Reimbursement in Private Practice

(occupational therapy, relative value codes, third party payers, unit value systems, workers’ compensation)

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Occupational therapists in private practice must develop sound business policies and procedures to help ensure third party reimbursement for their services. Carefully delineated protocols and proper documentation in treatment are of utmost importance. Fee schedules are established within the framework of local government regulations, using one or a combination of the following methods: unit value system, modalities and procedures, cost-plus or overhead, and state relative value system or maximum allowable fees. Blue Cross/Blue Shield or other private third party payers, Medicare or Medicaid, and workers’ compensation insurers are the usual parties billed for services rendered. Therapists must use good public relations methods to educate their present and future reimbursers and act as advocates for private practitioners in occupational therapy.

O ccupational therapists and other allied health professionals are in an exciting and advantageous position due to the changing climate of the health care delivery system in the United States. As hospitals seek more efficient and cost-conscious methods of providing health care to patients, in part due to Medicare’s diagnosis related group (DRG) system of prospective reimbursement, more opportunities for innovative and creative private practice in occupational therapy will appear.

In 1973 7.3 percent of occupational therapists were in private practice; 14.4 percent in 1978; and 18.3 percent in 1982 (1). Whether already in practice or considering opening a practice, the therapist should plan carefully, and develop and follow sound policies and procedures in all avenues of reimbursement to ensure the highest possible percentage of payment. Sound procedures are also needed because the health care field is being held accountable more than ever before.

The purpose of this article is to educate occupational therapists in the various methods and procedures of reimbursement in private practice and provide guidelines for enhancing reimbursement for occupational therapy services.

The basis for reimbursement is the delivery of the highest quality care available to the patient. In addition, reimbursement is aided by current treatment protocols, carefully reported evaluations, and faultless record management. Regulations for record keeping vary among states, but in general states’ minimum requirements for documentation should be adhered to, and amplified or expanded as is necessary for good patient care and for reimbursement.

Description of Services

In some states third party reimbursers, are represented by a health care professional who evaluates and approves the free-standing private practice as a requirement for third party reimbursement. Usually these persons investigate the practice, taking into consideration the qualifications of the private practitioner and his or her licensure. An administrative manual prepared by the private practitioner, which includes policies and procedures, treatment protocols, documentation of programs, and fee schedules including description of services, is helpful in expediting the approval process and ensuring reimbursement.

Another document that can be developed by the private practi-
Guides to Ensure Reimbursement

In organizing a practice and to ensure reimbursement, it is important to develop a fee schedule using proper codes, an itemized billing procedure, and careful protocols and documentation. The practitioner should also consider the long-range strategy of acting as an advocate for occupational therapy and as an educator of third party reimbursers and industry in improving the climate for third party reimbursement for occupational therapy services.

Practitioners must work within states' regulations pertaining to licensure and coverage for occupational therapy services under third party payers. The regulations, other than Medicare, vary widely from state to state; therefore, the following is offered as a general guide for protocols/documentation to increase reimbursement:

1. Provide evaluation and treatment in accordance with the prescription and directions of an attending physician. (If occupational therapists are not licensed, before rendering services to a patient, the occupational therapist should secure a prescription from a physician. A physician’s referral is generally considered a prerequisite for reimbursement for occupational therapy services. If a physician has not sent a written prescription, a therapy prescription form from the therapist’s office (see Figure 1) can be used to procure the physician’s written orders. (See sample policy and procedure in Figure 2.)

2. Evaluate patient, and submit a formal, written report of the evaluation to the attending physician and third party payer.

3. Write a treatment plan for the patient in accordance with the prescription that indicates the frequency and duration of treatment, and specific modalities and procedures to be used. Include the anticipated result in terms of measurable objectives.

4. In the patient’s medical record keep all records of evaluations, test results, and copies of treatment protocols specific to the diagnosis, operating room (OR) reports, and other information from the referring physician. Also, keep in the chart a copy of the patient’s appointment schedule, splint patterns, and a record of any communication, verbal or written, with the physician or third party payer. All records must be neat, legible, and up-to-date.

