Physical and Occupational Therapy Billing Best Practices
Flatirons Practice Management

Full-service RCM company based in Boulder, Colorado

PT/OT billing for 19 years

Bill for a few hundred PTs/OTs/STs

Bill tens of thousands of PT/OT claims each month
Agenda

Front desk best practices

FLR coding

Proper modifier usage

PQRS

Network status

Working your unpaid claims

Key Performance Indicators (KPI’s)
Verifying eligibility and benefits

This is NOT optional

Must verify eligibility and benefits at least on new patients and at the beginning of a new calendar or plan year for active patients. This applies to primary and secondary insurances as applicable.

Who do we bill for primary and secondary claims?

You need a robust Financial Policy

Patients must sign
They are responsible for anything their insurance doesn’t pay
Include attorney’s fees and collection costs
Have them authorize you to call their cell phones to collect
Accuracy is key

All data entry must be accurate and should match what’s on the patient’s insurance card.

Know the difference between Medicare and a Medicare-replacement plan.

Can’t get a claim paid if you don’t send it to the correct payer.
Auths and visit limitations

Is a pre-auth required?
  Worker’s comp
  MVA/Personal Injury
  Commercial payers and third party administrators, such as Optum Health & OrthoNet

Any restrictions on visits?
  Medicare Cap
  Annual PT limits
  What’s already been consumed?

Your EHR software should track this for you.
Time-of-service collections

Co-pays

Unmet deductibles

Co-insurance

Credit card on file
Calculating co-insurance to collect at TOS

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You can replicate this by payer with your actual contracted rates
Timely charge entry

Patient charts should be completed prior to charge entry

Best practice = same day

This applies to finalizing and signing your notes too

MediLinks allows you to document your charges real-time as you’re interacting with the patient

Quicker charge entry = quicker billing = quicker payments
FLR coding

Required when Medicare is primary or secondary. Medicare-replacement plans are excluded.

Select a primary limitation per patient along with their current status and their goal status.

Must report with the initial evaluation, every re-evaluation (at least every 10th visit) and at discharge or you won’t get paid. You can report earlier than the 10th visit in conjunction with a re-evaluation.

You are not required to report if the patient self-discharges but it’s a good idea in case they come back.
FLR coding

There are 6 code sets with 3 codes per set.

Example – Mobility
   G8978 – Current Status
   G8979 – Goal Status
   G8980 – Discharge Status

Report 2 codes with severity modifiers with each reporting event:
   > Current status and the goal status

When discharging the patient, the discharge status is the current status. You still need to report the goal.
FLR coding

Severity Modifiers:
- CH – 0 percent impaired
- CI – 1 to 20 percent impaired
- CJ – 20 to 40 percent impaired
- CK – 40 to 60 percent impaired
- CL – 60 to 80 percent impaired
- CM – 80 to 100 percent impaired

The key to FLR management is simply keeping track of your visits and MediLinks will do this for you.
Know your modifiers

Medicare: GP, GO, GN, KX

X series – preferred by Medicare and must use for 2+ modifiers on a given claim. Used to unbundle CPT codes.

59 – still permissible today when using only one on a given claim. Being phased out and replaced by the X series modifiers.
**X modifiers**

XE Separate Encounter: A service that is distinct because it occurred during a separate encounter.

XS Separate Structure: A service that is distinct because it was performed on a separate organ/structure.

XP Separate Practitioner: A service that is distinct because it was performed by a different practitioner.

XU Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.
Advance Beneficiary Notices (ABNs)

Use the GA modifier when you anticipate that Medicare will deny the charges so that Medicare will deny them to patient responsibility rather than as a contractual adjustment.

The patient must sign the ABN, it must be date of service specific (no blanket ABNs are allowed), and it must cite the CPT codes that you expect Medicare to deny.
PQRS

Provide PQRS codes or accept a 2% reduction from the Medicare fee schedule

Can be claims-based or registry

Examples of PQRS codes:

- 1101F – Fall reporting code
- G8420 – Body Mass Index calculated code
- G8440 – Pain Assessment not documented code
- G8427 – Current medication documented
PQRS

Perform PQRS measures

- Body Mass Index Screening and Follow-up
- Documentation and Verification of Current Medications
- Pain Assessment Prior to Initiation of Patient Treatment
- Falls
  - Risk Assessment
  - Plan of Care
- Functional Outcome Assessment

Document clinical findings and related care

- For each measure document the activity was completed and any relevant care or follow up
- For example Pain Assessment:
  - document that you performed a pain assessment (tool used, patient narrative)
  - If pain is present, address pain in your plan of care
PQRS: Errors to Avoid

Failing to include PQRS data on an original claim:
- Make sure PQRS codes are included on all eligible initial claims.
- Claims cannot be resubmitted for the sole purpose of adding a PQRS code.

Placing invalid modifiers on the PQRS codes including GP or KX:
- Placing a GP or KX modifier will cause the PQRS to reject from the system.
- You cannot resubmit the claim to correct PQRS code errors.

