



PHYSICAL THERAPY

How the Medical Billing Process Works

A guide and checklist for outpatient physical therapy private practices — from the first phone call to the final payment.

Every dollar a therapy practice collects travels the same path: from the moment a family calls, through the visit and the claim, to the payment that lands in your bank account. When one step is skipped or rushed, the problem rarely shows up right away. It shows up weeks later as a denial, a write-off, or a confused family. This guide walks through each stage of the revenue cycle for physical therapy, what can go wrong, and the habits that protect your revenue.

The revenue cycle, step by step

Stage	What happens	What protects your revenue
1. Intake and demographics	Collect the insurance card (front and back), subscriber name, date of birth, and relationship to the patient, plus any secondary coverage.	Names and dates of birth must match the payer's records exactly. Small typos are a leading cause of front-end rejections.
2. Eligibility and benefits	Confirm active coverage for the date of service, network status, deductible, coinsurance or copay, out-of-pocket maximum, and visit limits.	Ask whether visits are shared across PT, OT, and SLP, and whether PT has exclusions or habilitative limits.
3. Authorization and referral	Request prior authorization where required, and keep the referral or prescription on file.	Track approved visits or units and the date span. Request re-authorization before the current one runs out — not after.
4. Financial responsibility	Give the family a benefit estimate and get a signed financial agreement. Provide a Good Faith Estimate to self-pay and uninsured patients.	A benefit quote is a courtesy, not a guarantee. Many practices keep a card on file and collect the estimated share at each visit.
5. Documentation and charge capture	The evaluation, plan of care, and daily notes are what support every code you bill.	Record minutes for each timed code, link diagnoses, and apply the right modifiers.
6. Claim scrubbing and submission	Review each claim for NPI, taxonomy, place of service, authorization number, and diagnosis linkage before it goes out.	Submit within a few days of the visit and track each payer's timely filing limit.
7. Payment posting and reconciliation	Post each ERA or EOB, apply contractual adjustments, and move the patient's share to their balance.	Compare every payment to your contracted rate. Underpayments are easy to miss and add up fast.
8. Denials and A/R follow-up	Work denials and unpaid claims on a set cadence, appeal when appropriate, and fix the root cause.	A denial worked in week one is far more likely to be paid than one found at 90 days.
9. Reporting and rate review	Review clean claim rate, denial rate, days in A/R, and net collection rate every month.	Use the data to renegotiate payer rates and fix process gaps before they become trends.



How Wellness Works Management Partners handles it

Our W-2 team of coders, billers, and auditors serves as your Chief Billing Officer and your day-to-day back-end billing department. Claims are worked daily, and eligibility and authorization support is available as an add-on for billing clients. Most billing companies chase the lowest-hanging fruit. **We cut down the tree for you.**

The nine stages above describe the full revenue cycle, not the scope of our core fee: core billing services run from claim scrubbing and submission through payment posting, denial management, A/R follow-up, and reporting, while intake, eligibility and benefits verification, prior authorization, and family billing calls remain with your front office unless you add our separately priced eligibility and authorization services.

Physical Therapy codes at a glance

The codes most commonly billed by outpatient practices. Coverage, unit limits, and edits vary by payer, so confirm requirements with each plan.

Code	Description	Billing note
97161 / 97162 / 97163	PT evaluation — low / moderate / high complexity	Untimed. Complexity must be supported by history, exam, clinical presentation, and decision-making documented.
97164	PT re-evaluation	Untimed. Bill only for a documented change in status or plan of care.
97110	Therapeutic exercise	Timed, 15-minute units.
97112	Neuromuscular re-education	Timed, 15-minute units.
97116	Gait training	Timed, 15-minute units.
97140	Manual therapy techniques	Timed, 15-minute units. Subject to NCCI pairing edits (see watch-outs).
97530	Therapeutic activities (dynamic functional activities)	Timed, 15-minute units. Subject to NCCI pairing edits.
97535	Self-care / home management training	Timed, 15-minute units.
97750	Physical performance test or measurement	Timed, 15-minute units; requires a written report.
97150	Therapeutic procedures, group (2 or more)	Untimed, reported once per patient in the group.
97014 / G0283	Electrical stimulation, unattended	Untimed. Medicare and many Medicare-following plans require G0283 instead of 97014.
97760 / 97761 / 97763	Orthotic / prosthetic management and training; follow-up	Timed, 15-minute units.



PT billing watch-outs

- **Direct access is not the same as direct payment.** State law may let patients see you without a referral, but many plans still require a referral or a physician-signed plan of care to pay the claim.
- **Plan of care certification.** Medicare requires a physician- or NPP-certified plan of care, with recertification at least every 90 days. Track the dates like you track authorizations.
- **Timed-code math.** Medicare totals timed minutes across codes (the 8-minute rule); some commercial payers count each code separately. Know which method each payer uses.
- **NCCI pairing edits.** 97140 and 97530 are paired, and 97530 is also paired with the evaluation codes. When both are justified, document distinct time and purpose; a 59 or X-modifier may be required.
- **Therapy modifier.** Append **GP** to PT services for Medicare and the many Medicaid and commercial plans that require it.
- **Medicare therapy threshold.** PT and SLP share one annual KX-modifier threshold. Patients receiving both services reach it faster.



Physical Therapy billing process checklist

Print it, post it at the front desk, or build it into your workflow. Each box is a place revenue is commonly lost.

Before the first visit

- ☐ Insurance card (front and back) and photo ID on file; subscriber name and date of birth match the card exactly.
- ☐ Secondary insurance and coordination of benefits confirmed.
- ☐ Eligibility verified for the date of service; network status confirmed.
- ☐ Benefits verified: deductible, coinsurance or copay, out-of-pocket maximum, visit limits (and whether shared across PT/OT/SLP), exclusions.
- ☐ Referral or prescription on file if required.
- ☐ Evaluation authorization obtained if required; reference number recorded.
- ☐ Financial agreement signed and card on file; Good Faith Estimate given to self-pay or uninsured patients.
- ☐ Benefit estimate shared with the family as a courtesy, not a guarantee.

After the evaluation

- ☐ Plan of care signed or certified where required.
- ☐ Treatment authorization submitted with evaluation and plan of care; approved visits/units and date span entered in your tracker.
- ☐ Re-authorization reminder set well before visits or dates run out.

Every visit and every claim

- ☐ Note completed and signed promptly; codes match what the note describes.
- ☐ Minutes recorded for each timed code; diagnoses linked; modifiers applied.
- ☐ Patient's estimated share collected at the time of service.
- ☐ Claim scrubbed (NPI, taxonomy, place of service, authorization number) and submitted within a few days.

Weekly and monthly

- ☐ ERAs posted; payments compared to contracted rates; underpayments flagged.
- ☐ Denials worked and root causes tagged; appeals filed within payer deadlines.
- ☐ A/R over 60 and 90 days reviewed claim by claim.
- ☐ Patient balances reconciled after each EOB (additional charge or credit/refund).
- ☐ Key metrics reviewed: clean claim rate, denial rate, days in A/R, net collection rate.

PT-specific checks

- ☐ Referral or physician-certified plan of care on file when the plan requires it, even under direct access.
- ☐ Medicare plan of care recertification date tracked (at least every 90 days).
- ☐ G0283 used instead of 97014 for Medicare and Medicare-following payers.
- ☐ GP modifier applied where required; KX applied above the Medicare threshold.