DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Outpatient Therapy Functional Reporting Requirements

Note: We revised this article on March 4, 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® Special Edition Article is intended for physicians and providers submitting claims to Medicare contractors (Fiscal Intermediaries (FIs), Regional home Health Intermediaries (RHHIs), carriers, and A/B Medicare Administrative Contractors (MACs)) for Part B outpatient therapy services provided to Medicare beneficiaries.

Functional Reporting applies to all claims for therapy services furnished under the Medicare Part B outpatient therapy benefit and to Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services furnished under the Comprehensive Outpatient Rehabilitation Facility (CORF) benefit. Specifically, Functional Reporting is required of the following:

- Hospitals, including beneficiaries in Outpatient and Emergency Departments, and inpatients paid under Medicare Part B;
- Critical Access Hospitals;

- Skilled Nursing Facilities;
- Comprehensive Outpatient Rehabilitation Facilities;
- 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);
- Therapists in Private Practice: Physical Therapists, Occupational Therapists, and Speech Language Pathologists;
- Physicians: Medical Doctors, Doctors of Osteopathy, Doctors of Podiatric Medicine, and Doctors of Optometry; and
- Nonphysician Practitioners: Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants.

Provider Action Needed

This article describes the reporting requirements for Functional Reporting using 42 G-codes and seven severity/complexity modifiers.

The Functional Reporting data collection system is effective for therapy services with a Date of Service (DOS) on or after January 1, 2013. However, a testing period was in effect from January 1, 2013, through June 30, 2013, to allow providers to use the new coding requirements without penalty while they assured that their systems worked. During this period, claims were processed with or without the required G-codes and modifiers.

Background and Purpose of Functional Reporting

The Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012 required the Centers for Medicare & Medicaid Services (CMS) to implement a claims-based data collection strategy for outpatient therapy services. CMS developed this collection strategy known as "Functional Reporting" in the Calendar Year (CY) 2013 Physician Fee Schedule final rule (77 Federal Regulation (FR) 68958). Functional Reporting collects data on patient function during the therapy episode of care to understand beneficiary functional limitations and outcomes. Effective January 1, 2013, claims for outpatient therapy services are required to include non-payable G-codes and modifiers, which describe a beneficiary's functional limitation and severity level, at specified intervals during the therapy episode of care.

Functional Reporting Requirements

Definitions

A **reporting episode** is similar to the therapy episode of care. A reporting episode is defined as the period of time, based upon DOS, from the first reporting of functional codes for the functional limitation being treated by one therapy discipline (PT, OT, or SLP) until the date

of discharge (if one occurs) from the therapy episode. Within a reporting episode, there can be multiple reporting periods as defined below.

A **reporting period** covers the same period as progress reporting. A clinician (therapist, physician, or NPP) is required to report once every 10 treatment days. A reporting period is defined as the period from the first reporting of functional codes until reporting at the 10th treatment day. For subsequent reporting periods, the first visit is the treatment date following the 10th treatment date. Clinicians are permitted to report functional information prior to the 10th treatment day. Please note that a submission of G-codes and modifiers restarts the 10 day count towards the progress reporting period.

NOTE: A reporting episode links a beneficiary to a specific therapy Billing Provider NPI. For the purpose of tracking beneficiary's functional limitations, Functional Reporting data is reported **per beneficiary, per therapy discipline, and per Billing Provider NPI** on specified therapy claims for certain DOS.

Required Reporting of Functional Codes

Functional Reporting, using the G-codes and modifiers, is required on therapy claims for certain DOS as described below:

- At the outset of a therapy episode of care, i.e., on the DOS for the initial therapy service;
- At every progress reporting period, which occurs at least once every 10 treatment days;
- At the DOS that an evaluative or re-evaluative procedure code is submitted on the claim; and
- At the time of discharge from the therapy episode of care, unless discharge data is unavailable, for example, when the beneficiary discontinues therapy unexpectedly.

NOTE: Once one functional limitation is discharged and further therapy is medically necessary, reporting of the subsequent functional limitation begins on the next treatment DOS.

Discharge Reporting

Discharge reporting is required at the end of the reporting episode or to end reporting on one functional limitation prior to reporting on another medically necessary functional limitation. The exception is in cases where the beneficiary discontinues therapy expectantly. When the beneficiary discontinues therapy expectantly, we encourage clinicians to include discharge reporting whenever possible on the claim for the final services of the therapy episode.

