Clarification of Restore Motion's Medicare Status

June 12, 2006

Dear Restore Motion Client,

We have been in contact with Trailblazers and CMS to clarify our status as non-Medicare provider.

Initially, we were told that we could not see any person that was eligible for Medicare and, that we would have to stop seeing any of our clients that were Medicare patients. When we pointed out that this infringed on a whole population's right to choose whom they see for physical therapy it lead to more discussion. Medicare's concern is that Medicare patients should not be taken advantage of and that even if an "Advance Beneficiary Notice" of non-Medicare coverage is signed, it does not assure that the Medicare patient understands that they are not eligible for reimbursement.

As you know, Restore Motion is not a Medicare Provider. We do not have a medical provider number with Medicare. Because we do not have a medical provider number, Medicare does not recognize the work we do as being "physical therapy". Medicare views our work as being "wellness and maintenance" similar to the work of a massage therapist or personal trainer.

This "non-medical" status under Medicare guidelines dictates that Restore Motion issue a Sales Receipt or Invoice without any medical coding, ICD-9 or CPT numbers. (These code numbers help insurance companies and Medicare keep track of what medical modality is being performed or administered and for what purpose).

Medicare will not generate a denial of benefits or EOB for secondary insurance coverage because the services are not seen as medical or medically necessary. If a secondary insurance company reimburses you for services provided here, it could be interpreted as fraud against Medicare. The argument is that the submittal of a claim to the secondary insurance company implies that Medicare first recognized, and then denied coverage of a medical service. Again, since Medicare does not recognize us as medical providers there should be no claim for reimbursement for medical services.

Question: Is Restore Motion providing physical therapy or wellness and maintenance?

Answer: Medicare has strict guidelines as to what constitutes physical therapy. These include (but are not limited to) "medical necessity" status for treatment of problem, medical follow-up with a physician approximately every 30 days, frequency of treatment in PT 2-3 time per week basis and (or) have a chronic condition (onset greater than 6 months ago) that will take longer than the 4-6 week time frame to resolve.

(i.e. a person with a hip problem that can walk 150 feet safely, with or without a cane, drive, stand long enough to re-heat a meal and sit long enough to eat a meal would be considered "Independent" and not eligible for physical therapy and under Medicare guidelines.)

Question: Why doesn't Restore Motion get a Medicare Provider number?

Answer: Restore Motion does not want insurance companies to dictate the quality of care that we provide to our patient. We are able to spend more time with you, caring for your condition than we would if we had to keep up with the administrative responsibilities and updates/changes to the Medicare system.

We appreciate having the opportunity to work with you. If you have any further questions or concerns, please feel free to call us at 301-881-9313

Sincerely,

Reshma Rathod, PT, MSPT

Miriam Graham, PT, DPT

Signature below is only acknowledgement that you have received this notice of our Non-Medicare Participation.

Date: _____ Client Name: _____

Signature: _____

MEDICARE ABN

Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular service does not mean you should not receive it. Right now, in your case, Medicare will not pay for physical therapy treatment for the following reasons checked below.

- ✓ The services provided here will be considered as a management of a maintenance and/or wellness program, not rehabilitative in nature, under Medicare guidelines. Medicare does not consider management of a maintenance and/or wellness program as reasonable and/or necessary.
- ✓ The frequency of the physical therapy visits is less than two to three times per week.
- ✓ The duration of physical therapy services is longer than what Medicare considers reasonable and necessary, which is usually eight weeks.
- ✓ You will not be seeing the referring doctor every 30 days.
- ✓ Your physical therapist is not a participating provider for Medicare, therefore, you **will not** be able to submit claims to Medicare for reimbursement.

Beneficiary Agreement:

I have been notified by my physical therapist that in my case Medicare will deny payment for the services identified above for the reason stated. I agree to be personally and fully responsible for the payment.

Date_____ Client Name: _____
(Please Print)

Signature: _____