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EXPLANATION OF MEDICARE ADVANCE BENEFICIARY NOTICE (ABN)

This form is for physical therapy services that are anticipated to NOT be reimbursable by Medicare Original. This is NOT for patients/clients with Medicare Advantage through commercial insurance or any other insurance carriers.

The patient/client is responsible for payment at the time of service for the physical therapy activities.

An ABN form must be signed and dated by the Medicare patient/client or their representative. The physical therapist must keep the original and a copy must be given to the patient/client.

Blank B: Patient Name. When putting the patient/client name on the ABN form, the name must appear EXACTLY as it does on the Medicare Original card.

An ABN form is current for one year from the time it is signed OR for the amount of time indicated on the form when that time is under one year. Once the time limit is up, a new ABN must be signed for any continued care.

By signing the ABN, the patient/client acknowledges being notified of the out-of-pocket cost for the physical therapy services that are anticipated to NOT be reimbursed by Medicare and agrees to pay those costs prior to the service.

Why might physical therapy services NOT be covered?

- Physical therapy is no longer medically necessary
- Medicare does not cover that service
- Not research-based, effective, or timely for the treatment of a patient/client's injury, illness, health condition, or functional impairment
- Not requiring the skill of a physical therapist and can be effectively and safely done by the patient, a caregiver, or another professional
- Intended for consultation, screening, and/or prevention purposes only and do not include treatment of any diagnosed or undiagnosed injury, illness, health condition, or functional limitation
- Is for health/wellness or performance enhancing purposes only.
- Routine or maintenance*
    - *The exception being physical therapy services for a condition that will significantly regress without the care of a skilled physical therapist as in the case of serious chronic conditions

The types of physical therapy services that may be utilized for the patient/client include:

Initial Evaluation:

- 97161 Physical Therapy Evaluation - Low Complexity $100.00*
- 97162 Physical Therapy Evaluation - Medium Complexity $100.00

- 97163 Physical Therapy Evaluation - High Complexity $100.00
- 97164 Physical Therapy Re-Evaluation $100.00

*Evaluations last up to 120 minutes.

Type of interventions: *Sessions may consist of any combination of the following*

- 97032 Electrical Stimulation $15.00/unit*
- 97035 Ultrasound $15.00/unit
- 97110: Therapeutic Exercise $30.00/unit
- 97112: Neuromuscular Re-education $35.00/unit
- 97116: Gait Training $30.00/unit
- 97140: Manual Therapy $30.00/unit
- 97530: Therapeutic Activities $35.00/unit
- 97535: Self-Care/Home Management Training $35.00/unit
- 97760: Orthotic and Prosthetic Evaluation/Management $45.00/unit
- 97763: Orthotic and Prosthetic Management $50.00/unit

*One unit is for 8-22 minutes.

Frequency/Duration:

- Up to 3 sessions weekly for up to 90 days
- OR specific frequency/duration on script
- OR number of sessions requested by patient/client
- OR not yet scheduled

Fees: On the ABN form there are 3 options. For options 1 and 2 the patient is asked to pay for services at the time of the service. Rates vary as specified below:

Option 1 states, "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 states, "I want the (physical therapy service) 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.**"

The rate charged for option 2 is as follows:

- $100.00 for 1-60 min initial consultations
- $100.00 for 1-60 min follow-up sessions
- $270.00 for 3-60 min sessions
- $480.00 for 6-60 min sessions

There are different rates for option 1 versus option 2 because option 2 does not include a charge for the administrative cost of submitting a claim to Medicare. This charge applies whether I submit the claim or you submit the claim. Either way, it requires the same amount of administrative effort on my side.

In addition to completing an ABN, the patient/client is also required to receive and sign a "Good Faith Estimate" of charges that will be paid with cash. Explanation of this estimate will be given on a separate form.