Your

Guide to Navigating Insurance

YOUR RIGHT TO GREAT HEALTHCARE THAT GETS YOU BETTER WITHOUT SUPRISE COSTS

How to Use This Guide:

Our top priority is that you receive great care. Health insurance exists to help us negoitate healthcare costs, however it is becoming a major barrier for providers and an even bigger financial burden for members with increasing premiums and less coverage.

This guide is meant to help you understand your insurance, know what questions to ask and how to make an informed decision regarding your healthcare rights and options when it comes to choosing your provider.

We at Break Free Pelvic Health & Wellness do not currently accept insurance and are considered “out of network”. We get many questions on what this means for coverage and we will be answering those questions as best as possible with this guide.

Please note we are not employees of insurance companies or work directly with them. EVERY policy varies and changes constantly, so this guide is general guidelines based on our experience of helping patients with out of network reimbursement and our own personal nuances of insurance coverage to help you make an informed decision.

FAQ 1:
Why do you not accept insurance?

There are a few reasons and as the owner of Break Free Pelvic Health, this is why:

1. What the insurance companies as a whole reimburse for PT/OT services is not sustainable for a small practice that sees patients one at a time. To accept insurance and keep our doors open, we would have to limit our visit times to 30-45 minutes or have multiple patients being seen at once by one provider. This is not possible with the private nature of pelvic floor therapy.
2. Diagnosis codes that are specific to pelvic floor dysfunction (ie: pelvic and perineal pain) is not considered medically necessary. Doctors that work for insurance companies accept claims based on medical necessity and usually measure this by functional outcomes (those forms that show improvement) or by pain scales, which are difficult to quantify in pelvic health. Claims are often denied because of this. Pelvic health physical therapy is very different than physical therapy for your ankle, but they are investigated the same when it comes to medical necessity. An ankle sprain is much

more likely to show improvement accepted by an insurance company than a patient with painful sex.

3. I have seen the repercussions of patients that have been to an in-network practice thinking their insurance was covering claims to then be denied. Some hospitals are charging upwards to $400-800 per session, which is a costly amount the patient owes if claims are denied. Because claim denials happen frequently in pelvic health, this happens more commonly than we realize. Insurance acceptance does not guarantee coverage.

4. By not accepting insurance, we have the freedom to treat patients as long as we would like and how we find clinically appropriate, not based upon what treatments the insurance company will pay for. We do not have an ethical dilemma in choosing to treat for our patients needs based upon what we find clinically appropriate versus the insurance company determining what is medically necessary. This again occurs commonly because if we know an insurance company would deny dilator therapy, we may choose not to do that therapy because insurance would deny leading to appeals and possibly with the patient to pay the consequences of that.

FAQ 2:
How do I know what my out of network benefits are?

Look up your insurance benefits yourself in your benefit booklet. Do not trust calling the insurance company because honestly, they don't know and everyone gets a different answer. When you look at your benefit booklet, you should see a list of benefits where outpatient services for rehab are grouped together (PT/OT/ST). You will see a column explaining in-network benefits and out-of-network benefits. You may also see a column that says co-pay or co-insurance. It's very important to know all of these. Some co-pays for PT/OT are up to $100 per visit.

Also look at your deductible. Many plans have high, unattainable deductibles if you are healthy. If that is the case, you will be paying until your deductible is met and there may not be a price difference between in-network and out-of-network care.

If your out-of-network benefits state 50% for example, you may be eligible for 50% reimbursement for our services DEPENDING on other factors like deductible and co-insurance. This is where insurance is frustrating and confusing. Know your benefit plan.

FAQ 3:
How do I get reimbursed and how do I know if I will?

Reimbursement is not guaranteed, just like insurance coverage is not guaranteed. It is based on medical necessity decided by the insurance company (so frustrating, right?). At Break Free Pelvic Health, we provide a claim form also known as a superbill, that you can submit to your insurance carrier. Based on your benefit plan, deductible and any co-insurance - you may receive payment back in the mail.

If you do plan on calling your insurance company, there are few things you can ask. Ask them how they determine medical necessity for physical and occupational therapy (ask this EVEN if your deductible is met and you are going in-network). Ask them if you need prior authorization. If you know your diagnosis (pelvic pain, incontinence, etc.) tell them and ask about medical necessity for PT/OT. The most common treatment codes used by PT/OT are the following: CPT 97110 (therapeutic exercise), CPT 97140 (manual therapy), CPT 97112 (neuromuscular re-education), CPT 97163 (physical therapy evaluation), CPT 97167 (occupational therapy evaluation).

You can use these codes to get more information from your insurance carrier on what will be covered and deemed medically necessary. You may need a referral or other documentation.
We like to think of going out-of-network as paying more out of pocket up front without ANY surprise bills later. The only thing you may get later is a check in the mail to go back into your pocket. In-network can be more of a gamble - you may have no or very low cost upfront but you may receive a large bill later that is unexpected. This is not the case for every person and circumstance, so please do not take this for every situation. Consider your options and know that you DO have options.

FAQ 4:
How do I submit the claim form or "superbill"?

We have a portal through Reimbursify at no cost to you that can help you submit claims to your insurance company. This can also come with hurdles, so the best case is to call the insurance company and ask them how to self submit your claims. Sometimes they have an online portal, via email or snail mail.