



Body Awareness

Physical Therapy

The Body Beat

Fall 2002

Volume One

Number Three



Medicare Changes Needed

Medicare is a government funded health insurance program that covers people over 65, some people with disabilities under 65, and people with end stage kidney disease. As the population ages, more and more people will rely upon Medicare coverage.

Medicare has two parts; A and B. Part A is usually considered hospital insurance. It covers care in hospitals, nursing homes, and hospice. Part B helps pay for doctors services, outpatient hospital care, physical therapy, occupational therapy, speech therapy and home health care. Part B has an additional premium of \$54 per month, as of January 2002. For more information on coverage, check out www.medicare.gov.

In 1997, the Balanced Budget Act was passed in congress. This bill limited the amount that Medicare covered for all combined rehabilitation services, which includes

occupational therapy (OT), speech therapy (ST), and physical therapy (PT). The bill placed a payment limit at \$1500 for all services combined, per year. Common injuries that would need to utilize rehabilitation services include strokes, hip fractures and total joint replacements. For physical therapy services alone, this amount may not cover the total number of treatments needed, even if the services are considered medically necessary.

In 1999 this bill was placed on moratorium for two years, and in 2000, Congress extended the moratorium for an additional year. This bill will go back into effect on January 1, 2003 if congress does not pass another bill. This would again place the \$1500 limit on all rehabilitation services. The "Medicare Access to Rehabilitation Services Act" was introduced into congress to repeal the original Balanced Budget Act of 1997 and allow

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medically necessary treatment to be rendered without a limited maximum number.

Do your part to ensure that the bill will be passed. Write to your representative today. Log on to www.mygovernment.com to find the appropriate person in the House of Representatives, as determined by your zip code. Let your voice be heard.

California senators are:

Senator Feinstein
One Post St,
Suite 2450
San Francisco, CA 94104
Senator Boxer
1700 Montgomery St,
Suite 240
San Francisco, CA 94111

Q'N'A

Your questions answered by the Licensed Physical Therapists of Body Awareness Physical Therapy.

Q. What is the difference between an HMO and a PPO ?

A. HMO is an acronym for Health Maintenance Organization. This system uses a primary care physician (PCP), which is usually a general practitioner. They make referrals to specialists. When a health care provider chooses to accept the HMO's contract, they agree to be paid a flat rate for services. Patients are limited to access care within their HMO.

PPO is an acronym for Preferred Provider Organization. You have the choice of health care providers. In network providers are covered at a higher percentage than an out of network provider. The remainder is the patient's copay. Each provider is different so it is best to call before your appointment to discuss your cost.

The advantage to having an HMO is that it is usually less expensive. If you are generally healthy, you have a good relationship with your primary doctor, and your HMO has a wide variety of professionals in your area, an HMO may be good for you. The downside to an HMO is that you have less choice and usually a longer wait for procedures. The advantage of a PPO is that it gives the patient the power of choice. The process is often quicker for all areas of health care, including lab work, X-rays and other procedures. With a PPO, you can choose your doctor, and you can usually get in quicker. The downside of a PPO is often a high monthly premium.

Q. How do I choose an insurance plan?

A. First you must determine if you want an HMO or PPO. Compare the differences. Don't just look at payment per month, look at the coverage you are getting. Check the deductible. This amount is what you will need to pay every year before you can utilize services. Sometimes they will cover typically needed services before the deductible is expected, like one yearly physical, ob-gyn visit or a well-child exam. Deductibles can range from \$100 to \$2500 a year. Different services have an additional deductible, on top of the original deductible. An example of this is maternity benefits.

Next look at the copay. This is the amount expected at each visit to your health care provider. Also consider lifetime cap. This is the total amount the insurance will pay. Check ancillary services like physical therapy. How many visits does it cover, and is there a maximum amount per visit?

The bottom line is that getting good health insurance coverage requires work, but the time is well spent. No matter how healthy you may feel, you still need to consider what would happen if you were in an automobile accident, or hospitalized for an extended period, and had to pay those costs yourself.

BODY AWARENESS GRADUATE OF THE MONTH

Graduate of the Month: Jamin Shoulet, low back pain

Jamin Shoulet originally injured his back while power lifting at the gym in 1995 when he herniated a disc. The herniation was so severe, he underwent surgery for a microdiscectomy. The surgery did help to cure the burning pain down his left leg, but he continued to have back and leg pain intermittently through the years. Jamin began physical therapy in January 2002, seven years after his original injury. After so many years of pain, and limiting his activities, he had become very inflexible. This inflexibility put a lot of stress on his spine. Through a program of soft tissue and joint mobilization, yoga

and lumbar stabilization exercises, Jamin has been able to resume activities like playing lacrosse, bike riding and has returned to the gym. He has also found a new hobby; Yoga.

Community Corner

Do your part to ensure that Medicare benefits will not be cut. Below is a sample of a letter to your senator and/or congressman. Let your voice be heard. Write to your representatives today. Remember the \$1500 limit will be enforced as of January 1, 2003 if no action is taken!

The Honorable _____
U.S. Senate/U.S. House of Representatives
Washington, DC 20510/20515

As a concerned (citizen or Medicare beneficiary), I am writing you about a provision that originated in the Balanced Budget Act of 1997 (BBA), which adversely impacted senior citizens in 1999. The provision imposed an annual cap of \$1500 for outpatient physical therapy services. This limitation, or cap, affected services provided in all Part B practice settings, excluding those furnished in a hospital outpatient department.

Fortunately, Congress recognized the potential consequences of the therapy cap and has twice imposed a moratorium on its implementation. However, the moratorium is due to expire at the end of this year on December 31, 2002. I am asking for your help in permanently extending this moratorium by repealing this arbitrary cap once and for all.

The inherent problems with the \$1500 cap are as follows:

- The arbitrary cap will have a disproportionate effect upon the oldest and sickest Medicare beneficiaries; thereby denying access to care for the most vulnerable Medicare population.
- Beneficiaries requiring services above the \$1500 limit will have to seek care in an outpatient hospital department, if there is one available to them in their geographic region, or pay 100% of the cost out of pocket.
- The arbitrary cap limits access to therapy if a patient has more than one episode of care for therapy per year. For example, if a patient has a knee replacement and receives \$1500 in therapy but later has another condition that requires therapy in the same calendar year, Medicare would not cover services if the \$1500 limit had already been reached.

(You could add a paragraph how this has or could affect you, or a loved one.)

Both the Senate and the House have introduced legislation (S. 1394/HR 3834) that would repeal the \$1500 therapy cap once and for all. I urge you to cosponsor this extremely important bill that will protect Medicare beneficiaries.

Thank you for your consideration of my request.
Sincerely,

Have a question for our **Q'N'A** column or a suggestion on
what you would like to see in the *Body Awareness Body Beat*?
2951 Harbor Blvd. Phone (714) 546—7575
Costa Mesa, CA 92626 Fax (714) 546—7573
BodyAwarenessPT@aol.com

Healthy Hints

1. If your policy has restrictions or limitations that have been met, call for an extension. Sometimes benefits will be extended after a surgery or major illness.
2. If you need an elective surgery, try to have it scheduled earlier in the calendar year. If physical therapy is needed after surgery, your deductible will have already been met from surgery. Remember, deductibles are paid each year. If you have surgery in December, and you continue to need services in January, you will have to pay your deductible again.
3. Basically you get what you pay for. If you have questions, consult an insurance broker. We consulted with Mark Wolski, (310) 581- 0078.



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