PRECISION
ORTHOPEDICS & SPORTS MEDICINE

# Physical Therapy Department

## Medicare Notice of Exclusions from Medicare Benefits (NEMB) and Therapy Cap
## Patient Acknowledgement

There are items and services for which Medicare will not pay and as you know Medicare does not pay for all your health care costs as it relates to therapy services. Medicare only pays for what it determines as medically necessary covered benefits. Some items and services are not Medicare benefits and, therefore, Medicare will not pay for them. Their definition of medical necessity is that the services or items:

1. Must be reasonable and necessary as they relate to your problem/condition.
2. Must positively impact your condition in a functional and measurable manner.
3. Must contribute to the improvement of your condition in a reasonable and predicable time period and frequency.
4. Must be related to the improvement of essential activities of daily living, such as:
    a. Ambulation on level and/or irregular surfaces, including stair climbing
    b. Self feeding
    c. Self grooming and hygiene maintenance
    d. Dressing

- **Medicare will not pay for "Maintenance Program" or general exercises to promote overall fitness and flexibility or for recreational activities as these are considered not payable services.**

- **Medicare has placed a therapy cap of $2110 for all therapy services provided in 2021 to you from an outpatient therapy facility and home health therapy. In addition, Medicare added the requirement of a patient chart audit for any services delivered under the "exception process" that exceeds $3000. At this point we must submit a formal request to Medicare to continue services and to receive payment for them. We are also subject, at this time, to a Medicare audit of all documentation for services from the first day of service this year to and through the $3000 threshold.**

    - Medicare recommends that you be advised of the potential of payment denial as a result of their audit. This new process has staggered effective dates beginning in October 2012. **We carefully document medical necessity for all services delivered and will advise you if/when you have reach the cap.**
    - Please note that if you received other physical, occupational or speech therapy services this year, they, too, apply to the financial limitation, regardless of the place of service they are provided, i.e. doctors office, chiropractor, etc. Physical and Speech Therapy has a separate $3000 cap from Occupational Therapy.
    - Medicare has made some exceptions to the cap, which are based on your condition (Diagnosis) or other environmental issues; these have very specific medical necessity requirements and must meet all of Medicare's criteria for the exception.
    - Please know that we would not continue services if they were not clinically indicated. Medicare's medical necessary determination is a payment policy and does not mean that your services should be terminated. It simply means that Medicare is not willing to pay for any continuation of services not medically necessary, and you will be responsible for the difference.
    - Your options, if you are not eligible for a Therapy Cap Exception or Therapy Threshold are:
        1. Pay for any services rendered over $2110.00.
        2. Decrease the amount and/or frequency of services.
        3. Terminate services.
        4. Transfer to a wellness and prevention program.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive services that may be clinically indicated but not "medically necessary" according to Medicare's payment policy. If deemed not medically necessary, the payment liability will be transferred to you by law.

_____

Patient or Authorized Representative's Signature/Date
(Signature only indicates that this notice has been received per Medicare guidelines)

Rev: 12/29/2020

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# ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

***NOTE:* If Medicare doesn't pay for *Physical Therapy treatment* listed below, you may have to pay.**

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the ***Physical Therapy Treatment listed*** below.

**Additional physical/occupational therapy because:**

- Any services (or related items) provided over the **2021 Physical/Occupational Therapy Cap** of **$2110.00** are not covered.
- Supply: _____ (Medicare does not pay for this item)
- Other: _____

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the ***Physical Therapy Treatment*** above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

## OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the ***Physical Therapy Treatment*** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the ***Physical Therapy Treatment*** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the ***Physical Therapy Treatment*** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**Additional Information: This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY**: 1-877-486-2048).

**Signing below means that you have received and understand this notice. You will also receive a copy.**

| Signature: | Date: |
|---|---|

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# ***IMPORTANT: Home Health Services***

## *To Our Medicare Patients*

***Dear Patient,***

***We are in need of your help and speedy communication to avoid billing you for 100% of your therapy services.***

Many of you either have had or will have **Home Health Services** paid for by Medicare. We should not provide Physical Therapy to patients who are having home health services of any kind, not just physical therapy. All of the six services listed below must be provided and paid for by your Home Health Agency if your physician has determined that they are medically necessary. The services are:

- Skilled Nursing Services for the assessment and/or treatment of injuries or illnesses or for giving medications/injections, inspecting or inserting feeding tubes, catheters, wound care, etc.
- Occupational Therapy Services
- Physical Therapy Services
- Speech & Language Pathology Services
- Home Health Aide Services provide assistance with basic personal care, meal preparation, feeding, incidental household services such as preparation of meals, light cleaning, etc.
- Medical Social Services

If you have had home health services within six months of being referred to us we must know so we can verify your discharge from that service. If you are referred for home health services while you are being treated by us, we must be informed prior to you starting home health. We would like to avoid holding your responsible for payment if your Home Health Agency is not providing the services.

So, please tell us if you are receiving and/or will be receiving home health services of any kind.

Thank you for your help.

Patient/Guardian Name (Printed) Date

Patient/Guardian Signature Date

Rev: 12/29/2020

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**Physical Therapy Department**
2120 N. MacArthur, Suite 101
Irving, TX 75061
Phone: 972-438-3800 Fax: 972-438 3996

# Medicare Questionnaire

Patient Name: _____ Date: _____
Medicare ID#: _____ Date of birth: _____

1. Is the patient retired? _____ No _____ Yes
2. Is this injury a result of an auto accident?
   _____ No
   _____ Yes - fill out: Insurance Name: _____
   Address: _____
   _____
   Phone #: _____
   Policy #: _____
3. Is the patient enrolled in any other health insurance policy PRIMARY to Medicare (does not include Medicare Replacement Plans)
   ____ No ____ Yes - please notify front desk
   If the primary carrier of the other health insurance policy (not Medicare) is **NOT** retired and this policy is offered through their current employer: Does the employer that sponsors the group health plan (GHP) employ 20 or more employees? _____ No - Medicare is primary and the GHP is secondary
   _____ Yes - The GHP policy is primary to Medicare.
4. Is the patient receiving services from a Home Health Agency for **any** medical condition (related or unrelated to this injury you are being treated for today)?
   _____ No _____ Yes - please notify front desk
5. Is the patient currently a resident of a Skilled Nursing Facility?
   _____ No _____ Yes - please notify front desk

**By signing below, I certify that the information stated above is current and correct. If any of this information above changes during the course of treatment, you recognize an obligation to immediately notify our front office. You may be responsible for any balance or non-payment that occurs resulting from late or lack of notification.**

_____ _____
Patient/Guardian Signature Date signed

Office Use only:
HHA: _____ Ph#: _____
Reason for Tx: PT / OT / ST / Other: _____ Therapist/RN: _____
DC Date: _____ Confirmed by: _____