Failing to meet 50% reporting rate for all selected measures:
- Consistently report PQRS measures on all eligible patients throughout the year.
- Do not select different measures for each patient; report selected measures on all patients.
- Report on all eligible visits including 97002 and 97532.
PQRS

Must report on all required measures (6 for PT) on at least 50% of all Medicare evaluations and re-evaluations

Failing to include PQRS codes on re-evaluations is a common reason for failing PQRS

We recommend incorporating PQRS into your FLR processes
PQRS Resources

http://www.apta.org/PQRS/ClaimsBasedReporting/

http://www.aota.org/Advocacy-Policy/Federal-Reg-Affairs/Pay/Medicare/PQRS.aspx

https://www.asht.org/practice/federalstate-regulations/pqrs
In or out-of-network?

In-network providers agree to accept contractual rates, which may not always be desirable.

When you’re out-of-network, you can bill whatever you want and you can bill the patient for whatever the insurance doesn’t pay. Or not. Note that this does not apply to Medicaid patients.

Your reimbursement per visit is obviously better when you’re OON.

But you’re likely to get fewer patients.
In or out-of-network?

Referring physicians do like one-stop shopping.

Strategic decision with no right or wrong answer.

When in doubt, we recommend being in-network.

If you have an unusual sub-specialty (e.g., wound care) this will often open up previously closed networks.
Resolving unpaid claims

This is where the rubber meets the road

Possibly the single most important task in maximizing your total collections
Resolving unpaid claims

Organize and prioritize - don’t lose sight of timely filing limits

Drive accountability

When things get tough

Don’t forget about the patients
Patient statistics

The average deductible for people with employer-provided health coverage rose from $303 to $1,077 between 2006 and 2015. (source: Kaiser Family Foundation, 4-12-2016)

We routinely see patients with annual deductibles of $5,000 or more, especially family “aggregate” deductibles.
The patient’s share is on the rise

Costs Paid by Workers Increasing Faster than Payments by Health Plans

Workers’ Deductibles and Coinsurance Are Growing Faster Than Costs Paid by Insurance

- Spending on deductibles: 256%
- Spending on coinsurance: 107%
- Paid by insurance: 58%
- Spending on copayments: -26%

Maximizing total collections

The patient is responsible for 28% of the costs of their healthcare (source: Dept. Health and Human Services - 2011 data)

1 in 3 workers has a $1,000 plus deductible (source: Kaiser Family Foundation)

The percentage of patients with high deductible health plans is rising at 15% annually (source: America’s Health Insurance Plans annual census – July 2014)
Patient collections

If you collected at the TOS this is less of an issue

Statements protocol

Reminder phone calls

Not all billing organizations do this
Optimizing your reimbursement to payroll ratio

Disclaimer

MPPR – more yet shorter visits equals better reimbursement

Per diem and case rates
Key Performance Indicators (KPIs)

The Hawthorne effect

Average reimbursement per visit

Average collection rate(s)

Average charges per visit

Days in A/R (DSO)

Total aging relative to charges

A/R over 90 days
Average reimbursement per visit

Collections for the period divided by visits for the same period

Varies dramatically according to:

- Payer mix
- Fee-for-service vs. per diem rates vs. case rates
- Fee schedules and specific CPT code utilization
- Number of units per visit

Can quantify a future expected amount based on historic data

Trend over time
Average collection rates

Collections for a period divided by the charges for the same period

Can vary dramatically based on charge fee schedule and average reimbursement per visit

Example:

Avg. charge per visit - $180
Avg. collections per visit - $90
Collection rate = 50%

Trend over time
Average collection rates

We report:

Rolling 3 months collections rate

Rolling 12 months collections rate

YTD collections rate

Looking at the trends
Average charges per visit

Total charges for a period divided by visits for the same period

Trend over time

Harbinger for collections per visit
Days in A/R (DSO)

Average number of days to convert claims into money in the bank

Ending A/R divided by charges for last 3 months times 91

Example:

- Ending A/R - $100,000
- 3 months’ charges - $250,000
- Days in A/R = 36.4 days

PT/OT national average is ~44 days
Total aging relative to charges

Your total aging should be proportionate to your billed charges

The lower the ratio the better

A 30 day collections cycle translates to a 1:1 ratio

Example:
- Billed charges for July = $150,000
- Total aging as of July 31\textsuperscript{st} = $150,000
- Ratio of aging to charges = 1:1

Similar to DSO
A/R over 90 days

Percentage of your total A/R that’s 90 days old or older

The lower the better

Generally should be 20% or less

Highly impacted by:
  TOS collections
  Payer mix
  Accuracy of insurance verifications
  Accuracy of data entry
  Etc.
Summary

Have well established practices in place

Have strong discipline in implementing your practices

Don’t let the tail wag the dog on collections

Track your key metrics and trend them over time to quickly identify budding issues before they bloom into cash-flow problems
Questions?

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