

7910 Andrus Road, Suite 5
Alexandria, VA 22306
Ph: (571)481-4547
Fax: (571)551-6419



MEDICARE 2023

Date: _____

Patient: _____

Effective January 1, 2023, the financial threshold (limitation) was updated for outpatient rehabilitation services received by Medicare beneficiaries. Outpatient Physical Therapy and Outpatient Speech-Language Pathology has a **combined** annual threshold for 2023 of **\$2,230**.

An exception to the therapy threshold may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy to achieve their prior functional status or maximum expected functional status within a reasonable amount of time. Providers may utilize the automatic process for exception for any diagnosis for which they can justify services exceeding the initial threshold. *This exception will allow the beneficiary access to a yearly total of **\$3,000** of medically reasonable and necessary Outpatient Physical Therapy and/or Outpatient Speech-Language pathology services.*

I certify that I am aware of the therapy Medicare threshold of **\$2,230**. for the 2023 calendar year. I understand that I am responsible for any amounts not covered by my insurance. If your insurance carrier (primary or secondary) denies any part of your claim, or if you or your physician elects to continue therapy past your approved time or financial limitation you will be responsible for payment of your account balance in full.

I have had _____ number of **Outpatient Physical Therapy** (in private practice, physician offices, Part B skilled nursing facilities for outpatient or residents who are not in Medicare certified parts of the facility, outpatient rehabilitation facilities) and **Speech Therapy** visits during the 2023 calendar year.

Patient's Signature

Date

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Medicare does not cover Outpatient Physical Therapy if you are currently receiving any home health services (Nurse, Physical Therapy, Occupational Therapy, Speech Language Pathology, or Home Health Aide).

Are you currently receiving any home health services?

YES NO

What was the name of the Homecare Agency from which you, or a household member, last had home health services:

___ INOVA VNA

___ Encompass Health

___ Goodwin House

___ Other _____

Patient's Signature

Date