

CLARIFICATION OF RESTORE MOTION'S MEDICARE STATUS

Dear Restore Motion Client,

We have been in contact with Trailblazers and CMS to clarify our status as a 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 who 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, then denied coverage of a medical service. Again, since we are not recognized as medical providers by Medicare 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 times per week, and significant objective and functional improvement within a 4-6 week time frame.

Most of our clients have conditions that do not require medical follow-up that frequently, do not require PT on a 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.

(ie 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 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 patients. 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.

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

Signature

Date