

June 6, 2013

Dear Physical Therapy Patient:

As you may know, Medicare limits or “caps” the amount it will pay for **outpatient physical therapy services** in a calendar year. Your physical therapist is aware of this financial limitation and can apply for an exception if your care requires medically necessary services—as defined by Medicare—above the \$1,900 cap. After your care exceeds \$3,700, it may be difficult to get approval for your physical therapy services to be covered. Your physical therapist can explain how Medicare defines “medically necessary” and how it applies to your condition and treatment.

**If you are receiving skilled therapy in your home under Medicare's home health benefit Part A, in a skilled nursing facility under Medicare Part A, or an inpatient hospital setting under Part A, the cap does not apply to your care.**

#### **What provider settings are subject to the therapy cap in 2013?**

Effective January 1, 2013, if you receive therapy services in a private practice, a physician's office, an outpatient hospital department, a skilled nursing facility under Medicare Part B, or a rehabilitation facility, the \$1,900 therapy cap with an exceptions process will apply to you. The cap does not apply to patients who receive skilled therapy at home under the Medicare home health benefit Part A, those who receive services under Part A in skilled nursing facilities, or those under a Part A inpatient hospital stay.

It is important that you understand the basic facts about Medicare therapy cap policy. You are encouraged to speak with your physical therapist about the cap and review the following frequently asked questions to learn more about 2013 Medicare therapy cap guidelines and exceptions.

#### **What is the therapy cap amount for 2013?**

The annual per beneficiary therapy cap amount for 2013 is \$1,900 for outpatient physical therapy and speech-language pathology services combined. There is a separate \$1,900 amount for occupational therapy services. If your outpatient therapy services are medically necessary beyond \$1,900, your therapist can obtain an exception that will enable you to continue therapy. It may become more difficult for your therapist to obtain an exception when your outpatient therapy services exceed \$3,700 in the calendar year.

**What is the exceptions process?**

The exceptions process allows you to receive outpatient therapy services in excess of the cap amount delivered in a calendar year. In 2013 there are 2 exceptions processes—an automatic exceptions process and a manual medical review exceptions process.

**What is the difference between an "automatic" exception and a "manual medical review" exception?**

Your physical therapist can apply for an automatic exception to the therapy cap by using a special code on your claim form if you require outpatient services above \$1,900. If you require outpatient services beyond \$3,700 your claims must be reviewed by Medicare in order to continue to receive therapy services. Due to the complexity of the review process at \$3,700, and the uncertainty it creates, your physical therapist will not be able to tell you at the time of the session whether or not your treatment will be covered by Medicare. It could be several weeks before your therapist knows whether or not services that exceed \$3,700 will be covered.

**What happens if Medicare decides that my physical therapy services are not medically necessary and will not pay for the services?**

If your physical therapist and Medicare believe that your services will be deemed not medically necessary, your physical therapist should provide you with a notice, called an Advanced Beneficiary Notice (ABN), and you can agree to pay cash for these services in the event the claim is denied.

**If a Medicare beneficiary receives outpatient physical therapy services January-March for a hip replacement and is discharged, then returns in September as a result of a stroke, is there 1 cap for the first episode of treatment and a new cap for the second episode of treatment?**

No. The therapy cap is an annual per-beneficiary cap.

**Where can I find more information on the therapy cap?**

Medicare beneficiaries can find more information on the cap on the American Physical Therapy Association's website at <http://www.apta.org/PatientActionCenter/>.

**How can I tell Congress that the therapy cap should be eliminated?**

Medicare beneficiaries can ask their members of Congress to repeal the therapy cap by going to the American Physical Therapy Association's Patient Legislative Action Center at <http://capwiz.com/amerpta/home/>.

*The American Physical Therapy Association (APTA) represents more than 85,000 physical therapists, physical therapist assistants, and students of physical therapy nationwide. APTA's mission is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public.*