WSC ADVISORY #2018-016
MEDICARE PART B THERAPY COVERAGE

ACTION REQUIRED

EFFECTIVE DATE: MAY 22, 2018

This advisory is to inform Waiver Support Coordinators (WSCs) about the availability of Physical Therapy, Occupational Therapy, and Speech Therapy services through Medicare. Medicare law no longer limits how much Medicare pays for the medically necessary Physical, Occupational, and Speech Therapy services in one calendar year. Therefore, there is no longer the therapy cap dollar limit. However, the therapist will need to add information to the claim confirming the service is medically necessary if services reach $2,010 for physical and speech therapy combined and $2,010 for occupational therapy

WSCs who serve consumers who need therapies and are Medicare eligible, must access the therapies through Medicare prior to accessing Waiver funding.

To assist in accessing these therapies through Medicare, the WSC must:

- Check the client's Medicare Part B eligibility, and renew it if necessary
- Ensure the doctor or therapist is a participating provider and request that the billing is completed through Medicare Part B
- If submitting a request for iBudget funded therapy services, the WSC must provide documentation of attempts to access the services through Medicare and why the services are not available.
    - This may include a denial from Medicare or case notes/narrative information of the attempts made to access the service, names of providers contacted, dates, and the outcome.

The Developmental Disabilities iBudget Waiver Handbook Rule 59G-13.070, F.A.C., page 2-13 states:
"Services must not be authorized under the iBudget Waiver if they are available from another source. It is the WSC's responsibility to first ensure that the same type of service offered through the waiver cannot be accessed through other funding sources, such as:
• Natural and community supports.
• Third Party Payer (e.g., private insurance).
• Medicare.
• Other Medicaid programs (e.g., Medicaid State Plan or Medicaid managed care plan).

If a recipient is dually-eligible under Medicare and Medicaid, the WSC must secure services from providers enrolled as Medicare and Medicaid providers so that any services that are covered by Medicare can be billed to Medicare first before billing to Medicaid (e.g., Medicaid cannot reimburse a non-Medicaid home health agency for Medicare reimbursable services provided to a dual-eligible recipient)."

Further information regarding this change in Medicare law can be found at the following links:

Medicare.gov provides this updated information: https://www.medicare.gov/coverage/pt-and-ot-and-speech-language-pathology.html

The Medicare Interactive article reflects this change, see the link here: https://www.medicareinteractive.org/get-answers/medicare-covered-services/rehabilitation-therapy-services/outpatient-physical-speech-and-occupational-therapy