STRETCHLEARN · WORKBOOK

Physiotherapy & Rehab Practice Management — Workbook

This workbook turns the course into the systems a clinic owner or rehab director runs every day: a charge-capture and 8-minute-rule routine, a denial tracker, a productivity-and-break-even calculator and ideal-day template, an outcome-tracking and KPI dashboard, and a referral-source and physician-relationship manager. Work through one section per module, filling the worksheets and standing up the systems in your own software (WebPT, Prompt EMR, Jane, or Net Health) as you go. By the end you will have a complete, reusable practice-management toolkit — code and collect what you earn, fill the schedule by design, prove your outcomes, and grow a referral network that does not depend on one source.

Therapy Billing, Coding, and the 8-Minute Rule

Stand up the cash cycle: code timed and untimed services correctly, apply the 8-minute rule and modifiers, document medical necessity, and work denials so you collect above 95 percent net.

Exercise: Code Three Real Visits With the 8-Minute Rule

Pull three recent visit records and recode each one from the documented minutes using the Medicare 8-minute rule. Compare your result to what was actually billed and note any dropped or over-billed units.

• For each visit, list every service delivered, its CPT code, whether it is timed or untimed, and the documented minutes.

• Sum the total timed minutes and convert to total allowable units using the 8-minute bands (8-22=1, 23-37=2, 38-52=3, 53-67=4).

• Allocate units to the largest timed services first; record which service lost a unit to the remainder rule.

• Compare your unit total to what was billed — was the visit under-coded, over-coded, or correct, and by how much in dollars?

Worksheet: Pre-Treatment Insurance & Authorization Verification Sheet

Complete one sheet per new patient before the first treatment, using your clearinghouse or a payer call. Record a reference number for any phone verification and confirm the authorization before, not after, care begins.

Patient name, subscriber name, member ID, group number

Payer and plan name, plus verification reference number and date

PT benefit: copay, coinsurance %, deductible amount and amount met

Visit limit per year and visits used / remaining

Authorization required? Auth number, number of visits authorized, expiration date

Therapy threshold tracking — does the KX modifier apply for this patient?

Unit/visit caps, plan-of-care recertification requirement, timely-filing window

Direct-access / self-referral allowed by this plan? Any physician-signature requirement

Estimated patient out-of-pocket per visit

Checklist: Clean-Claim Checklist (run before every therapy claim goes out)

[ ] Correct CPT code(s) for the services actually performed and documented
[ ] Timed units match the documented minutes under the payer's unit rule (8-minute vs. AMA)
[ ] Discipline modifier present (GP for PT) on every line that requires it
[ ] KX modifier appended where the patient is above the annual therapy threshold and care is necessary
[ ] Modifier 59 / X-modifier added only where two services were genuinely separate, with documentation
[ ] CQ / CO modifier applied where a PT assistant furnished the service
[ ] Clinical note supports medical necessity and skilled care — no upcoding, no plateau-only maintenance
[ ] Patient and subscriber data matches the payer's records exactly (name, DOB, member ID, group)
[ ] Authorization on file and not expired; visit is within the authorized count
[ ] Submitted electronically within 24 to 72 hours and inside the timely-filing window

Exercise: Work One Week of Denials by Reason Code

Pull this week's denials, sort them by reason code, and work them in batches. Record the root cause of each so the upstream step can be fixed and the denial prevented next time.

• List every denial with its reason code, dollar amount, and date of service.

• Group the denials by reason — missing auth, missing modifier, exceeds limit, documentation, timely filing.

• For each fixable denial, take the action (resubmit, attach documentation, appeal) and record the outcome.

• Identify your top three denial reasons this week and name the upstream step that will prevent each next month.

Caseload, Scheduling, and Therapist Productivity

Fill the schedule by design: set a defensible productivity target from your break-even, template the ideal day, manage caseload to a healthy visits-per-evaluation, and kill cancellations and no-shows.

Worksheet: Break-Even & Productivity-Target Calculator

Fill in your real numbers to work backward from cost to the daily and per-therapist visit target you need. Update it whenever rent, staffing, or reimbursement changes.

