Austin Physical Therapy, PLLC

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Medicare Limits on Therapy Services

Medicare limits how much it pays for your medically necessary outpatient therapy services in **one calendar year**. These limits are called "therapy caps." The cap amounts are:

- $1920 for physical therapy (PT) and speech-language pathology (SLP) services combined.
- $1920 for occupational therapy (OT) services

Medicare will keep paying its share for your therapy services until the total amount paid reaches either one of the therapy cap limits. This total amount includes what Medicare paid and any amounts paid by you like the deductible and coinsurance. If your services go over the $1920 therapy cap limit, your therapist or doctor can ask for an exception. **Even if your therapist or doctor asks for an exception, this is not a guarantee that you won't have to pay for costs above the $1920 therapy cap amounts.** If Medicare decides, at any time (even after your therapy services have been paid for), that your therapist or doctor didn't show enough proof that your therapy services were medically necessary, you may have to pay for the total cost of the services above the $1920 therapy cap amounts.

The $1920 physical therapy and speech-language pathology cap includes any services you received during the year from any outpatient office. So for example, if you received either of these services at a hospital outpatient department for $1000, then you only have $920 left to reach the therapy cap.

The Therapy cap applies to all Part B outpatient therapy settings and providers including:

- private practices
- skilled nursing facilities
- home health agencies
- outpatient rehabilitation facilities
- comprehensive outpatient rehabilitation facilities
- hospital outpatient departments

Please let us know if you have had services at any other location and what the total cost is of those services. We will keep track of the cost of therapy and let you know when the therapy cap is approaching. At that time we can discuss the medical necessity of your services and decide the options for continuing therapy services.

Please sign below to show that you have read and understand this information.

_____ _____

Signature Date

_____

Print client's name

Copy to be given to patient
Copy to be kept in records