PHYSICAL THERA**PT**

SUPERBILL BASICS

OUTSIDE-THE-BOX CARE

Changes in insurance reimbursement require practices to see a high patient volume, diluting the attention you receive from a licensed practitioner. Out-of-network PT and AT allow for greater customization of care, and our team of sports specialists are here to help you reach your movement goals, no matter how big.

All sessions are HSA / FSA eligible, and meet qualifications for corporate employee wellness incentives.

Insurance companies can stipulate treatment choices. Your clinician can evaluate your body as a system, without limitations.

Know what to expect when budgeting for your recovery. Escape from delayed charges and misleading co-payments.

After each appointment, we'll provide you with a superbill that you can submit to insurance. Each superbill contains key standardized details about your provider, your injury, and the treatment you received. All you need to do is submit them according to your plan's guidelines.

IMPORTANT TERMS

Allowed Amount: The highest amount a plan will cover / pay for a service.

CPT Codes: Codes used to describe tests, surgeries, evaluations and any other procedures performed by a healthcare provider on a patient.

ICD-10 Codes: Codes used by healthcare providers to classify and track all diagnoses, symptoms and procedures.

Medically Necessary (or Medical Necessity): Services, supplies or prescription drugs that are needed to diagnose or treat a medical condition. Also, an insurer must decide if this care is:

- Accepted as standard practice. It can't be experimental or investigational.
- Not just for your convenience or the convenience of a provider.
- The right amount or level of service that can be given to you.

Non-covered Charges: Charges for services and supplies that are not covered under the health plan. Examples of non-covered charges may include things like acupuncture, weight loss surgery or marriage counseling. Consult your plan for more information.

Out-of-pocket Cost: Cost you must pay. Out-of-pocket costs vary by plan and each plan has a maximum out of pocket (MOOP) cost. Consult your plan for more information.

Reason Codes: Alphanumeric codes used by insurance companies which correspond to a list of justifications for denying a claim. These may be referenced on your EOB or online.

HOW IT WORKS

Suzie spends $200 to see a clinician who doesn't take her insurance. Depending on the treatment she receives and the type of insurance plan, her insurance company might say the amount she paid exceeds the "allowed amount". For out-of-network services, the patient is usually responsible for paying the difference.

Our example: The allowed amount is $160.

The allowed amount is what gets applied to her benefits policy. Most plans have an out-of-network deductible which has to be fulfilled first. This means she pays the initial expenditures in full for these services.

Her deductible is $750 and has already been fulfilled.

Since her deductible has been fulfilled, the entire allowed amount gets processed according to her plan benefits. However, there's one more step to reimbursement: the out-of-pocket maximum (OOPM).

The out-of-pocket max (OOPM) of $3,750 has NOT been reached.

Now we can finally calculate her reimbursement amount! In this case, her policy pays 70% and she pays 30% (often called coinsurance).

A reimbursement for 70% of $160, or $112, is paid for the session.

Example from Reimbursify.com