

MEDICARE PATIENTS ONLY

MEDICARE THERAPY CAP 2021 FOR PHYSICAL /SPEECH-LANGUAGE PATHOLOGY

HOW OFTEN IS IT COVERED? Medicare Part B (Medical Insurance) helps pay **for medically necessary outpatient physical/speech-language pathology**. There are limits on these services when you get them from most outpatient providers. These limits are called “Therapy Caps” or “Therapy Cap Limits.”

The therapy cap limits for 2021 are: ♦ \$2110 for physical therapy (PT) and speech-Language pathology combined

You may qualify to get an exception to the therapy cap limits so that Medicare will continue to pay its share for your therapy services after you reach the therapy cap limits.

Your therapist must: ♦ Document your need for medically reasonable & necessary services in your medical record

♦ Indicate on your Medicare claim for services above the therapy cap that your outpatient therapy services are medically reasonable & necessary.

A Medicare contractor will review your medical records to check for medical necessity if you receive outpatient physical therapy services in 2020 higher than these amounts: ♦ \$3000 for PT and SLP combined

In general, if your therapist provides documentation that your services were medically reasonable & necessary, you won't have to pay for costs above the \$2110 therapy cap limits. Your therapist must give you a written notice, called an **“Advance Beneficiary Notice of Non-coverage” (ABN)**, before providing services that aren't medically reasonable & necessary. Medicare does not pay for services that aren't medically reasonable & necessary. The ABN lets you choose whether or not you want the therapy services. If you choose to get the services, you agree to pay for them if Medicare doesn't pay. If you get therapy services that aren't medically reasonable & necessary and Medicare doesn't pay for them, you won't have to pay for the services unless an ABN was given to you beforehand.

Your therapist will need to determine if you qualify for an exception to the therapy cap limits..

Who is eligible? All people with Medicare are covered if Medicare finds that the services are medically reasonable & necessary. Medicare will pay its share for therapy services until the total amount paid by you and Medicare reaches either one of the therapy cap limits. Amounts paid by you may include costs like the deductible and coinsurance.

Your costs in Original Medicare: You pay 20% of the Medicare approval amount and the Part B deductible applies

NOTE: Your doctor or other health care provider may recommend you get services more often than Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you have to pay some or all of the costs. It's important to ask questions so you understand why your doctor is recommending certain services and whether Medicare will pay for them.

By signing below I am acknowledging that I have read and understand the Medicare Therapy Cap for 2020. I was also provided a copy of this notice for my records.

DATE: _____ SIGNATURE: _____

(IF INSURED / PATIENT IS UNABLE TO SIGN, LEGAL CUSTODIAL GUARDIAN MUST SIGN)

Performance Physical Therapy & Sports Conditioning

PATIENT: _____

Patient/legal custodial guardian/parent responsibilities:

■ Confirming & understanding the benefits the insurance plan provides for outpatient physical therapy treatment. If a referral form is required, I understand I am responsible for obtaining one. If I do not provide a referral form and choose to proceed with physical therapy, I will be responsible for payment at time of service. It is also my responsibility to verify proof of insurance by ensuring that the office staff has the most current/valid insurance card on file. I am aware that the Insurance company reserves the right to make final decisions until processing the bill.

■ I understand that all co-payments are due at time of service or weekly payable by check, cash or Venmo only.. **Further appointments will be cancelled if copayments are not made within 1 week of your appointment.** I am also responsible to pay other amounts due; these amounts may include annual deductibles, charges for home exercise equipment, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action. (E.G. collection agency, court or attorney costs). Also, please be advised our office may contact you via telephone/email regarding appointments and/or account status.

If you are seeking legal counsel for an injury, please be aware that we do not accept letters of protection and you will be financially responsible for treatment at time of service.

■ **No Show:** If you are unable to keep an appointment and fail to notify our office, a **NO SHOW FEE of \$50** will be charged. This fee will be your responsibility and will not be submitted to insurance. The office will attempt to contact the patient and confirm or schedule another appointment. If the office does not receive a return call, all further appointments will be cancelled (if applicable). The referring physician will be notified that the patient is non-compliant with their physical therapy program.

■ **Cancellation:** We encourage our patients to notify our office within a timely manner, at least 4 hours in advance (preferably 24 hours in advance). Failure to notify our office will result in a **CANCELLATION FEE of \$50**. This fee will be your responsibility and will not be submitted to insurance. Prior to continuing with treatment, this fee must be paid along with any other outstanding fees.

■ **Inclement Weather:** For your safety and ours, in case of inclement weather, we ask that you follow the above cancellation policy. At times, we may not be able to make it in due to inclement weather and will attempt to notify you. If you intend on making your appointment during inclement weather, please call to make sure we are open.

■ **Returned Checks:** A fee of \$30 will be applied to patient's account for any returned checks.

■ **Patient Records:** A fee of \$1.00 per page will be charged as allowed by State requirements for copying medical records. A record search fee of \$15 will also be applied and will be additional to the copying fee.

I hereby give my authorization to Performance Physical Therapy & Sports Conditioning, through its appropriate personnel to use or disclose the above patient's protected health information to any person(s) and/or organization that is responsible for payment on patient's account until advised otherwise. Notice of privacy practices is visible and if I choose to have a copy of this notice for my records, I have the right to request one.

I authorize payment of medical benefits to Performance Physical Therapy & Sports Conditioning from my insurance carrier(s). I authorize Physical Therapy & Sports Conditioning to appeal any insurance denials on my behalf as my designated representative.

I consent to treatment necessary for the care of the above named patient.

DATE: _____ SIGNATURE: _____
If patient is a minor and/or unable to sign, legal custodial guardian or parent must sign)