



Billing Specialist Knowledge Assessment Physical Therapy

1. What is a Medicare Local Coverage Determination? How does it affect PT billing?
2. What is the difference between a CPT code and an ICD-9 code?
3. Can a modality be billed on the same day as a re-evaluation?
4. What modifier needs to be on all physical therapy codes when being billed to Medicare?
5. When is it appropriate to bill a re-eval under the Medicare program? When is it not?
6. What are some common "timed codes" for PT? How are the units counted?
7. What is the difference between pre-certification and pre-authorization?
8. What is the difference between a supplement and a secondary? How might it affect PT reimbursement, particularly for Medicare?
9. What would your procedure be for insurance aging account followup?
10. What might be the cause of the following denial codes and what would you do if presented with it on an EOB?
 - a. Patient cannot be identified as our insured.
 - b. Missing or invalid referring physician.
 - c. Missing or invalid date last seen.
 - d. Applied to deductible.
 - e. Denied for authorization.
11. What is the difference between med-pay and third-party-liability insurance?
12. What is a "letter of protection" and why is it important to have one?
13. How long does it take Medicare to pay a claim if the provider is participating and bills electronically?
14. What are CCI edits? How do they impact PT billing? Do all carriers use them?
15. What is line-item posting? What is the primary benefit of posting in this manner?



**Billing Specialist Knowledge Assessment
Physical Therapy
Answer Key**

1. What is a Medicare Local Coverage Determination? How does it affect PT billing?
 - a. A Medicare LCD indicates procedures that are covered under the Medicare program, a general guideline of utilization, and diagnosis codes that support medical necessity. By understanding your Medicare LCD, you will know when you should obtain a signed ABN from your patient.
2. What is the difference between a CPT code and an ICD-9 code?
 - a. A CPT code describes the procedure that was performed (what was done) and an ICD-9 code indicates the patient's diagnosis (why the procedure was performed).
3. Can a modality be billed on the same day as a re-evaluation?
 - a. Yes. By adding a -59 modifier to the re-evaluation code, both the re-eval and the modality can be billed and paid on the same day.
4. What modifier needs to be on all physical therapy codes when being billed to Medicare?
 - a. A -GP modifier should be used on all PT codes when billed to Medicare.
5. When is it appropriate to bill a re-eval under the Medicare program? When is it not?
 - a. It is appropriate to bill a re-eval code when a patient's condition has changed significantly enough to need to develop a new treatment plan and goals. It is inappropriate to bill a re-eval code solely for the development of a plan of care for the referring/ordering physician.
6. What are some common "timed codes" for PT? How are the units counted?
 - a. Some common timed codes are 97110 therapeutic exercises, 97140 manual therapy, 97113 aquatic therapy, 97112 neuromuscular re-education. (Any of the codes between

97032 and 97546 would qualify.) Services performed less than 8 minutes should not be reported. A 15-minute unit is defined as a minimum of 8 minutes to less than 23 minutes. Two units is 23 minutes to less than 38; and so on.

7. What is the difference between pre-certification and pre-authorization?
 - a. A pre-certification means that a procedure may be performed, given the patient's diagnosis, as in "a paraffin bath can be performed for carpal tunnel." Pre-authorization means that you will be paid for the procedure, as in "We are authorizing 20 treatments for Ms. Jones commencing on X date."
8. What is the difference between a supplement and a secondary? How might it affect PT reimbursement, particularly for Medicare non-covered charges?
 - a. A "supplement" covers the balance (usually the 20% co-insurance and deductibles) of Medicare-covered charges. Supplements will not cover charges that are not covered by Medicare. A true "secondary" insurance is usually a policy provided by a patient's past employer throughout retirement. Secondaries should provide the same coverage for their retirees as they do for their actively-employed participants, regardless of whether Medicare covers it or not. So procedures such as Muscle Testing, which are not routinely covered by Medicare, may be a COVERED benefit for a secondary, but would not be by a supplement.
9. What would your procedure be for insurance aging account followup? Why?
 - a. Aging should be followed up on by largest amount, oldest timeframe, not alphabetically. (Most people either work from the As, or the next month, start at Zs, so the Ms never get worked!). Consideration is also given to specific insurance requirements, such as Carelink requires a 90-day timely filing window.
10. What might be the cause of the following denial codes and what would you do if presented with it on an EOB?
 - a. Patient can not be identified as our insured.
 - i. Some part of the patient information is incorrect, probably the patient's ID number, but may also be the date-of-birth, or even the address. Verify the patient's insurance and demographic information and resubmit the claim.
 - b. Missing or invalid referring physician.

- i. Either the referring physician is missing entirely from the claim, or the referring doctor's name, UPIN, and taxonomy code do not match. Add and/or verify the referring doctor's information and resubmit claim.
 - c. Missing or invalid "date last seen."
 - i. The date of the patient's last signed plan of care is missing from the claim, or is outside of the acceptable date range. Add or correct the date and resubmit the claim.
 - d. Applied to deductible.
 - i. Transfer the balance of the claim to the patient, less the contractual adjustment (if applicable), and send a statement.
 - e. Denied for authorization.
 - i. Review the insurance verification information that was obtained by the biller, or the person responsible for that function. Was authorization required? Was it obtained? The authorization number may have been left off of the claim. In that case, you'll need to add it and resubmit. Perhaps the procedure codes submitted did not match those that were authorized, at which time you'll need to contact the insurance company and try to amend the authorization (they may or may not be cooperative!) If none was obtained and the insurance company won't issue you one retroactively, you may be forced to write off the entire bill. You should review this with the person responsible for authorizations.

11. What is the difference between med-pay and third-party-liability insurance on personal injury patients?

- a. Med-Pay is coverage on the patient's own insurance policy to cover medical expenses. Medpay "follows" both the insurances and the car, i.e. it covers the insured regardless of what vehicle the insured was occupying at the time of the accident; and it also covers any person occupying the insured vehicle at the time of the accident. Usually paid right away. Coverages usually range from \$500 to \$10,000. If a person has med-pay coverage, it is usually billed prior to the third-party-liability company. Third-party-liability covers damages caused by the negligence or fault of an insured, usually the "other party." Claims are usually not paid until a "settlement" occurs.

12. What is a "letter of protection" and why is it important to have one?

- a. A "letter of protection" is an agreement that the patient will pay their bills at the conclusion of the case from the proceeds

of a settlement or verdict. Usually the patient's attorney prepares it, indicating that the doctor will be paid prior to the funds being disbursed to the patient. It is important to have one, because without it, the patient will directly receive the proceeds from the suit. Oftentimes, they patient will "run with the money," and not pay the provider. Without one, the provider then must pursue the patient through the court system or through collections, oftentimes with little or no recovery.

13. How long does it take Medicare to pay a claim if the provider is participating and bills electronically?
 - a. Thirteen days.
14. What are CCI edits? How do they impact PT billing? Do all carriers use them?
 - a. Correct Coding Initiative edits are used to determine the appropriate billing of CPT codes and HCPCS codes. The objective is to electronically identify inappropriate "unbundling" of codes in order to maximize reimbursement. They were initially developed for Medicare. However, many insurance companies have adopted them. The problem is that they are updated quarterly, and not all carriers are "up to date" at any one time, meaning that the rules are applied differently with each carrier.
15. What is line-item posting? What is the primary benefit of posting in this manner?
 - a. Line item posting means that the payment and adjustment is applied to each separate charge line. It allows you to run reports and analyze data *by procedure code, by payor* to determine payment amounts, denial patterns, and other information.