

APTA State Reimbursement Chair Forum
December 3-4, 2004
Baltimore, Maryland

Frequently Asked Questions

Practice Management

1. How should a therapist bill for home visits provided by hospital or out-patient clinic based PTs vs. home health PTs?

Home health services provided by physical therapists working for a Home Health Agency are paid under a prospective payment system under Medicare. Please refer to: <http://www.apta.org/reimb/coding/denials/setting>. Private healthplans may have their own network of therapists that provide physical therapy in the home setting. A provider can call a healthplan to find out their procedures for home care services.

If physical therapy services are provided by hospital based or out-patient clinic based PTs for Medicare patients, the PTs must be enrolled in the Medicare program as providers. Please refer to:

http://www.apta.org/Govt_Affairs/regulatory/Medicare/becoming_provider.

Claims for physical therapy services provided in the home setting by outpatient based PTs must specify the “place of service” in box 24b of the claim form using the number “12”.

2. Please explain PTA supervision in different practice settings?

Guidelines for PTA supervision are based on state practice acts and payer-specific policies. The state practice acts can be accessed through the APTA web site: http://www.apta.org/PT_Practice/ptlicensure. APTA also has recommended supervision guidelines for PTAs. Please refer to:

http://www.apta.org/PT_Practice/for_clinicians/Use_of_Personnel.

Medicare’s regulations for PTA supervision based on specific site of care are described at:

http://www.apta.org/Govt_Affairs/regulatory/Medicare/assistants_aides_students/pta_supervisionchart.

3. How can I find out more information regarding billing software?

Every August, PT Magazine published a buyer’s guide. This supplement has a list of vendors that sell billing software. Listing in this guide is not an endorsement by APTA. APTA recommends that any potential buyer of software determine their needs and spend time evaluating the software before purchase.

4. Please explain the 60-day certification process.

Medicare requires that a physician re-certify a patient's plan of care every 30 days after the initial physical therapy visit. The patient does not have to see the physician until some time in the first 60 days after the initial physical therapy visit and then every 30 days thereafter. For more details, please refer to:

http://www.apta.org/Govt_Affairs/regulatory/Medicare/treatment_settings/privatepractice/conditions/guidelines_privatepract.

This question is also answered in the March/April 04 issue of Reimbursement News which can be obtained from the APTA Service Center (800-999-2782, x3395).

5. Can a physical therapist "opt-out" of Medicare?

No. Physical therapists are not eligible to "opt-out" of Medicare. (The only providers that can are doctors of medicine and osteopathy, dentists, podiatrists and optometrists.) Any physical therapist who treats a Medicare beneficiary must be enrolled in the program as a supplier. Refer to:

<http://www.cms.hhs.gov/medlearn/matters/mmarticles/2003/MM3016.pdf>

6. Can I waive copays and deductibles?

In the vast majority of cases, the answer is NO. A provider should not routinely waive a patient's copay and/or deductible. Discounts and/or waivers could subject a provider to civil, criminal and administrative violations of both federal and state laws.

Congress has delineated certain circumstances that provide limited protection for certain waivers of copays and deductibles. The following criteria must be met: 1) the waiver is not offered as part of any advertisement or solicitation 2) the person making the waiver does not routinely waive the amounts 3) the person making the waiver determines in good faith that the patient is in financial need and/or fails to collect the deductible or copay after making reasonable collection efforts. The provider must document the reason for the waiver in the medical record.

A claim sent to a payer for an amount that does not reflect the provider's intention to discount or waive the deductible or copay may be a "false claim". And, if the claim is submitted via the mail, then the provider has committed mail fraud. Last, if the waiver is interpreted as an inducement for the patient to come to that therapy office, there is a potential anti-kickback violation.

While most state practice acts are silent on this issue, the Ohio state practice act specifically states that waiving copays and deductibles is not permitted.

A more detailed explanation of this can be found in the APTA September/October 2004 Reimbursement News newsletter available from the APTA Service Center (800-999-2782, x3395).

7. Please explain the 8-minute guidelines.

The 8-minute guidelines were outlined in Medicare's Program Memorandum AB-00-14 dated March 2000. Please refer to:

http://www.cms.hhs.gov/manuals/pm_trans/AB001460.pdf (see page 8).

Medicare has outlined how they will consider use of the timed procedure CPT codes (e.g. therapeutic exercise 97110) for payment. The memorandum states that if a service is provided for less than 8 minutes, it is not billable. A procedure or modality performed for greater than or equal to 8 minutes and less than 23 minutes is considered one unit. A procedure or modality performed for greater or equal to 23 minutes and less than 38 minutes is considered two units. Please refer to the program memorandum for further details.

