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The PT Patient's Guide to Understanding Insurance

Insurance 101 for PT Patients

So, your insurance "covers" physical therapy—which means you won't have to pay anything out-of-pocket for your therapy visits, right? Not quite. The fact that your insurance plan covers PT services—or any other services, for that matter—doesn't necessarily mean you're off the hook as far as payment goes. In many cases, you'll still have to pay a deductible, co-insurance, or copayment. Talk about tricky.

To better understand the terms of your plan, you first must understand the terminology. Here are a few common questions regarding insurance lingo:

What is a deductible?

This is the total amount you must pay out-of-pocket before your insurance starts to pay. For example, if your deductible is $1,000, then your insurance won't pay anything until you have paid $1,000 for services subject to the deductible (keep in mind that the deductible may not apply to every service you pay for). Furthermore, even after you've met your deductible, you may still owe a copay or coinsurance for each visit.

What is a copay?

This is a fixed amount that you must pay for a covered service, as defined by your health plan. Copays usually vary for different plans and types of services. Typically, you must pay this amount at the time of service. Again, copayments are fixed—which means you will always pay the same amount, regardless of visit length. In most cases, copayments go toward your deductible.

What is a coinsurance?

This type of out-of-pocket payment is calculated as a percent of the total allowed amount for a particular service. In other words, it's your share of the total cost. For example, let's say:

- Your insurance plan's allowed amount for an office visit is $100.
- You've already met your deductible.
- You're responsible for a 20% coinsurance.

In this situation, you'd pay $20 at the point of service. The insurance company would then pay the rest of the allowed amount for that visit. Keep in mind that the coinsurance amount may vary from visit to visit depending on what services you receive.

What is the coinsurance for Medicare Part B?

Medicare Part B patients are responsible for a 20% coinsurance, which typically amounts to $11-25 per visit. If you have original Medicare as your primary insurance, but you also have a secondary insurance, the secondary

payer becomes responsible for the 20%. In some cases, the secondary insurance also charges a copay, coinsurance, or deductible. We recommend contacting your secondary insurance carrier to find out.

So, how much will I owe for each visit?

Your patient responsibility will be determined by your insurance provider and your specific plan. These plans vary widely. We will not know the exact amount you owe until your claims are processed and we receive an Explanation of Benefits from the insurance company, typically 3-6 weeks after your visit.

Deductibles

If you have not met your deductible, we will charge you our contracted rate for your visits at the time of service until you provide verification that you have met your deductible. When your claims are processed we will adjust your balance accordingly and bill you for the difference of any amounts determined to be patient responsibility. If we don't have a set contracted rate for your insurance provider, we will initially charge you $60 as a payment toward your deductible. **This is not necessarily the amount you will owe.** We will adjust this payment amount when we receive confirmation of your patient responsibility from your insurance provider after your claim is processed.

Coinsurance & Copays

Copays are a set amount billed to you at the time of your visit. We charge coinsurances as a dollar amount equal to the percentage of the average insurance allowable amount of $75 per appointment until we receive an exact amount from your Explanation of Benefits. For example, if you have a 20% coinsurance, you'll pay $15; if you have a 10% coinsurance, you'll pay $7.50, etc. You'll then owe any applicable coinsurance or deductible balances after we receive the Explanation of Benefits (EOB) from your insurance company. Conversely, if we find that you have overpaid, we will refund you via check as soon as possible. As for copays—these amounts rarely vary, so if your copay for physical therapy visits is $10, you will owe $10 at each visit.

Examples of EOBs for PT Services

Here are a few examples of Explanations of Benefits (EOBs) for physical therapy services. An EOB is a document your insurance sends to explain the various costs—including the amount you, as the patient, are responsible for—associated with your care. For definitions of the terms included in these examples, skip down to the bottom section of the page.

Insurance 1: Patient has not yet met his or her annual deductible. Therefore, the patient is responsible for 100% of the allowed amount.

Date of Service	CPT Code	Units	Billed Amount	Adjusted Amount	Patient Responsibility	Insurance 1 Paid
03/01/2017	97110	1	50.00	20.04	29.96	0.00
03/01/2017	97140	2	100.00	44.58	55.42	0.00
TOTALS:		3	150.00	64.62	85.38	0.00

Insurance 2: Patient owes a 20% coinsurance for PT services.

Date of Service	CPT Code	Units	Billed Amount	Adjusted Amount	Patient Responsibility	Insurance 2 Paid
03/01/2017	97110	2	100.00	42.47	11.69	45.84
03/01/2017	97140	2	100.00	54.19	9.31	36.50
TOTALS:		4	200.00	96.66	21.00	82.34

Insurance 3: Patient owes a $10 copay for PT visits.

Date of Service	CPT Code	Units	Billed Amount	Adjusted Amount	Patient Responsibility	Insurance 3 Paid
03/01/2017	97140	2	100.00	30.00	10.00	60.00
03/01/2017	97535	1	45.00	45.00	0.00	0.00
TOTALS:		3	145.00	75.00	10.00	60.00

A Few Handy Definitions

Date of Service: The date of your visit.

CPT Code: The code denoting each service provided to you during your visit (e.g., manual therapy, therapeutic exercise, self-care instructions, aquatic therapy, etc.). You can request a list of these codes—along with their explanations—from your insurance company.

Billed Amount: This is the amount we billed the insurance company for that particular service. The billed amount may vary depending on the duration of the service, the facility in which the service was provided, or the state in which the facility is located.

Adjusted Amount: This amount is not a payment, but rather a write-off or “reduction.” It is based on the contract in place between your provider (us) and your insurance company. Neither you nor the insurance company pays this amount. The provider essentially writes it off (which is why it is sometimes called the provider’s responsibility).

Patient Responsibility: This column may be labeled “Deductible,” “Copay,” “Coinsurance,” or “Patient Pay.” It is the amount that you, the patient, are responsible for paying. If a secondary insurance is on file, we will forward this amount to that insurance for payment. Once we get the secondary EOB back, you will receive a bill for any outstanding balances in the patient responsibility column.

Insurance Paid: This is the amount the insurance company paid us for the services you received on that date of service.

A Couple of Notes

- Most insurance companies offer several different plans or subsidiaries. Thus, two patients with Blue Cross Blue Shield, for instance, may have completely different benefits, and therefore, completely different financial responsibilities. Some plans have no copays or deductibles; others may have a $10,000 deductible. Furthermore, some providers may not accept all plans from a particular insurance. This is why it is crucial that you investigate the details of your specific plan.
- If your insurance offers an online patient portal, sign up for it! These resources typically enable you to:
    - check your benefits,
    - track your deductible,
    - see which providers in your area accept your particular plan,
    - track your claims, and
    - compare claims to your receipts from the doctor's office (if they don't match up, you can then follow up on any discrepancies).

The Self-Pay Option

If I don't want to use my insurance, can I just pay for services myself?

The discounted self-pay rate for all follow-up visits at Kime Performance PT is $89 as of 2021. Because an insured patient with a deductible may have to pay $75 or more for the same service, many insured patients ask if we can essentially "pretend" they are uninsured. However, if we contract with your insurance company, we are obligated to honor that contract—which means we must bill your insurance for services rendered. Some contracts also prohibit us from providing discounts or waiving patient financial responsibility (e.g., copays or coinsurance). That said, if we do not contract with your insurance, or if you have exhausted your benefits for the year, then you may be eligible to receive services on a cash-pay (i.e., self-pay) basis.