DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9933 Revised | **Related Change Request (CR) #: CR 9933**

Related CR Release Date: January 27, 2017 | **Effective Date: January 1, 2017**

Related CR Transmittal #: R1775OTN | **Implementation Date: July 3, 2017**

Updated Editing of Professional Therapy Services

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® is intended for physicians, therapists, and other practitioners who submit professional claims to Medicare Administrative Contractors (MACs) for therapy services provided to Medicare beneficiaries.

Provider Action Needed

Change request (CR) 9933 instructs the MACs to apply certain coding edits to the new Current Procedural Terminology (CPT) codes that are used to report physical therapy (PT) and occupational therapy (OT) 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 the evaluation or re-evaluation code. The edits also ensure that Functional Reporting occurs, which is to say that functional G-codes, along with severity modifiers, always accompany codes for therapy evaluative services. These edits were applied to institutional claims in CR9698. A related article is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9698.pdf. CR9933 applies these edits to professional claims.

For Calendar Year (CY) 2017, eight new CPT codes (97161-97168) were created to replace existing codes (97001-97004) to report PT and 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 CR9782, 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. CR9782 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 related article for CR9782 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9782.pdf.

CR9933 applies the coding requirements for certain evaluative procedures that are currently outlined in the "Medicare Claims Processing Manual (MCPM)," Chapter 5, to the new codes for PT and OT evaluative procedures. These new PT and OT codes 97161 – 97168 were added to the applicable code lists in MCPM, Chapter 5, by CR9698.

Key Points

CR9933 implements the following payment policies related to professional claims for therapy services for the new CPT codes for PT and OT evaluative procedures – claims without the required information will be returned/rejected:

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

CMS coding requirements for Functional Reporting applied through CR9933 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.

For the documentation requirements related to Functional Reporting, please refer to the "Medicare Benefits Policy Manual," Chapter 15, Section 220.4, which is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf.

Claims Coding Requirements:

Therapy Modifiers. Your MAC will return/reject professional claims when:

- Reporting codes 97161, 97162, 97163, or 97164 without the GP modifier.
- Reporting codes 97165, 97166, 97167, or 97168 without the GO modifier.
- Reporting an "always therapy" code without a therapy modifier

For these returned/rejected claims, your MAC will supply the following messages:

- Group code CO
- CARC – 4: The procedure code is inconsistent with the modifier used or a required modifier is missing.

Functional Reporting. Your MAC will return/reject claims when:

- The professional claims you submit for the new therapy evaluative procedures, 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.

Your MAC will provide the following remittance messages when returning such submissions:

- Group code of CO (contractual obligation)
- Claim Adjustment Reason Code (CARC) – 16: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- Remittance Advice Remarks Code (RARC) – N572: This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.

Additional Information

The official instruction, CR9933 issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1775OTN.pdf.

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	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.
February 27, 2019	Initial article released