Every attempt is made to make the estimate accurate; however, insurance plans can be very complex, prescriptions change, and variances can occur. These variances may require that we ask you to complete a new Admission Agreement each year so that you are informed about any updated out of pocket amounts you are responsible for.
- When you are admitted to our service, we will ask you to sign papers that will let us bill directly for your therapy, and will let us collect payment directly from your payer. This is called an "**assignment of benefits**".
- We make every effort to bill correctly and accurately. We will contact your insurance provider if any errors are made in the payment we receive. **If we do not receive a response from the insurance company after a payment error or rejection, it may be in your best interest to contact them directly.**
- If you have an insurance plan as a "secondary" insurance to your primary Medicare or other insurance plan, it will be billed after we receive notification from the primary payer that they have fulfilled their responsibility.

- In many cases, we may choose to collect the co-payment when we make your medication delivery. This "C.O.D." method helps us keep our billing costs and prices under control. If we are going to request payment on delivery, we will tell you before our arrival.
- For your financial protection, always let us know when any significant changes occur in your health plan coverage. This includes:
  - Your employer changes insurance providers.
  - You change health plan coverage due to divorce, death of a spouse, or a change in employment status.
  - You elect to "drop" Medicare and use a Medicare HMO instead or make any changes in your insurance coverages.
  - Your legal name changes on your insurance coverage.
  - Your insurance coverage lapses or expires.

Important Information about Medicare and Medicaid Billing

In most cases if we are an approved provider for your insurance plan, we accept the payer's fee schedule or allowable rate as the amount we are due. You will be responsible for a percentage co-payment of that approved "allowable" rate as specified within your insurance plan benefits.

It is against Medicare, Medicaid, and most commercial payer rules to routinely "waive" or "write off" the co-payment that the patient owes us. Our standard procedure is to bill the patient for any co-payment or yearly deductible that is owed.

If you are unable to pay your portion of the bill, you must tell us when you receive the bill so that we can try to arrange a suitable payment plan. "Waiving" your bill, if allowed, will only be considered if a hardship situation exists, and must be documented carefully to comply with payer rules. Our pharmacy will communicate with you all payment options available up to and including automatic drafts to credit cards, online payments, flexible payment plans, and waiver of interest or fees levied on late payments. You will receive an account statement based on the financial agreement(s) made with our pharmacy and as presented on the Admission Agreement.

Medicare also has rules for the billing of rental equipment such as infusion pumps. You will receive a letter from us if the rental period reaches its end, and will be given the option of purchasing the pump at that time. More information will be sent to you at that time by our billing staff.

Medicare Part B

Medicare Part B provides very limited coverage for a small list of infusion medications that are given by pump, and for immunoglobulin therapy.

If your primary insurance plan is Medicare, we will ask for specific information when you are first admitted into our program. Medicare has very strict guidelines about how and when it will pay for these therapies. We will need to review your medical history to determine if Medicare will pay for your therapy. If your infusion therapy qualifies for Part B reimbursement, you will be responsible for a 20% co-payment on every claim, and a yearly deductible unless you have supplemental insurance that covers these amounts.

Medicare Part C

These are also called Medicare HMOs, Medicare Advantage Plan, or sometimes by their older name, Medicare-Plus Choice plans. Your Medicare Part C plan might cover the cost of home infusion therapy. Every Medicare Advantage (Part C) plan is different. We will call your plan to see if they cover the cost of the medications and supplies.

You might have a co-payment amount and an annual deductible.

Medicare Part D

If you have opted to enroll in a Medicare Part D plan, it might cover the drug cost of the prescribed home infusion therapy. Every Medicare prescription drug plan is different. We will call your plan to see if they cover the cost of the medications. You might have a co-payment and annual deductible.

Using a Part D plan to pay for infusion is very challenging because these plans do NOT pay for the supplies, equipment rental, or professional pharmacy services needed to receive the infusion therapy. You might have reimbursement for these other items through another insurance plan.

Medicaid

Each state has different rules concerning Medicaid and home infusion therapy. When we receive your patient information and prescription, we will contact Medicaid to see if payment is available for your therapy.

Most Medicaid programs require a co-payment. It is usually between $5.00 and $10.00 per delivery.

If you have any additional questions about Medicaid or how Medicaid reimburses for your home infusion therapy, please contact our office.

Private "Major Medical" Plans

Many patients have what is called "major medical" or "indemnity" insurance. Some plans have a limited list of home care providers that can be used, while others are "open" where there is little restriction on which provider you choose, as long as the prices charged are typical.

Most "major medical" plans have provisions for home infusion therapy.

Health Maintenance Organizations (HMOs)

HMOs are plans that control costs by having a limited list of home care providers in their network. Most HMOs have coverage for home infusion therapy, although the type of coverage varies tremendously from one HMO to another. If you have received our supplies and this pamphlet then, we have been approved as a provider for your therapy by your HMO.

If you have any questions concerning your infusion bills and statements, please contact our pharmacy.