

*Palisades Rehabilitation Center of Cresskill  
220 Knickerbocker Road, Cresskill, NJ 07626*

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January 4, 2010

To all Palisades Rehab Medicare Patients:

As you may or may not know, effective January 1, 2010, the therapy cap is being implemented with financial limits on outpatient therapy services of \$1,860 for combined physical therapy and speech-language pathology services; and \$1,860 for occupational therapy services. In 2009, the exceptions process had been allowed for medically necessary outpatient therapy services beyond the arbitrary cap of \$1,860. It is with great disappointment that we must inform you that the exceptions process to the therapy cap expired December 31, 2009.

**What does this mean to you? You may receive therapy up to the \$1,860 cap for physical therapy and another \$1,860 for occupational therapy. This translates into 18 treatment sessions for physical therapy and 18 treatment sessions for occupational therapy.**

Once you reach the cap, Medicare will not reimburse Palisades Rehab on your behalf. At that time, you may pay privately to continue receiving therapy. We are also encouraging patients to discuss the appropriateness of our maintenance program with your therapist.

If you would like further information about the therapy cap, we recommend you visit the Centers for Medicare & Medicaid Services website at [www.cms.hhs.gov](http://www.cms.hhs.gov).

Congress has recognized the potential consequences of the therapy cap and on several occasions imposed a moratorium to prevent its implementation. It is expected that Congress will vote on a permanent solution to the therapy cap situation by the beginning of March. You can be assured that we will provide you with updated information as it becomes available. Until Congress acts, the exceptions to therapy caps are restricted to those medically necessary services billed by the outpatient departments of hospitals only.

Please feel free to contact me with any questions. Thank you.

Sincerely,

*Deborah M. Longest, MS, OTR/L*

**I HAVE READ AND UNDERSTAND ALL OF THE ABOVE, AND CERTIFY THAT I AM THE PATIENT (OR HIS/HER LEGAL GUARDIAN) PRESENTING FOR SERVICES OR AN AUTHORIZED AGENT BY THE PATIENT TO EXECUTE THIS FORM.**

**Patient Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Relationship to patient: SELF / GUARDIAN / AGENT / OTHER:** \_\_\_\_\_ **Date:** \_\_\_\_\_