

Frequently Asked Questions on Patient Financial Responsibility for Device Follow-Up Services

Q: What does Medicare Part B cover?

A: Medicare Part B is also referred to as Medical Insurance and it helps cover physician services and hospital outpatient care.¹

Q: What is coinsurance, a deductible, and a copayment?

A: Deductible²: The amount you must pay on an annual basis for healthcare or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Copayment²: An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit or a prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription.

Coinsurance²: An amount you may be required to pay as your share of the cost for services, after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Q: Does a Medicare patient have a payment responsibility for every covered service?

A: Yes. At the beginning of every calendar year, a patient is responsible to pay the Part B Physician Services/ Outpatient Care deductible before Medicare starts to pay their share. This payment will be made to the provider of services. The 2009 Part B deductible is \$135.

Q: Is the patient billed by the physician practice for every service billed to Medicare?

A: Yes. Once the patient has met their Part B deductible (\$135), they will receive a bill directly from the physician practice for the coinsurance. If the patient has a supplemental insurance policy, the coinsurance and deductible amounts will most likely be sent to this payer.

Q: How does Medicare determine the patient's coinsurance amounts for physician services?

A: For every service covered by Medicare, the coinsurance amount is equal to 20% of the geographic adjusted payment rate.

Example A:

CPT^{®3} code 93280: Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; dual lead pacemaker system

CPT Code 93280 Dual Chamber Programming Device Evaluation

2009 Medicare national global physician payment rate	\$66.00
Medicare payment @ 80%	\$52.80
Patient responsibility (coinsurance) @ 20%	<u>\$13.20</u>
Total payment received by Physician Practice	\$66.00

Q: How much is the patient coinsurance if the technical component (TC) is billed to Medicare by the hospital and the professional component (PC) is billed by the physician practice?

A: The patient is responsible for the coinsurance amount associated with the Medicare covered service provided at the hospital. This dollar amount may be equal to 20% of the Ambulatory Payment Classification (APC). Eventually, all coinsurance amounts will be equal to 20% of the APC payment rate. However, this is a few years in the future.

Example B (Hospital TC and Physician Practice PC): CPT code 93280 Dual Chamber Programming Device Evaluation

93280	
2009 Medicare national APC 0690 hospital payment rate	\$23.17
Medicare payment	\$14.50
Patient responsibility (coinsurance) ⁴	\$ 8.67 (a)
Total payment received by Hospital	\$23.17
	+
93280-26	
2009 Medicare national professional component payment rate	\$43.28
Medicare payment @ 80%	\$34.62
Patient responsibility (coinsurance) @ 20%	\$ 8.66 (b)
Total payment received by Physician Practice	\$43.28
Total Patient Coinsurance	\$17.33 (a+b)

Q: If the service provided to the patient (CPT³ 93299: Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results) by the physician practice is Carrier Priced, is there a coinsurance amount that will be billed to the patient or their supplemental insurer?

A: Yes, Medicare will pay 80% of the Carrier Priced dollar amount and the patient or their supplemental insurer will be billed for the remaining 20%.

Q: Does the hospital have any "Carrier Priced" services?

A: No, CPT code 93299 is classified under APC 0209 with an identified national payment rate.

Q: Is there a coinsurance amount if the patient is covered under a Medicare Advantage Plan, like an HMO (Health Maintenance Organization) or a PPO (Preferred Provider Organization)?

A: No, there is usually a copayment amount such as \$20 for each physician practice service.

Q: Is there a limit to the amount of coinsurance a patient may pay for each Medicare covered hospital outpatient service?

A: Yes, there is a limit to the patient's coinsurance when a service is provided in the hospital outpatient setting (APCs). The patient's responsibility is capped at the Part A Inpatient Hospital Part A deductible. The 2009 Part A deductible is \$1,068. For example, if a Medicare patient receives an ICD in an outpatient setting (APC 0108), the current national minimum coinsurance amount is \$5,650.13,⁴ so the patient's financial responsibility would be limited to \$1,068.

These coding suggestions do not replace seeking coding advice from the payer and/or your own coding staff. The ultimate responsibility for correct coding lies with the provider of services. Please contact your local payer for interpretation of the appropriate codes to use for specific procedures. Medtronic makes no guarantee that the use of this information will prevent differences of opinion or disputes with Medicare or other third party payers as to the correct form of billing or the amount that will be paid to providers of service.

References

¹ "Medicare & You 2009" can be found at <http://www.medicare.gov/publications/pubs/pdf/10050.pdf>.

² Pages 115-116 of "Medicare & You 2009."

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⁴ *Federal Register*/Vol. 73, No. 223/Tuesday, November 18, 2008/Rules and Regulations, page 68826 (APC 0690) and page 68818 (APC 0108).

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