

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



MLN Matters® Number: MM9698 **Revised** Related Change Request (CR) #: CR 9698
Related CR Release Date: December 1, 2016 Effective Date: January 1, 2017
Related CR Transmittal #: R3670CP Implementation Date: April 3, 2017

Update to Editing of Therapy Services to Reflect Coding Changes

Note: We revised this article on March 5, 2019, to inform providers that, as established through CY 2019 PFS rulemaking, effective for dates of service on or after January 1, 2019, Medicare no longer requires the functional reporting nonpayable HCPCS G-codes and severity modifiers – adopted to implement section 3005(g) of MCTRJCA – on claims for therapy services. For details about these payment policies, see MLN Matters article MM11120 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11120.pdf>.

Provider Types Affected

This MLN Matters® Article is intended for providers submitting claims to Medicare Administrative Contractors (MACs) for physical and occupational therapy services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9698 instructs the MACs to apply certain coding edits to the new Current Procedural Terminology (CPT) codes that are used to report physical and occupational therapy evaluations and re-evaluations, effective January 1, 2017. Make sure your billing staffs are aware of these coding changes.

Background

Original Medicare claims processing systems contain edits to ensure claims for the evaluative procedures furnished by rehabilitative therapy clinicians – including physical therapists, occupational therapists and speech-language pathologists – are coded correctly. These edits ensure that when the codes for evaluative services are submitted, the therapy modifier (GP, GO or GN) that reports the type of therapy plan of care is consistent with the discipline described by

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the evaluation or re-evaluation code. The edits also ensure that Functional Reporting occurs, that is, that functional G-codes, along with severity modifiers, always accompany codes for therapy evaluative services.

For calendar year (CY) 2017, eight new CPT codes (97161-97168) were created to replace existing codes (97001-97004) to report physical therapy (PT) and occupational therapy (OT) evaluations and reevaluations. The new CPT code descriptors include specific components that are required for reporting as well as the typical face-to-face times. In another recent issuance, CR 9782, the Centers for Medicare & Medicaid Services (CMS) described the new PT and OT code sets, each comprised of three new codes for evaluation – stratified by low, moderate, and high complexity – and one code for re-evaluation. CR 9782 designated all eight new codes as “always therapy” (always require a therapy modifier) and added them to the 2017 therapy code list located at <http://www.cms.gov/Medicare/Billing/TherapyServices/index.html>. For a complete listing of the new codes, their CPT long descriptors, and related policies, see the article related to CR 9782 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9782.pdf>.

CR 9698 applies the coding requirements for certain evaluative procedures that are currently outlined in the “Medicare Claims Processing Manual,” Chapter 5 to the new codes for PT and OT evaluations and re-evaluations. These coding requirements include the payment policies for evaluative procedures that (a) require the application of discipline-specific therapy modifiers and (b) necessitate Functional Reporting using G-codes and severity modifiers. The new codes are also added to the list of evaluation codes that CMS will except from the caps after the therapy caps are reached when an evaluation is necessary, for example, to determine if the current status of the beneficiary requires therapy services.

This notification implements the following payment policies related to claims for therapy services for the new codes for physical therapy (PT) and occupational therapy (OT) evaluative procedures – claims without the required information will be returned as unprocessable:

Therapy modifiers. The new PT and OT codes are added to the current list of evaluative procedures that require a specific therapy modifier to identify the plan of care under which the services are delivered to be on the claim for therapy services. Therapy modifiers GP, GO or GN are required to report the type of therapy plan of care – PT, OT, or speech language pathology (SLP), respectively. This payment policy requires that each new PT evaluative procedure code – 97161, 97162, 97163 or 97164 – to be accompanied by the GP modifier; and, (b) each new code for an OT evaluative procedure – 97165, 97166, 97167 or 97168 – be reported with the GO modifier.

Functional Reporting. In addition to other Functional Reporting requirements, current payment policy requires Functional Reporting, using G-codes and severity modifiers, when an evaluative procedure is furnished and billed. CR9698 adds the eight new codes for PT and OT evaluations and reevaluations – 97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168 – to the procedure code list of evaluative procedures that necessitate Functional Reporting. A severity

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modifier (CH – CN) is required to accompany each functional G-code (G8978-G8999, G9158-9176, and G9186) on the same line of service.

For each evaluative procedure code, Functional Reporting requires either two or three functional G-codes and related severity modifiers be on the same claim. Two G-codes are typically reported on specified claims throughout the therapy episode. However, when an evaluative service is furnished that represents a one-time therapy visit, the therapy clinician reports all three G-codes in the functional limitation set – G-codes for Current Status, Goal Status and Discharge Status. For the documentation requirements related to Functional Reporting, please refer to the “Medicare Benefits Policy Manual,” Chapter 15, Section 220.4.

CMS coding requirements for Functional Reporting applied through CR9698 ensure that at least two G-codes in a functional set and their corresponding severity modifiers are present on the same claim with any one of the codes on this evaluative procedure code list. The required reporting of G-codes includes: (a) G-codes for Current Status and Goal Status; or, (b) G-codes for Discharge Status and Goal Status. Remember that your MAC will Return to the Provider (RTP):

1. Claims you submit for the new therapy evaluative procedures, HCPCS codes 97161-97168, without including one of the following pairs of G-codes/severity modifiers required for Functional Reporting: (a) A current status G-code/severity modifier paired with a goal status G-code/severity modifier; or, (b) A goal status G-code/severity modifier paired with a discharge status G-code/severity modifier.
2. Institutional outpatient claims reporting HCPCS codes 97161, 97162, 97163, and 97164 that you submit without including modifier GP.
3. Institutional outpatient claims reporting HCPCS codes 97165, 97166, 97167, and 97168, that you submit without including modifier GO.

Additional Information

The official instruction, CR9698, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3670CP.pdf>. The updated “Medicare Claims Processing Manual,” Chapter 5 (Part B Outpatient Rehabilitation and CORF/OPT Services), Sections 10.3.2 (Exceptions Process), 10.6 (Functional Reporting), and 20.2 (Reporting of Service Units with HCPCS) is attached to CR9698.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

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DOCUMENT HISTORY

Date of Change	Description
March 5, 2019	<p>We revised this article to inform providers that, effective for services on or after January 1, 2018, Section 50202 of the Bipartisan Budget Act (BBA) of 2018 repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold of incurred expenses above which claims must include a KX modifier as confirmation that services are medically necessary as justified by appropriate documentation in the medical record; and retains the targeted medical review process, but at a lower threshold amount. In addition, effective for dates of service on or after January 1, 2019, as established through CY 2019 PFS rulemaking, Medicare no longer requires the functional reporting nonpayable HCPCS G-codes and severity modifiers – adopted to implement section 3005(g) of MCTRJCA of 2012 – on claims for therapy services. For details, see MLN Matters article MM11120 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11120.pdf.</p>
December 6, 2016	Initial article released

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