Total monthly fixed costs (rent, base salaries, software, insurance)

Total monthly variable costs (supplies, hourly labor, billing %)

Total monthly cost = break-even revenue needed

Average net collection per visit (after contractual adjustments and denials)

Break-even visits per month = total cost / net per visit

Working days per month and number of treating therapists (FTE)

Break-even visits per day, and per therapist per day

Target operating margin % and the visits-per-month it requires

Final target: visits per therapist per day (capped for quality and one-on-one integrity)

Worksheet: Ideal-Day Schedule Template

Design one therapist's templated day, then lock it in your EMR. Reserve evaluation slots, set the follow-up cadence to your treatment model, and protect documentation and recert time.

Number of reserved new-evaluation slots and their length (45-60 min each)

Follow-up model: strict one-on-one (solo slots) or overlap (staggered pairs) — and slot length

Total follow-up slots planned for the day

Protected documentation block(s) — time and length

Plan-of-care review / recert checkpoint time

Standby / waitlist queue process for filling cancellations

Target total visits for the day vs. the productivity target above

Checklist: Cancellation & No-Show Defense Checklist

[ ] Attendance expectation set verbally at the evaluation (recovery depends on the full plan of care)
[ ] Whole plan of care booked up front, not visit by visit
[ ] Automated text/email reminders sent 48 and 24 hours out with one-tap confirm
[ ] Written cancellation policy in place, signed by the patient, and enforced consistently
[ ] Standby/waitlist worked the same day to fill any freed slot
[ ] Next visit booked at checkout for every patient before they leave the building
[ ] Cancellation and no-show rate tracked weekly against the under-10-percent target

Exercise: Audit Caseload Against Plans of Care

Run a list of every active patient and review each against their plan of care to catch patients drifting past their goals or dropping out early.

• List each active patient with their visit count so far and their planned discharge target.

• Flag any patient well past their expected visits-per-evaluation with no documented reason — over-utilization risk.

• Flag any patient who has stopped attending or is far behind their plan — dropout risk to recover.

• List every plan of care due for recertification in the next 30 days and assign the follow-up as a hard task.

Outcome Tracking and Proving Value

Make results measurable and reportable: choose validated outcome tools, embed frictionless collection, run a weekly KPI scoreboard, and package outcomes into authorization and referrer reports.

Worksheet: Outcome-Measure Selection & Collection Plan

Choose the standardized outcome instruments your clinic will use by body region and set the collection cadence so the data is complete enough to report.

Region-specific measures chosen: lower extremity (LEFS), low back (ODI), neck (NDI), upper extremity (QuickDASH)

Global measure chosen for cross-condition tracking (AM-PAC / OPTIMAL)

MCID for each chosen measure (e.g., LEFS ~9 points)

Collection cadence: at evaluation, every __ days or __ visits, and at discharge

Collection method: waiting-room tablet, pre-visit text link, or in-EMR auto-score

Who is responsible for ensuring the measure is captured each interval

Whether the clinic will join a benchmarking system (e.g., FOTO) for risk-adjusted comparison

Worksheet: Weekly KPI Scoreboard

Fill this in every Monday and review it in a 15-minute huddle. For any metric out of range, assign a named owner and a fix by next week.

Net collection rate (target >95%) — value and trend

Days in accounts receivable (target <40) — value and trend

Visits-per-evaluation / utilization (target ~9-12) — value and trend

Cancellation & no-show rate (target <10%) — value and trend

Units-per-visit (watch ~3.5-4.5) — value and trend

New patients this month and top referral sources

Average outcome change relative to MCID (arrival-to-discharge)

Owner and corrective action for each red metric

Exercise: Write One Authorization Narrative

Take a real patient who needs additional visits and draft the authorization narrative that proves medical necessity and asks for a specific number of visits.

• State the functional deficit and the patient's goal in their own terms (return to work, climb stairs, lift a child).

• Show the objective trajectory: baseline score, current score, change relative to the MCID, and remaining gap to goal.

• Give the skilled justification — why a licensed therapist is still required and the plan for the next interval.

• Make a specific ask: the exact number of additional visits over a defined period, with the Plan of Care and progress note attached.