Included with the release of the 8-minute guideline is the "total time guideline" that states that the total treatment time should be reflected in the billing. If a patient received 10 minutes of therapeutic exercise (97710), 10 minutes of gait training (97116) and 10 minutes of neuromuscular reeducation (97112), the provider should only bill for a total of 30 minutes of service (2 units). In this situation, the provider should select two procedure codes for billing and the documentation should reflect all the services that were provided.

These guidelines only refer to Medicare patients; other payers may have different requirements however, the physical therapist must be able to defend and support any claims submitted and should not bill for de minimus services.

8. I am still unsure how to bill one-on-one vs. group therapy. Is there a reference I can use?

APTA's web site has plenty of information on this issue at:

http://www.apta.org/reimb/coding/cptcd/OneonOne_Group.

9. Should I consider first party pay?

Any business that offers physical therapy services should evaluate the possibility of increasing their base of patients that would directly pay for services (first party pay) at each visit. Historically, most physical therapists have relied on third-party payment from insurance companies or managed care organizations. It would be prudent to evaluate what percentage of your business is dependent on third-party payment. And, it is important to assess if the business is located in an area where people could afford to pay out of pocket.

Increasingly, employer-sponsored health plans are offering high-deductible policies and/or some hybrid of health savings accounts. In either of these situations, the enrollees will have to cover routine first dollar coverage of medical expenses themselves so first party payment is likely to become more common.

10. What are important considerations when establishing a contract with a payer?

First and foremost, a provider should have an estimate of how much it costs to provide care. Without a working knowledge of costs (both direct and indirect), determining the profitability of a contract is virtually impossible. Second, the payer will undoubtedly offer a contract that is to their benefit. Remember that all contracts are negotiable. Be prepared to walk away from the table if the contract does not meet your needs. Make sure to read the entire contract and ask your attorney for input. Review any supporting materials including policies and procedures that the payer will be following. Ask questions about any provisions in the contract that are not clear including wording such as “medical necessity”. Obtain information on payment policies, utilization management procedures, claims procedures (e.g. timely payment or retroactive adjustments to payments), and provider profiling. Determine the length of the contract and what provisions are available to the payer and to the provider to terminate the contract.

The APTA Reimbursement Department has a list of reprints that are available and a few reference contracting issues. Please refer to: <http://www.apta.org/reimb/conted/reprints>.

11. Are there any good electronic documentation systems?

APTA is currently developing an electronic documentation system called “CONNECT”. Please refer to: http://www.apta.org/PT_Practice/For_Clinicians/aptaconnect. Look for information on product availability at the end of 2005 or 2006.

12. How come I cannot get into a network?

There are two kinds of provider networks. First, a payer can develop a restricted provider network that is available to their plan participants. This is typical in a Preferred Provider Organization (PPO). Second, a group of like providers can join together to form a network that contracts with a payer to provide services for the enrollees. This kind of network negotiates a contract on behalf of all the network participants and usually assumes some of the administrative costs associated with provision of the services.

As managed care has evolved and as managed care organizations have consolidated, provider networks are firmly established and no longer need new participants. This is why many providers opening new practices are having a difficult time accessing a network. It is recommended that you investigate who in your area is a participating provider and determine if you are offering any services that are not covered by existing preferred providers. For example, do you offer hand therapy or a vestibular rehabilitation

program that no one else is offering? If so, you can use this as a bait to get your foot in the door with the payer. If not, ask that your name be placed on a waiting list and continue to submit a request 2-3 times per year.

The recent Jan/Feb 2005 issue of Reimbursement News has an article about this. A reprint can be purchased from the APTA Service Center by calling 1-800-999-2782, x3395.

13. How do I bill for supplies?

It is important to determine if the supplies in question are part of the procedure. For instance, electrodes are required to provide electrical stimulation. Therefore, there should not be separate billing of electrodes. That would be considered “unbundling”. Under a Resource Based Relative Value Scale (RBRVS) payment system such as Medicare, supplies are part of the practice expense and already covered within the value of the code. If the supplies are utilized in the office, the supplies are not billable. However, if the patient takes home supplies to be utilized as part of a home exercise program (e.g. Theraband), then the patient can be billed at the time of service. It is advisable to check contract language prior to billing the patient.

Some supplies can be billed to a third party. If this is done, the CPT code for supplies is 99070 and the claim form should state what supplies were provided. The payer should be asked in advance if they will accept a bill for supplies and if there are any restrictions.

If the supplies are related to a procedure that is not a covered benefit, then patient can be billed.

15. How can I maximize collection of copays and deductibles?

First, when the patient calls to make their first appointment, explain that you will be checking with their insurance company to find out their copay and deductible. Explain that you will be expecting payment at the time of each visit. When your office verifies patient eligibility and benefit language with the payer, ask what the patient’s copay and deductible are.

At the time of the first visit, make sure the patient understands their financial obligation. You may ask them to sign a statement verifying that they understand their out-of-pocket obligations. Ask the patient’s to pay at the end of each visit. Allow them to pay with cash, check and/or credit card.