Medicare Coverage of Therapy Services

Important: This information only applies if you have Original Medicare. If you have a Medicare Advantage Plan (like an HMO or PPO), check with your plan for information about your plan’s coverage rules on therapy services.

In 2018, Congress eliminated the limits on how much Medicare pays for therapy services in one calendar year (also called “therapy caps” or “therapy cap limits”). However, for Medicare to pay for your services, the law requires your therapist or therapy provider to confirm that your therapy services are medically reasonable and necessary when they reach certain amounts each calendar year.

What does my therapist need to do?

Your therapist or therapy provider will need to add information to your therapy claims and your medical record if your therapy services reach these amounts in 2018:

- $2,010 for physical therapy (PT) and speech-language pathology (SLP) services combined
- $2,010 for occupational therapy (OT) services

If your therapy services reach these amounts, your therapist or therapy provider will need to add a special notation to your therapy claim. By adding this notation, the therapist or therapy provider confirms that:

- Your therapy services are reasonable and necessary
- Your medical record includes information to explain why the services are medically necessary

A Medicare contractor may review your medical records to be sure your therapy services were medically necessary. This review may happen if your therapy services reach these amounts in 2018:

- $3,000 for PT and SLP services combined
- $3,000 for OT services
Do I need to do anything?
No. Generally, Medicare will continue to cover its share of your medically necessary therapy services.

What will I pay for medically necessary therapy services?
After you pay your Medicare Part B (Medical Insurance) deductible, you’ll pay 20% of the cost for therapy services. Medicare will pay 80%.

What if my therapy services aren’t medically necessary?
Because Medicare doesn’t pay for therapy services that aren’t reasonable and necessary, your therapist or therapy provider must give you a written notice before providing services that aren’t medically necessary. This notice is called an “Advance Beneficiary Notice of Noncoverage” (ABN). The ABN lets you choose whether or not you want the therapy services. If you choose to get the medically unnecessary services, you agree to pay for them.

Who can give me outpatient therapy services?
- Physical therapists
- Speech-language pathologists
- Occupational therapists

Doctors and other health care professionals (like nurse practitioners, clinical nurse specialists, and physician assistants) may also offer PT, SLP, and OT services.

Where can I get outpatient therapy services?
- Offices of privately practicing therapists
- Many medical offices
- Outpatient hospital departments
- Critical access hospital (CAH) outpatient departments
- Rehabilitation agencies (sometimes called “other rehabilitation facilities” (ORFs))
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Skilled nursing facilities (SNFs) (when Medicare Part A (Hospital Insurance) doesn’t apply)
- At home, from certain therapy providers, like privately practicing therapists and certain home health agencies (if you aren’t under a home health plan of care)
Where can I get more information?

Call your State Health Insurance Assistance Program (SHIP) to get free personalized health insurance counseling. To get the phone number for your state, visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you’ve been discriminated against. Visit Medicare.gov/about-us/nondiscrimination/accessibility-nondiscrimination.html, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

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