

MEDICARE BENEFITS FOR OUTPATIENT PHYSICAL THERAPY

Provider Notice:

Medicare will pay only for services that it determines to be “reasonable and necessary” under Section 1862 (a)(1) of the Medicare law. If Medicare determines that a particular service is not “reasonable and necessary” for the condition being treated, Medicare benefits will be denied.

A condition for determination of medical necessity for physical therapy treatment is that the referring medical provider must provide a signed order/prescription for physical therapy that is good for thirty days (30) days from the date that physical therapy treatment is initiated. It is required by Medicare that the provider who referred you to physical therapy review your treatment plan and progress in physical therapy every 30 days and provide certification for continued physical therapy if he/she determines that this treatment remains medically necessary.

In all cases Medicare B imposes a maximum benefit limit of \$1840 per calendar year for outpatient physical therapy and speech therapy combined. Medicare B will deny benefits for outpatient physical therapy or speech therapy that exceeds this maximum allowance.

Beneficiary Agreement:

I understand that my progress in physical therapy treatment is subject to referring provider certification every 30 days to determine that treatment is medically necessary. I have been notified by Orthopedic and Sport Therapy Services that Medicare will deny benefits for services provided that are not deemed medically necessary by the medical provider who referred me to physical therapy.

I further understand that my annual maximum benefit allowance for combined physical therapy and speech therapy is \$1840 and that Medicare B will not provide benefits greater than that limit. Having been notified that my annual Medicare benefit is limited to \$1840 for combined physical therapy and speech therapy, I understand that I will be responsible for payment of charges for any physical therapy services that exceed this maximum allowable limit.

Signed: _____
Patient Date