5. Re-evaluate a patient as frequently as is deemed necessary by the patient’s condition, prescrip-
Occupational Therapy Services

The geographic region of the referral base and the practice site often determine the most frequent reimbursement source for the private practice. For example, therapists contracting with nursing homes and home health agencies receive Medicare and Medicaid reimbursement. A caseload from an industrial area may be mostly reimbursed through workers' compensation. Most patients fall into one of the following reimbursement source categories: Medicare; Medicaid; private third party carrier, such as Blue Cross/Blue Shield or other commercial insurance companies (group or individual plans); workers' compensation; or self-pay. Recommendations for procuring reimbursement for each category are discussed in the following section. Whatever the category, the fee schedule and payment policies must be explained to patients before they have their first appointment for therapy. Although some therapists may hesitate to discuss fees with patients before providing treatment, most patients prefer to know about the payment policy and are familiar with this type of procedure from their physicians' offices.

A frank and open discussion of the fee in advance of treatment is the best way of making certain that patients understand and accept treatment costs. A patient is buying needed services and is entitled to know their price . . . before buying. A patient who has been warned in advance about an expensive procedure is less likely to react with shock when he sees the bill and more likely to pay promptly. (2, p 53)

**Private Insurance Carriers.** There are hundreds of policies written by each commercial carrier, and coverage of occupational therapy services varies. Therefore, it is wise to adopt a policy that is growing in many medical offices today. Ask for payment when treatment is rendered—do not accept assignment. Accepting assignment indicates willingness of the service provider to accept whatever portion of the fee the insurance carrier will allow. If the policy of a private practice is to ask for payment when treatment is rendered, patients need to know before their first visit (a) that assignment is not accepted, (b) the fee schedule, and (c) the expected time of payment. Also, patients will need assistance from the therapist at this time in filling out insurance forms.

The practitioner has the option to accept assignment if coverage from the carrier is assured (for example, if Blue Cross/Blue Shield routinely covers private outpatient occupational therapy services in the state) or if it is an extreme hardship for the patient to carry the cost of treatment before being reimbursed. For patients who have no insurance coverage the provider may choose to use a sliding fee scale based on the patient's ability to pay, bill the patient with the knowledge that this fee may have to be written off, or refer the patient to another facility where coverage may be forthcoming. The idea is not to deny patients treatment because they cannot pay, but to provide alternate solutions for receiving therapy services that are covered by their insurance.

**Medicare/Medicaid.** Medicare is a federal program available in all states. A Medicare provider number is not available to private practitioners; however, services provided by practitioners contracting with hospitals, home health agencies, or nursing homes will be reimbursed through the particular facility's provider number. In addition, services provided by a therapist employed in a physician's office will be reimbursed by Medicare when the physician bills for the service.

The Medicaid program is supported by both federal and state funding. Medicaid coverage for occupational therapy services varies from state to state because occupational therapy is an optional service in this program. Several states that cover outpatient occupational therapy provide practitioners with Medicaid provider numbers.
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Figure 3a
Sample policy and procedure for obtaining authorization for workers' compensation patients

Policy:
Authorization from the involved insurance carrier or self-insured employer (an employer who pays the medical and rehabilitation costs of work-related injuries directly rather than through a workers' compensation insurance policy) must be received in order to evaluate and/or treat compensation cases.

Procedure:
a. When a physician refers a compensation case, the therapist or secretary must call the insurance company to get authorization for evaluation and treatment.
b. An "uptake" or "new patient" (Figure 3b) form must be filled out including the date and the name of the person authorizing the evaluation and treatment.
c. The physician must be called for the diagnosis, prescription, and precautions, and copies of his or her summary and operating room (OR) reports must be requested. A check (/) will be placed by the physician's name, and, when the reports are received by the center, a cross check (%) will be made.
d. Subsequent courses of treatment and reevaluations must be authorized by the physician and the insurance carrier.
e. If a patient cancels or does not show for an appointment twice in a row, this will be reported to the insurance carrier and the physician. If the insurance company recommends that treatment be discontinued, the physician must be advised immediately.
f. When a patient is referred from a self-insured company, authorization must be obtained from the company in the same manner as outlined above.
g. All phone calls to and from the insurance company must be documented in the patient's chart, noting the name of the claims agent and the therapist's or secretary's initials and date.

numbers. These practitioners can accept sliding fee scale for patients who cannot meet payment in full, or refer the patient to another facility. In addition, in some states prior authorization from Medicaid is necessary before treatment begins.

