



Medicare Limits on Therapy Services

Medicare limits how much it covers for medically-necessary outpatient physical therapy, speech-language pathology, and occupational therapy.

What are the outpatient therapy limits for 2009?

- \$1,840 for physical therapy and speech language pathology combined
- \$1,840 for occupational therapy

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 therapy cost. The Part B deductible is \$135 for 2009. Medicare will keep paying its share for therapy services until the total amount paid, including the deductible and copayments, reaches the therapy limit. You may qualify for an exception to the therapy limits (which would allow Medicare to pay for services after you reach the limits) if the services are medically necessary. See “What can I do if I need services that will go above the outpatient therapy limits?” on the next page.

The outpatient therapy limits don’t apply to therapy services you get at hospital outpatient departments or hospital emergency rooms. There is no limit on Medicare payments for medically-necessary outpatient therapy services if you get them in a hospital outpatient department or a hospital emergency room.

The therapy limits apply to outpatient therapy you get from the following:

People	Places
<ul style="list-style-type: none"> • Doctors • Physical therapists • Occupational therapists • Speech-language pathologists • Nurse practitioners • Clinical nurse specialists • Physician assistants 	<ul style="list-style-type: none"> • Most medical offices • Outpatient rehabilitation facilities/rehabilitation agencies • Comprehensive outpatient rehabilitation facilities • Skilled nursing facilities (SNFs) for outpatients or residents who aren’t in Medicare-certified parts of the facility • Home, from certain therapy providers



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

You or your therapist can ask for an exception if you have a condition that requires services that will go above the therapy limits. You don't have to submit a written request to get an exception. However, your therapist must keep information in your medical record to justify the need for services beyond the therapy limits. If your condition is documented and your costs are above the therapy limits, your therapist's billing office will add an explanation to the claim to justify your continuing need for services above the limits.

Note: If you had therapy services that were above the therapy limits in July 2008, you may qualify for an exception. If you paid more than your usual coinsurance (after the deductible), you should ask the therapy provider to request an exception and pay you back the difference.

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

If you get all your therapy in the same place, your therapist's billing office will know if your services will go above these limits. You can also check your Medicare Summary Notice. 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. You can also 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.

Where can I go for more information?

For free, personalized health insurance counseling, call your State Health Insurance Assistance Program (SHIP). To find the most current telephone number for your state, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.