Frequently Asked Billing Questions

Q: Can you explain the cost of these appointments and why they are this amount?

A: Medical appointments are billed using ICD-10 and CPT codes which indicate what body part was treated and what treatment methods are used during your appointment. Your **payer** (health insurance company, worker's compensation representative, motor vehicle accident insurance or any company or person you've designated as responsible for the cost of your medical visits) determines reimbursement to your **provider** (in this case physical or occupational therapist, but a provider could be a physician, chiropractor, nurse practitioner, speech therapist, etc.) based on which codes your provider used when they submitted the claim for your appointment . If your payer deems the codes billed during your visit **medically necessary** your provider will be paid a previously agreed upon and contracted amount for the services provided to you. This amount will vary each visit because the treatment methods used will vary depending on how well your body responds to them.

Q: Why did my insurance only pay for part of these appointments?

A: Each patient's policy is a little bit different. It's likely your policy has a deductible and an out-of-pocket maximum. You are typically responsible for a co-pay (due at the time of service) or a coinsurance percentage (calculated when your payer processes your claims) for each medical appointment you have. You will likely see a decrease in cost when you meet your deductible. When you eventually meet your out-of-pocket maximum, your payer will cover 100% of the cost of your medical appointments. Most patient deductibles and out-of-pocket maximums are re-set on January 1st of each year.

Q: I have a co-pay or owe a coinsurance percentage, but why did I get billed more for some appointments than for others?

A: There are a number of reasons your cost may vary from appointment to appointment. Most frequently this happens because your payer reimburses your provider differently depending on what code is billed and you owe a percentage of what your insurance pays prior to meeting your deductible or out-of-pocket maximum. If you have questions about your specific coverage we encourage you to contact a representative from your payer's company to discuss outpatient, in-office physical therapy coverage. Please see the back of this notice for a list of our most common payer's customer service phone numbers.

Q: This bill is more expensive that I anticipated. Can you discount my visits?

A: We are always sorry when physical or occupational therapy is more expensive than our patients originally thought, however, once we have sent claims to a payer we are not permitted to make adjustments to the cost billed or transferred to you. We offer a discounted cash-pay rate to our patients who choose not to use a third-party payer of $120.00 per visit. If you are receiving a bill with a balance higher than you are able to pay right now, please call Accounts Coordinator Sara Clough at (831) 464-8200 ext. 208 to set-up a payment plan. If you do not set-up a payment plan and your balance becomes delinquent your account will be transferred to a third-party collections agency.

Q: My secondary insurance usually covers the remainder cost of my Medicare visits. Why didn't it in this case?

A: If you are a Medicare patient that received a bill from us, one of the following scenarios is likely:

1. You have not yet met your annual deductible and your supplemental insurance does not cover this cost. In 2016 the Medicare Part B (outpatient coverage) deductible is $166.00.
2. Your supplemental health insurance policy does not cover physical or occupational therapy. In this case, Medicare Part B will cover 80% of the cost of your visit and you will be billed for the remaining 20% your supplemental insurance policy does not cover. This cost ranges from $18 - $35 per appointment.
3. Your Medicare Part B or supplemental insurance policy has lapsed. If you suspect your coverage has lapsed, please contact 1-800-MEDICARE or the customer service phone number on the back of your supplemental insurance ID card.
4. Your Medicare Part B or supplemental insurance policy has been put on hold due to a **coordination of benefits** (how your coverage is organized and in what order Medicare communicates with other existing insurance policies). If you have opted into an organized care plan, an HMO, changed supplemental policies or made other changes to your Medicare Part B policy, claims filed on your behalf may be denied because your insurance carriers are confused about who should pay in what order. If you suspect your claims may be denied due to a recent change, please contact 1-800-MEDICARE or the customer service phone number on the back of your supplemental insurance ID card.

Blue Shield of California: (800) 393-6130
Anthem Blue Cross of California: (866) 249-4844
Health Net: (888) 926-4988
Cigna: (800) 997-1654
AARP: (888) 687-2277
United Health Care: (866) 633-2446
Medicare: (800) 633-4227
Physician's Medical Group: (831) 465-7800

We hope you find this information helpful. If you have a question that we did not answer or want more information about the topics discussed here you can reach us directly at (831) 464-8200 or by e-mail at cori@prefitpt.com. Thank you for choosing Precision Physical Therapy & Fitness!