Workers' Compensation. Every year approximately 14,000 workers die, another 100,000 are permanently injured, and more than two million miss one or more days of work because of job-related injuries or diseases. Ten million workers require medical treatment annually or are forced into restricted activity due to such injuries, while the overall cost of work-related accidents is estimated at approximately $10 billion annually. Thus, the workers' compensation system plays a key role in the economy, with implications for every working man and woman. The rapidly changing economic and political scenes in this country, to which medical practitioners must respond, have created a growing number of cases in which a third party pays compensation for work-related disabilities (3).

The services of private practitioners provide a cost-effective vehicle with which to rehabilitate the workers' compensation patient. Third party payers (insurance carriers) are very involved in rehabilitation, reflecting their growing financial involvement in claims. They must return people to work in order to make a profit and keep the insurance premiums of their industrial clients at a minimum. The losses in the American insurance industry due to upper extremity care alone in 1980 were $4.5 million (3). Private practitioners have helped carriers' attain the goal of rapid return to work for injured workers. The private sector in health care continues to grow, along with the carriers' needs to serve their claimants.

All laws provide payment for medical care and lost wages, but the controls, limits, and policies vary widely from state to state. Because each law includes specific rehabilitation provisions, private practitioners need to become familiar with them.

Private practitioners should use a specific procedure in obtaining authorization for and handling compensation (work-related) cas-

Developing a Fee Schedule
Establishing a fee schedule for services is a difficult yet important task because it is tied directly to income for the practice and therefore to the guarantee of financial means to continue that practice. In today's health care marketplace, fees must be established by a method that accounts for all elements of cost. Fee formulas need to be developed before discussing or submitting fees to the patient or the third party payer.

The trend today, and in many cases the rule because of some state's regulations, is to use one fee schedule for all reimbursers. This makes sense because increasing numbers of patients have medical insurance or are covered by government programs that pay for a large percentage of medical costs (2).

There are four major methods of determining fees, all of which are relative to the "going rate" in a given geographic area, since most such professional fees vary due to the cost of living in an area. It is advisable to conduct a survey of fees charged by other similar professionals in a geographic area before applying any of the following methods. Also, a complete fee schedule must be posted or available on request. Fees should be listed according to the description of services (see under subhead "Coding Services") and may include fees for evaluation and treatment time or modalities, as well as for equipment and supplies.
Unit Value System. The unit value system is based on increments of time (usually 15 minutes, although this can vary) with an assigned current value for each increment. A higher value can be assigned for more difficult procedures or those that involve more intensive labor costs, such as a 1:1 evaluation versus 3:1 treatment sessions. (For example, $15 for 15 minutes, with $15 value applied to all therapy procedures, whether 1:1 or 3:1; or $20 for 15 minutes for evaluations (1:1) and $10 for 15 minutes for treatment sessions (3:1).) In this case, when it becomes appropriate to raise fees, only the dollar amount charged for each increment of time used is changed. The variations of this system include charging decreasing amounts for ensuing 15-minute periods or adding the cost of materials to splinting. This system is general and based on time increments, but there is no definitive formula for using it. Equipment is usually extra, with or without a percentage mark-up (usually 50 to 100% of cost).

Modalities. In this method of determining fees, each type of modality or procedure is charged separately, with more difficult or time-consuming procedures having a higher fee. (One must take into account a method similar to the unit value system to arrive at these fees, assigning higher fees to the more difficult procedures.) For example:

- ADL evaluation: $60.00 (might take 1 hour);
- Kinetic activities: $30.00 (might take 1/2 hour);
- Range of motion: $15.00 (might take 15 minutes).

Cost-plus or Overhead. This method of establishing a fee is based on a ratio of labor cost to charge. It is generally recognized that to make a profit one must charge 2.5 to 3 times the labor cost involved, that is, the cost of the time a therapist spends with a patient. The difference between the labor cost and the fee charged allows for overhead, which includes operating expenses of the business and the “down” time, time spent on administrative matters and paperwork.

Allowable Fees for Workers’ Compensation. Several states’ workers’ compensation or industrial boards have established a system of relative values or of maximum allowable fees for individual modalities or procedures using a uniform description and coding system. This system could be used as a fee schedule, providing the amount allowed as a maximum fee for each modality is comparable to a reasonable charge. In some states, the maximum allowable fee may be half or even less than half of what is normally charged, while in others, particularly where a compensation board has had input from therapists as to reasonable charges, the maximum allowable fee may be equal to a reasonable charge.

