

Functional Reporting: PT, OT, and SLP Services Frequently Asked Questions (FAQs)

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Providers, Plans, and Payers Subject to Functional Reporting

Q1) What providers are required to include functional reporting on their claims?

A1) Functional Reporting is required of:

- Skilled Nursing Facilities (for beneficiaries in a Part B stay)
- Rehabilitation Agencies
- Home Health Agencies (for beneficiaries who are not under a Home Health plan of care, are not homebound, and whose therapy or other services are not paid under the Home Health prospective payment system)
- CORFs (PT, OT, and SLP services)
- Hospitals, including beneficiaries in Outpatient and Emergency Departments, and inpatients paid under Part B
- Critical Access Hospitals
- Therapists in Private Practice: Physical Therapists (PTs), Occupational Therapists (OTs), and Speech Language Pathologists (SLPs)
- Physicians: Medical Doctors (MDs), Doctors of Osteopathy (DOs), Doctors of Podiatric Medicine (DPMs), and Doctors of Optometry (ODs)
- NPPs: Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), and Physician Assistants (PAs)

Q2) Which Home Health claims are subject to the Functional Reporting requirements?

A2) Functional Reporting requirements apply to TOB 34X, which are Home Health claims for beneficiaries who are not under a Home Health plan of care, are not homebound, and whose therapy or other services are not paid under the Home Health prospective payment system. Medicare's outpatient therapy rules and regulations apply TOB 34X claims, including the therapy caps, the exceptions process, and the manual medical review required over the therapy thresholds of \$3,700.

Q3) Does Functional Reporting apply to the hospital inpatient beneficiary with Part B coverage who has exhausted his/her Part A benefit?

A3) If the beneficiary is admitted as an inpatient to a hospital without Part A, but with Part B, coverage, all Functional Reporting (including related documentation) requirements apply. In addition to the Functional Reporting requirements, all other outpatient therapy Part B rules and manual provisions apply.

Q4) Does Functional Reporting apply to Medicare Advantage Plans as well as regular Medicare?

A4) Medicare does not require Functional Reporting for Medicare Advantage Plans. However, providers should check with their plan to determine if the plan imposes requirements.

Q5) Does Functional Reporting apply when Medicare is the Secondary Payer?

A5) Yes, Functional Reporting is required when Medicare is the secondary payer.

How to Report Functional Information

Q6) Can therapists use any of the G-code sets or are they limited to those corresponding to their discipline?

A6) The category G-codes sets are not discipline specific. The G-code set that best describes the functional limitation being treated should be used, regardless of your discipline.

Q7) I have been reporting during the testing period, do I just continue or do I need to do something different?

A7) If you have been submitting Functional Reporting data during the testing period, you can continue reporting and will not need to restart Functional Reporting on the first date of service (DOS) on or after July 1, 2013 for episodes of care for which Functional Reporting began during the testing period. In other words, for those episodes of care, for which you included Functional Reporting on the claims for DOS prior to July 1, 2013, reporting after July 1, 2013 is required at the next regularly scheduled reporting.

Q8) I documented the G-codes and modifiers for the end of the primary functional limitation and those to begin the start of the second functional limitation in the progress report on 3/12/13. Is this acceptable or do the G-codes and modifiers for the second functional limitation need to be documented in the daily treatment note on the same day they are reported on the claim?

A8) Yes, you can document the G-codes and modifiers used to end the reporting period of the first (primary) functional limitation and those for the second functional limitation in the progress report. At the next treatment day, the therapist could simply note where the G-codes and

modifiers for the second functional limitation are located in the medical record. For example, the therapist could document the following in the daily treatment note for 3/15/13: “The G-codes and modifiers used in today’s functional reporting are found in the progress report dated 3/12/13.”

Q9) In the above scenario, could a therapy assistant furnish the therapy services on the day that the second functional limitation is reported on the claim?

A9) Yes, the therapy assistant who furnished the services can report the G-codes and modifiers to begin reporting for a second functional limitation when a therapist previously determined the functional information.

Q10) When I begin reporting on my patient’s second functional limitation, how do I report the severity of its current status? Do I use the severity modifier that reflected the current status at the time of the initial evaluation or the one from the time I began reporting?

A10) The severity modifier used to indicate the beneficiary’s current status, reflects the severity of the functional limitation at the time of the visit for which Functional Reporting occurred. [Note: The severity modifier used to report the goal status of the second (or other subsequent functional limitation) would be the same as that established in the plan of care unless the goal has been modified as a result of a significant change in the beneficiary’s condition.]

