



Medicare Limits on Therapy Services

Note: This information only applies if you have Original Medicare. If you have a Medicare Advantage Plan (like an HMO or PPO), check with your plan for information about your plan’s coverage rules 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.”

What are the outpatient therapy limits for 2012?

- \$1,880 for physical therapy (PT) and speech-language pathology (SLP) services combined
- \$1,880 for occupational therapy (OT) services

After you pay your yearly deductible for Medicare Part B (Medical Insurance), Medicare pays its share (80%), and you pay your share (20%) of the cost for the therapy services. The Part B deductible is \$140 for 2012. Medicare will pay its share for therapy services until the total amount paid by both you and Medicare reaches either one of the therapy cap limits. Amounts paid by you may include costs like the deductible and coinsurance.

Can I get an exception to the therapy cap limits?

You may qualify for an exception (which would allow Medicare to pay for services after you reach the therapy cap limits) if you get medically-necessary PT, SLP, and/or OT services over the \$1,880 therapy cap limit. See the next page for more information.

Who can give me outpatient therapy services?

You can get outpatient therapy from any of these health care professionals:

- Physical therapists
- Speech-language pathologists
- Occupational therapists

Doctors and other health care professionals (like nurse practitioners, clinical nurse specialists, and physician assistants) may also offer PT, SLP, and OT services.



Where can I get outpatient therapy services?

- Offices of privately practicing therapists
- Many medical offices
- Outpatient hospital departments
- Rehabilitation agencies (sometimes called outpatient rehabilitation facilities)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Skilled nursing facilities (SNFs) for outpatients or residents who aren't in Medicare-certified parts of the facility
- At home, from certain therapy providers, like privately practicing therapists and certain home health agencies (if you aren't under a home health plan of care)

What can I do if I need services that will go above the outpatient therapy cap amounts?

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. Your therapist must document your need for medically-necessary services in your medical record, and your therapist's billing office must indicate on your claim for services above the therapy cap that your outpatient therapy services are medically necessary.

Even if your therapist provides documentation that your services were medically necessary, you might still have to pay for costs above the \$1,880 therapy cap limits. If Medicare finds, at any time (even after your therapy services have been paid for), that the services above the therapy cap limits weren't medically necessary, you might have to pay for the total cost of the services above the \$1,880 therapy cap limits.

Starting October 1, 2012, a Medicare contractor may review your medical records to check for medical necessity if you got outpatient therapy services in 2012 higher than these amounts:

- \$3,700 for PT and SLP combined
- \$3,700 for OT

Note: The Medicare contractor may conduct this review of your medical records **before you get any additional outpatient therapy services.**

Are there limits to outpatient therapy services I get at the hospital?

Until October 1, 2012, the outpatient therapy services provided in a hospital are exempt from the therapy cap limits. **Starting October 1, 2012**, however, the exemption ends and the outpatient therapy caps **will apply** to therapy services you get in an outpatient hospital department or hospital emergency room and **will count** toward the therapy cap limits.



Are there limits to outpatient therapy services I get at the hospital? (continued)

Even though the outpatient therapy caps don't apply to therapy services provided in hospitals before October 1, 2012, **the costs for your hospital therapy services from January 1, 2012–September 30, 2012 will count towards the yearly therapy caps starting on October 1, 2012.**

Example 1: Mrs. Smith got outpatient PT services for a knee injury in March 2012. Her initial PT services were from her hospital emergency room. After that, she got more PT services from the hospital outpatient department. The total cost of her therapy services in March was \$2,000. Even though these costs are higher than the therapy cap amounts, **the caps don't apply** because she got the services in March 2012, when the hospital PT services were exempt from the therapy caps.

In November 2012, Mrs. Smith gets additional PT services from her hospital outpatient department. The total cost of her PT services in March (\$2,000) **will now count** toward her therapy caps, which means that all of her PT services in November will be above the \$1,880 limit. Her therapist will need to document her need for these medically-necessary PT services in her medical record, and her hospital's billing office must indicate on her claim that she needs these outpatient PT services. Even in this situation, **Mrs. Smith might have to pay** for some or all of the PT services she gets over the therapy cap of \$1,880 if Medicare finds that the services above the therapy cap limits weren't medically necessary.

Example 2: After having a mild stroke in June 2012, Mr. Simpson got OT services from his hospital outpatient department. The total cost of his OT services in June was \$1,500. The **therapy caps don't apply** to Mr. Simpson's OT services because the costs for his therapy services are below the \$1,880 therapy caps limit and because he got the services in June 2012 when the hospital outpatient department was exempt from the therapy caps.

In October 2012, Mr. Simpson returns to his hospital outpatient department to get additional OT services. The total cost of his OT services in June (\$1,500) **will now count** toward his therapy caps, which means that if his OT services after October 1, 2012 are more than \$380, he'll be above the \$1,880 therapy cap limit. For Medicare to keep paying, his therapist will need to document his need for medically-necessary OT services in his medical record, and his hospital's billing office must indicate on his claim that he needs outpatient OT services. Even in this situation, **Mr. Simpson might have to pay** for some or all of the OT services he gets over the therapy cap of \$1,880 if Medicare finds that the services above the therapy cap limits weren't medically necessary.



How can I find out if my therapy services will go above the therapy cap limits?

- Ask your therapist's billing office. If you get all your therapy in the same place, your therapist's billing office will have the most up-to-date information and will know if your services will go above these limits.
- Visit www.MyMedicare.gov to track your claims for therapy services. This website is Medicare's secure online service for accessing your personal Medicare information.
- Check your "Medicare Summary Notice" (MSN). This is the notice you get in the mail (usually every 3 months) that lists the services you had and the amount you may be billed.

Where can I get more information?

Call your State Health Insurance Assistance Program (SHIP) to get free personalized health insurance counseling. To get the phone number for your state, visit www.medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.