(a) Relative Value System. A relative
value system (RVS) is used by some states that have an official fee schedule for allowable fees for workers' compensation patients (for example, California, Arizona, Maryland, New York, Utah, and Montana). In this type of system, all procedures are evaluated and weighted relative to one another by assigning a numerical value to each procedure or time unit of procedure. The value is then multiplied by a conversion factor (in dollars) to arrive at the maximum allowable fee for each procedure or time unit thereof. This basic formula may be modified by other variables, such as specific locations in a state. For example, a surgeon in New York City may be allowed to collect more for a given procedure than a surgeon in Buffalo. A state that uses RVS codes makes available from the state's workers' compensation board or industrial commission, a book listing the relative values of all procedures and the formula used to arrive at the corresponding maximum allowable fees.

(b) Maximum Allowable Fees. Several states, including Massachusetts, Florida, Hawaii, Rhode Island, and North Carolina, use a schedule of maximum allowable fees. This works like the RVS, except that there is no conversion factor. The maximum allowable fees for each procedure or time unit thereof are listed in the state's fee schedule for workers' compensation patients.

States that have not used either system may be moving to this type of methodology in the near future. A private practitioner should consult the state workers' compensation board for the most current information applying to allowable fees for rehabilitation of the compensation patient.

Coding Services
In addition to arriving at the proper dollar amount to charge for services, therapists must consider whether to code by number or to use modalities. The decision to use modalities is often based on the specific modality provided and the reimbursement policies of the insurance company. Some carriers and state compensation boards have adopted the numerical codes of the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association, for use in their schedule of allowable fees for workers' compensation (5). The numerical codes used presently by several states in their RVS for workers' compensation were derived from an early version of the CPT codes. The CPT codes that apply to therapy have been expanded to allow for separate coding for multiple procedures and services. For example, a patient may be treated for a fracture, and the therapist may charge separately for each service that is provided. This can be done by using the CPT codes for each service, and the insurance company will only pay for the services that are listed.

Billing Procedures
Using proper billing procedures will also help ensure third party reimbursement. In cases where private practitioners do not accept assignment, only the patients' insurance forms need to be processed. Even this is not necessary if the therapist uses a "super bill" like those used in many physicians' offices; these contain all the pertinent information for third-party reimbursement, that is, patient's name; diagnosis; date; evaluation and/or treatment procedures performed and fees thereof; and name, address, telephone, signature, tax identification number, and licensure or certification number of the provider. (The patient can fill out the form and attach the insurance copy of the super bill to it.) If a balance is due on a private patient's account, a bill is sent to the patient each month, and collection procedures are used if necessary.

In cases where practitioners may accept assignment, such as Medicare or Medicaid, Blue Cross/Blue Shield, and workers' compensation, the following recommendations are offered:
1. Bill monthly, on about the 25th of the month. (Most bills are sent on the 1st, so this will put your bill a few days before the majority received and may help it get processed more quickly.) New practices need to bill twice a month for the first three months. Use a clear, well-designed bill card that includes all the appropriate information. Use numerical codes if applicable.

2. Include the patient's insurance form if applicable. Make sure patients have completely filled out their section, the employee's section, and they have signed the section assigning benefits to the provider. Fill out the provider's section completely, although you may write "bill card attached" across the section where procedures and charges are to be listed. Keep a photocopy of the completed insurance form in the patient's medical record, and note on the bill card the date that the insurance form was submitted.

3. Enclose a copy of the patient's most recent evaluation and treatment report, including testing results, treatment plan, goals and objectives, and duration of treatment.