Checklist: Referrer Report Loop Checklist

[ ] Initial note sent to the referrer within a few days of the evaluation confirming the patient was seen and the plan
[ ] Interim note sent when the case changes materially or the physician will see the patient again
[ ] Discharge summary sent showing outcome-score change against the MCID and the functional goal achieved
[ ] Report kept to one page and written for the referrer's reassurance, not just compliance
[ ] Risk-adjusted benchmark result (if available) included for self-insured employers and large groups
[ ] Outcome data reviewed monthly to surface wins worth taking back to top referrers

Referral Networks and Sustainable Growth

Build new-patient volume that survives any one departure: measure concentration risk, diversify sources, run physician relationships like accounts within the rules, and lead the team that delivers the experience.

Exercise: Map Your Referral Concentration Risk

Pull a 12-month report of new patients by referral source and calculate how exposed the clinic is to losing any single source.

• List your top ten referral sources by new-patient count over the last 12 months.

• Calculate the share of total new patients from your top one, top three, and top five sources.

• Flag any single source above 20-25 percent of volume as a concentration risk that needs diversification.

• Name three under-developed sources (direct access, past patients, other professionals, employers) to grow next quarter.

Worksheet: Physician Relationship Account Sheet

Keep one sheet per key referral source and treat it like a managed account — track volume, results, and the communication cadence that earns the next referral.

Referrer name, specialty, practice, and primary contact / coordinator

New patients sent in the last 3, 6, and 12 months (trend up or down?)

Average outcome result for their referred patients (to share back)

Date of last communication and last liaison visit

Outstanding reports owed (initial, interim, discharge) for their patients

Next planned outreach and what outcome data to bring

Is this referrer at risk (retiring, acquired, building in-house PT / POPTS)? Mitigation

Checklist: Compliance & Referral-Rules Checklist

[ ] Referral relationships are based on clinical value and service, never financial inducement
[ ] No payment or thing-of-value offered or accepted in exchange for referrals (Anti-Kickback Statute)
[ ] Arrangements involving referring physicians reviewed against the Stark Law and state rules
[ ] Marketing meals and educational events kept within narrow, documented, fact-specific limits
[ ] State direct-access rules and visit/day limits confirmed and followed
[ ] Where competing with an in-house / POPTS department, the strategy is demonstrably better service and outcomes, not inducements

Checklist: Team Operating-Rhythm Checklist

[ ] 10-minute morning huddle: review evaluations, recerts due, standby slots, and at-risk patients
[ ] Same-day documentation expectation protected by the schedule template
[ ] Same-day rebooking standard enforced at every checkout
[ ] 15-minute weekly KPI huddle with a named owner and fix for each red metric
[ ] Monthly referral and outcome review covering concentration risk and results to share
[ ] Routine for requesting reviews from delighted, discharged patients to feed word-of-mouth growth

Your Action Plan

1. Stand up the pre-treatment verification and clean-claim checklist this week so no patient is treated without confirmed benefits, authorization, and the right modifiers.
2. Recode three recent visits with the 8-minute rule to find your typical under- or over-coding, then build the modifier and unit logic into your EMR at charge entry.
3. Start a weekly denial review sorted by reason code, fix the top three upstream causes each month, and drive net collection rate above 95 percent.
4. Calculate your break-even and set a sustainable per-therapist visit target, then template the ideal day in your EMR with reserved evaluation, documentation, and recert time.
5. Enforce same-day rebooking at checkout, automate 48- and 24-hour reminders, and adopt a written cancellation policy to push cancellations and no-shows under 10 percent.
6. Choose your outcome measures by region, embed frictionless tablet or text-link collection at evaluation, intervals, and discharge, and report change against the MCID.
7. Build the weekly KPI scoreboard, review it in a 15-minute Monday huddle, and map every red metric to a specific lever and owner.
8. Close the referrer loop with initial, interim, and outcome-anchored discharge reports so physicians see that their patients get better.
9. Map your referral concentration, flag any single source above 20-25 percent, and deliberately grow direct access, past-patient, and non-physician sources.
10. Install the team operating rhythm — morning huddle, same-day documentation and rebooking, weekly KPI and monthly referral reviews — so the systems run when you are treating.