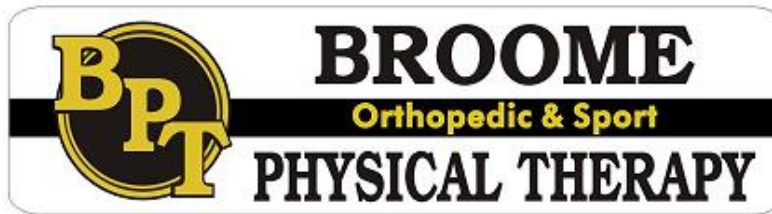



BROOME ORTHO & SPORTS PHYSICAL THERAPY
800 VALLEY PLAZA, SUITE 9
JOHNSON CITY,NY 13790-3305

# NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

The Balanced Budget Act 1997,P.L. 105-33, Section 4541 set annual caps for Part B Medicare Patients. These limits change annually. The Deficit Reduction Act of 2005 (signed Feb.8,2006) directed that a process for exceptions to therapy caps for medically necessary services be implemented. Subsequently, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was enacted on July 15,2008 and Section 141 extended the effective date of the exceptions process to the therapy caps to December 31,2017. The exceptions process will continue unchanged for the time frame directed by Congress.

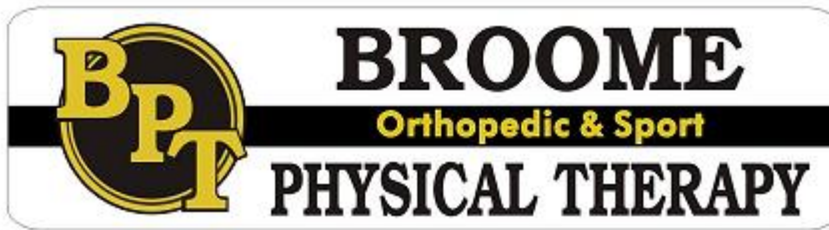
For Physical Therapy/Speech Services, the limit is **$1980.00** for the calendar year **2017.** The limit is based on incurred expenses and includes applicable deductible and coinsurance.

I HAVE READ THIS NOTICE AND UNDERSTAND THAT THE LIMIT FOR PHYSICAL THERAPY/SPEECH SERVICES FOR THE CALENDAR YEAR **2017** IS : $**1980.00.**

______________________________________________
**PATIENT NAME**

______________________________________________
**PATIENT SIGNATURE**

DATE OF SIGNATURE ______________________




## Medicare Secondary Payer Questionnaire

Patient Name: _________________________ Date of Birth:______________________

## Part I

1. Are you receiving Black Lung Benefits? ________________
2. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility? _________________
3. Was the illness/injury due to a work-related accident/condition? ___________________
4. Was the illness/injury due to an automobile accident? ___________________

## Part II

1. Was the illness/injury due to a non-work related accident? ____________________
   Date of Accident:_____________________
2. What type of accident caused the illness/injury? _____________________________

   Name, address and claim number for No-Fault insurer:

   ______________________________________________________________________________

   Name, address and claim number for Liability insurer:

   ______________________________________________________________________________

   Name, address, claim number and employer for Worker's Comp insurer:

   ______________________________________________________________________________

## Part III

1. Are you entitled to Medicare based on age or disability? _________________________
2. Are you currently employed? __________. If currently employed name and address of your employer: ___________________________________________________________
3. Is your spouse currently employed? __________. If your spouse is currently employed employer name and address _______________________________________________
4. Do you have group health plan coverage based on your own current employment or based on employment of your spouse? ___________. If yes please list name of Group health provider

QuickDASH - Initial Patient name:_______________________________________ Date:__________

**INSTRUCTIONS**
This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer every question, based on your condition in the last week, by circling the appropriate number.
If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.
It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

**1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN**

| | NO DIFFICULTY | MILD DIFFICULTY | MODERATE DIFFICULTY | SEVERE DIFFICULTY | UNABLE |
|---|---|---|---|---|---|
| 1. Open a tight or new jar | 1 | 2 | 3 | 4 | 5 |
| 2. Do heavy household chores (e.g., wash walls, floors). | 1 | 2 | 3 | 4 | 5 |
| 3. Carry a shopping bag or briefcase. | 1 | 2 | 3 | 4 | 5 |
| 4. Wash your back | 1 | 2 | 3 | 4 | 5 |
| 5. Use a knife to cut food. | 1 | 2 | 3 | 4 | 5 |
| 6. Recreational activities in which you take some force or impact through your arm, shoulder or hand(e.g., golf, hammering, tennis, etc.). | 1 | 2 | 3 | 4 | 5 |
| | NOT AT ALL | SLIGHTLY | MODERATELY | QUITE A BIT | EXTREMELY |
| 7. During the past week, to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups? | 1 | 2 | 3 | 4 | 5 |
| | NOT LIMITED AT ALL | SLIGHTLY LIMITED | MODERATELY LIMITED | VERY LIMITED | UNABLE |
| 8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? | 1 | 2 | 3 | 4 | 5 |
| Please rate the severity of the following symptoms in the last week. (circle number) | NONE | MILD | MODERATE | SEVERE | EXTREME |
| 9. Arm, shoulder or hand pain. | 1 | 2 | 3 | 4 | 5 |
| 10. Tingling (pins and needles) in your arm, shoulder or hand. | 1 | 2 | 3 | 4 | 5 |
| | NONE | MILD | MODERATE | SEVERE DIFFICULTY | SO MUCH DIFFFICULTY THAT I CAN'T SLEEP |
| 11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number) | 1 | 2 | 3 | 4 | 5 |