4. Special notes for billing for workers' compensation patients:
   a. In states that do not use an RVS or schedule of maximum allowable fees, it is necessary to bill for services "by report." Providers must bill the carrier for their usual fees and file an evaluation report. This author recommends sending a copy of each evaluation report to the carrier and referring physician. Carriers may dispute charges they believe are too high, following the procedures used in that state. Some states may use a combination of maximum allowable fees and the "by report" procedures. For example, custom-fabricated splints, which vary widely in cost, may be billed "by report" in a state that has a schedule of maximum allowable fees for most other procedures.
   b. Include on the bill card the following information (in addition to the information on a noncompensation patient's bill card): patient's claim or file number with the insurance carrier; name of the insurance carrier's "insured" (the patient's employer); and the name of the rehabilitation nurse or compensation claims agent handling the case to whose attention the bill should be addressed.
   c. Follow up accounts that are 45 days overdue by phone call to the insurance carrier. The balance may increase quickly if a patient is seen three times a week or daily; it is not unreasonable to ask for a letter of authorization guaranteeing payment of the outstanding amount.
   d. Bill the carrier directly if there is a third party payer. Some physician's offices may incorrectly identify the employer as self-insured; if you bill through the employer this will delay payments.
   e. In some states, particularly in those that use an RVS, the allowable fees for workers' compensation may be considerably lower than a therapist's regular fees. You can appeal to the state workers' compensation board for a review of fees, but realize that until a formal adjustment is made, a therapist may not collect more than the maximum allowable fees (see under subhead "Acting as an Advocate to Increase Reimbursement").
   f. The best method of ensuring reimbursement from carriers for workers' compensation patients is to keep an open communication system with the rehabilitation nurse or compensation claims agent. Keep them advised about a patient's progress (send copies of all evaluation reports) and problems, and call for authorization for any extra items (such as Jobst garments) so no unexpected items will be on the bills. If you are dissatisfied with the communication process with a claims agent, ask to speak to the compensation claims supervisor to speed things along.
   g. Be aware that cash flow for operations is limited by a 4- to 12-week delay in payments from carriers.

**Acting as an Advocate to Increase Reimbursement**

Individual private practitioners and patients, and state professional associations, can act as advocates for increased third party reimbursement for private occupational therapy services. Following are two examples of this kind of active involvement.

First, a patient can call the insurance carrier to emphasize the need for payment authorization and perhaps influence the decision by the carrier concerning reimbursement. In one case, a patient called his major medical company and was told his plan did not specifically include or exclude occupational therapy as a benefit. The insurance representative informed the patient that he needed a letter from his physician specifying the kind of therapy needed, including the type of treatment and the credentials and qualifications of the therapist. At that point a decision would be made to allow or disallow therapy as a benefit. The letter was sent from the physician to the insurance carrier, and authorization was obtained for reimbursement.
Second, in one state, occupational therapists can bill workers' compensation carriers for their own services or for services rendered when supervised by a physiatrist. When the service is associated with a physiatrist, the allowable fee is higher. Occupational therapy is not reimbursable if the therapist is working with any other physician specialist. Therapists functioning under this particular state's law identified the fact that physiatrists were heavily involved in writing the compensation laws. If occupational therapists working with other physician specialists wanted to be reimbursed, they would have to work on a legislative change. In fact, in this case, occupational and physical therapists have joined forces in attempting to change this law.

In cases like these, therapists and patients can help effect changes in reimbursement for services by third party payers. It is important to realize that changes in existing laws and allowances for reimbursement can be made, and an active role in furthering the profession must be taken. Therapists should try to have input into the boards that govern reimbursement in their states. Recently, physical therapists in New York petitioned the legislature and won the right, by amending the Workers' Compensation Law, to be represented on the board beginning in January 1984. Occupational therapists can also work for this kind of representation. In addition, therapists need to urge patients to be advocates for reimbursement in occupational therapy by writing letters to insurance companies and the legislature as satisfied health care consumers.

**Consumer Education**

Educating consumers about occupational therapy services (third party payers are consumers as well as patients, since they pay for the services) through public relations is a long-range method of increasing reimbursement for private practice in occupational therapy. Be active and spend time meeting with third party payers and private industries to show them how they can get patients back to work sooner, and thereby keep costs down by using your services. A slide presentation to illustrate a talk is persuasive. Make yourself available to speak to groups or professional organizations in the insurance industry whose members would be in a position to realize how increasing reimbursement for private occupational therapy practitioners can help reduce their claims.

Take advantage of any positive public relations methods that will help improve the image of private practitioners in the eyes of third party payers. Educating these consumers can affect the reimbursement situation for you and many of your colleagues, so be creative in your dealings with third party payers.

**Conclusion**

Private practitioners in occupational therapy can have a great influence on third party reimbursement for their services. Well-planned strategies in ongoing care take the form of proper documentation, careful development of fee schedules for coding, and clear billing procedures. Acting as an advocate for your services and educating third party consumers will also yield results over the longer term and increase the percentage of third party reimbursement for private occupational therapy services. Therapists must use sound business practices in day-to-day operations and take advantage of the benefits of public relations to meet both these goals.

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**REFERENCES**


**RELATED READINGS**