Your Medicare Coverage

Is my test, item, or service covered?

Searc

Physical therapy/occupational therapy/speech-language pathology services

How often is it covered?

Medicare Part B (Medical Insurance) helps pay for medically necessary outpatient physical and occupational therapy, and speech-language pathology services. There are limits on these services when you get them from most outpatient providers. These limits are called “therapy caps” or "therapy cap limits."

The therapy cap limits for 2017 are:

- $1,980 for physical therapy (PT) and speech-language pathology (SLP) services combined
- $1,980 for occupational therapy (OT) services

You may qualify for an exception to the therapy cap limits. If so, Medicare will continue to pay its share for your therapy services after you reach the therapy cap limits. Your therapist or therapy provider must:

- Establish your need for medically reasonable and necessary services and document this in your medical record
- Indicate on your Medicare claim for services above the therapy cap that your outpatient therapy services are medically reasonable and necessary

As part of the exceptions process, there are additional limits (called “thresholds”). If you get outpatient therapy services higher than the threshold amounts, a Medicare contractor may review your medical records to check for medical necessity. The threshold amounts for 2017 are:

- $3,700 for PT and SLP combined
- $3,700 for OT

In general (when an exceptions process is in effect), Medicare will continue to cover its share above the $1,980 therapy cap limits if these apply:

- Your therapist or therapy provider provides documentation to show that your services were medically reasonable and necessary
- Your therapist or therapy provider that your services were medically reasonable and necessary on your claim

Your therapist or therapy provider must give you a written notice before providing generally covered therapy services that aren't medically reasonable and necessary for you at the time. This notice is called an "Advance Beneficiary Notice of Noncoverage" (ABN). In this situation, your therapist or therapy provider must give you the ABN because Medicare doesn't pay for therapy services that aren't medically necessary. 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's eligible?

All people with Part B are covered if Medicare finds that the services are medically reasonable and necessary. Medicare will pay its share for therapy services until the total amounts paid by both you and Medicare reaches either one of the therapy cap limits. Amounts paid by you may include costs like the deductible and coinsurance.

Your costs in Original Medicare

You pay 20% of the Medicare-approved amount, and the Part B deductible applies.

Note

To find out how much your specific test, item, or service will cost, talk to your doctor or other health care provider. The specific amount you'll owe may depend on several things, like:

- Other insurance you may have
- How much your doctor charges
- Whether your doctor accepts assignment
- The type of facility
- The location where you get your test, item, or service

Note

Your doctor or other health care provider may recommend you get services more often than Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you may have to pay some or all of the costs. It's important to ask questions so you understand why your doctor is recommending certain services and whether Medicare will pay for them.

Related resources

- Get more information about therapy caps
- Medicare & You: National Physical Therapy Month (video)

Return to search results

Medicare.gov

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