DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM8166 Revised **Related Change Request (CR) #: CR 8166**

Related CR Release Date: March 8, 2013 **Effective Date: April 1, 2013**

Related CR Transmittal #: R1196OTN **Implementation Date: April 1, 2013**

Outpatient Therapy Functional Reporting Non-Compliance Alerts

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 physicians and other providers who submit claims to Medicare contractors (carriers or Part B Medicare Administrative Contractors (B MACs)) for outpatient therapy services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 8166, from which this article is taken implements alert messaging that conveys supplemental information regarding your claims for outpatient therapy from April 1, 2013, through June 30, 2013.

For therapy claims, with dates of service on and after January 1, 2013, processed on and after April 1, 2013, through June 30, 2013, you will receive a Remittance Advice (RA) message to alert you to include the applicable new functional limitation G-codes (from the list of 42) and the appropriate severity/complexity modifier (from the list of 7) on future specified therapy claims.

Your carrier or B MAC will continue to process and adjudicate your therapy claims without the required G-codes and severity/complexity modifier.

Please note that no changes are being made to the policy on the claims-based data collection for outpatient therapy.

Background

Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA) (see https://www.congress.gov/112/plaws/publ96/PLAW-112publ96.pdf) states that "The Secretary of Health and Human Services shall implement, beginning on January 1, 2013, a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of Section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)). Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes."

In response, CMS issued regulations on November 1, 2012 creating such a system The Centers for Medicare & Medicaid Services (CMS implemented a new claims-based data submission requirement for outpatient therapy services, effective January 1, 2013. It requires reporting with 42 new non-payable functional Healthcare Common Procedure Coding System (HCPCS) G-codes and 7 new severity/complexity modifiers on claims for Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services. (You can find the associated MLN Matters® Article at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8005.pdf on the CMS website.

Dates to Remember

A testing period is in effect from January 1, 2013, through June 30, 2013, during which claims without the required G-codes and severity/complexity modifier will be processed to allow providers to use the new coding requirements to assure that your systems work. During the testing period, your carrier or B MAC will continue to process and adjudicate your therapy claims without the required G-codes and severity/complexity modifier.

For therapy claims, with dates of service on and after January 1, 2013, processed on and after April 1, 2013, through June 30, 2013, contractors will send alerts reminding you to include the new functional limitation G-codes (from the list of 42) and the appropriate severity/complexity modifier (from the list of 7) on future specified therapy claims through a new RA message. The scenarios below illustrate what will be effective April 1, 2013.

Effective April 1, 2013 to June 30, 2013

1. Effective for therapy claims with dates of service on or after January 1, 2013 and processed on and after April 1, 2013 through June 30, 2013, contractors will alert providers, who submit claims containing functional G-codes (G8978-G8999, G9158-G9176, and G9186) without a severity/complexity modifier (CH-CN), that functional G-codes require a severity/complexity modifier, and effective July 1,

2013, claims that do not include required functional reporting information will be returned or rejected. The following Claim Adjustment Reason Code (CARC) and RA Remark Code (RARC) will be used as the alert message:

- CARC 246 – "This non-payable code is for required reporting only" and
- RARC N565- "Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed." when nonpayable HCPCS codes G8978 to G8999, G9158 to G9176, or G9186 are submitted without the appropriate modifier (CH – CN).

2. Effective for therapy claims with dates of service on or after January 1, 2013 and processed on and after April 1, 2013, through June 30, 2013, contractors will alert providers, who submit claims containing any of the following CPT evaluation/re-evaluation therapy codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004 without functional information, that these codes require functional G-code(s) and appropriate severity/complexity modifier (s), and effective July 1, 2013, claims that do not include required functional reporting information will be returned or rejected. The following CARC and RARC will be used as the alert message:

   - CARC 246- "This non-payable code is for required reporting only." and
   - RARC N566- "Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed."" **when CPT codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003, or 97004 are submitted without the nonpayable HCPCS codes G8978 to G8999, G9158 to G9176, or G9186 and the appropriate modifier (CH – CN).**

Beginning July 1, 2013

- Beginning July 1, 2013, your claims will be returned or rejected using a new RA message when you do not comply with these reporting requirements.

Note: CR8166 is not applicable to institutional claims. There will be no alert messaging for institutional claims between April 1, 2013, and July 1, 2013.

Additional Information

You can find more information about outpatient therapy functional reporting non-compliance alerts by going to CR 8166, located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1196OTN.pdf on the CMS website.

You may want to refer to CR 8005, Pub 100-04, Transmittal 2622, dated December 21, 2012, for detailed instructions on the implementation of the 42 nonpayable G-codes and 7 severity/complexity modifiers.

You can find this at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2622CP.pdf.

The related MLN article may be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf.

For more information, please see the 2013 Physician Fee Schedule Final Rule in the Federal Register, dated November 16, 2013, at http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf.

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

Document History

Date of Change	Description
March 5, 2019	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.
March 18, 2013	Initial article released.