Q11) Do I need to end reporting of the current primary functional limitation when a new functional limitation develops, e.g. a new condition, before reporting on the second functional limitation?

A11) You need to end reporting on the first functional limitation by reporting the appropriate goal and discharge status codes before reporting on a second functional limitation can begin. Discharge reporting applies in all situations, except when the patient unexpectedly does not return to therapy and discharge information is not available.

Q12) How do I report the functional information when I provide an evaluation only and determine that the patient does not need further therapy services?

A12) For one-time visits, you report all three G-codes for the functional limitation being evaluated, along with the corresponding severity modifiers for each.

Q13) Does Functional Reporting apply to beneficiaries in observation status in the hospital?

A13) Yes. Observation services are, by Medicare’s definition, outpatient services in the hospital. As such, Functional Reporting applies. Once the decision is made to admit the beneficiary to the inpatient hospital, Functional Reporting no longer applies. If the beneficiary’s treatment was furnished on just one date of service, the therapist would report all three (3) G-codes in the set for the functional limitation being reported.

Q14) How do I report an evaluative procedure when it is for a different functional limitation than I am currently reporting?

A14) You should report the evaluative procedure furnished for a second/different functional limitation other than the primary functional limitation for which ongoing reporting is occurring as a one-time visit (i.e., report all three (3) G-codes in the code set for the functional limitation that most closely matches that for which the evaluative procedure was furnished). The ongoing reporting of a primary functional limitation is not affected when all three (3) G-codes in a code set are reported for the evaluative procedure for a second functional limitation. Note: The reporting of all 3 G-codes for the evaluative procedure for a second functional limitation and the ongoing reporting of a primary functional limitation CAN both occur on the same date of service.

Q15) How do I report functional information when the beneficiary has two plans of care from two different physicians for separate conditions?

A15) Assuming the same provider submits the claim for services under both POCs, only one functional limitation can be reported at a time per discipline. You will need to decide upon which POC Functional Reporting will occur. Treatment days for both conditions are counted towards the reporting frequency – counting each treatment day towards the total number of days the beneficiary received services, under both POCs. Note: It counts as one treatment day when services are received on the same date of service under both POCs.

Assessment Tools

Q16) Is there a list of Medicare-approved functional assessment tools?

A16) CMS does not have a list of approved or endorsed functional assessment tools.

Q17) What do I need to do if I use a functional assessment tool where 100 means no disability and zero (0) means totally disabled to obtain the severity modifier? Can I directly crosswalk the score from the tool to the CMS severity modifier scale to select the modifier?

A17) You will need to convert the score from the “wellness” scale, a scale in which 100 means no disability, to the CMS “disability” scale in which zero (0) means no disability. For example, if a beneficiary scored 60 (out of 100) where 100% means no disability), this score converts to a 40 on a scale where 100% means totally disabled. To make this conversion, the wellness score of 60 is subtracted from 100 to yield a score of 40 on the disability scale.

Q18) Should I report the “other” PT/OT G-codes when using a functional assessment tool that yields a “composite” score?

A18) A PT/OT categorical G-code set should be reported when it best describes the functional limitation being treated – even though the assessment tool used surveyed the beneficiary’s overall functional abilities, such as the ability to carry out his/her daily routine and other quality of life measures.

There may be times, however, that the “other” PT/OT G-code sets will be appropriate, especially when the beneficiary’s functional limitation is not described by one of the four (4) categories of functional limitations or the beneficiary is not being treated for a functional limitation.

Claims Requirements

Q19) Are revenue codes required on the line of service for the nonpayable functional G-codes for institutional claims?

A19) Yes, on the line of service for each nonpayable functional G-code, use the appropriate therapy revenue code – 420, 430, or 440 – to correspond to the therapy modifier – GP, GO, or GN, respectively.

Q20) Can I use the general therapy revenue code – 420, 430, or 440 – for all functional reporting on institutional claims or, do I have to use revenue codes – 424, 434, or 444 – when billing for an evaluative procedure?

A20) You are not required to use the revenue codes specific to evaluation – 424, 434, or 444 – when functional reporting is related to billing for an evaluative procedure.

Q21) Does the “units” field need to be completed for the functional G-code line of service?

A21) Yes. The “units” field is required to be completed. Use “1” to complete the “units” field.

Q22) Are the KX and 59 modifiers required on claims with the G-codes when they are applicable to other codes on the claim?

A22) No, the KX and 59 modifiers are not appropriate and should not be used on the line of service with the functional G-codes.