When a beneficiary discontinues therapy without notice, and returns less than 60 calendar days from the last recorded DOS to receive treatment for:

- **The same functional limitation,** the clinician must resume reporting following the reporting requirements outlined in the "Required Reporting of Functional Codes" subsection; or
- **A different functional limitation,** the clinician must discharge the functional limitation that was previously reported and begin reporting on a different functional limitation at the next treatment DOS.

NOTE: A reporting episode will automatically be discharged when it has been 60 or more calendar days since the last recorded DOS.

Functional Reporting Example

In the example below, the self care G-code set (G8987-G8989) is used to illustrate the required reporting of functional G-codes and severity modifiers at specified reporting intervals. See the "Functional Reporting Codes" section for a complete list of G-codes and modifiers used in Functional Reporting.

	At the outset of the therapy episode of care	At the end of each progress reporting period	At the time of discharge from the therapy episode of care
Self Care G-code set (G8987-G8989)			
G8987 Current Status + Corresponding Modifier	X	X	
G8988 Goal Status + Corresponding Modifier	X	X	X
G8989 Discharge Status + Corresponding Modifier			X

If further therapy is medically necessary once reporting for the self care functional limitation has ended, the clinician may begin reporting on a subsequent functional limitation using the appropriate G-code set on the next treatment DOS.

Unique Functional Reporting Scenarios

When Functional Reporting is required at specified intervals for a treatment DOS, generally two G-codes are required. The following exceptions exist:

1. One-time therapy visit. When a beneficiary is seen for a one-time visit and future therapy services are either not medically indicated or are going to be furnished by a different provider, the clinician reports as a one-time visit. The clinician reports on the claim for the DOS of the visit, all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.

2. Reporting evaluative procedures for multiple POCs for the same therapy discipline. The clinician should report the evaluative procedure furnished under a separate/different POC for a functional limitation that is not subject to reporting as a one-time visit by reporting all three G-codes and corresponding severity modifiers for the functional limitation that most closely matches the evaluative procedure that was furnished.

3. Therapy services from more than one therapy discipline. Claims will contain more than two non-payable functional G-codes in cases where a beneficiary receives therapy services on the same treatment DOS from more than one therapy discipline (PT, OT, and/or SLP) from the same therapy provider.

NOTE: In unique scenario two, the DOS that functional codes are reported as a one-time visit alongside separately payable procedure code(s), including evaluative/re-evaluative services, does not count as a treatment day for the progress reporting period of the functional limitation subject to reporting.

Claims Requirements

Claims containing any of these functional G-codes must also contain:

- Another separately payable (non-bundled) service;
- Functional severity modifier in the range CH – CN;
- Therapy modifier indicating the discipline of the plan of care (POC) – GP, GO or GN – for PT, OT, and SLP services, respectively;
- Date of the corresponding payable service;
- Nominal charge, for example, a penny;
- Completion of the units field with "1" unit of service; and
- All other currently required claims data elements as described in the claims processing manuals.

Out of Sequence Claims

An out of sequence therapy claim has a DOS earlier than the last DOS recorded by the claims processing system. To avoid claims being returned or rejected, we encourage clinicians to submit claims in order by treatment DOS. An out of sequence claim that does not meet the Functional Reporting requirements outlined above may be returned or rejected and providers will need to resubmit the out of sequence claim, and possibly other claims, to correct the information.

Other Requirements

Evaluative Procedures

As described in the "Required Reporting of Functional Codes" subsection, Functional Reporting is always required when a HCPCS/CPT evaluation or re-evaluation code is reported on a DOS. These HCPCS/CPT codes are listed below:

Evaluation/Re-evaluation Codes

92506	92597	92607	92608	92610
92611	92612	92614	92616	96105
96125	97001	97002	97003	97004

NOTE: Clinicians are not required to furnish an evaluative or re-evaluative procedure every time G-codes and modifiers are reported. An evaluation or re-evaluation should be furnished when it is medically necessary and not solely for reporting at the required intervals.

Tracking and Documentation

The clinician furnishing the therapy services must report the functional information on the therapy claim, and must also track and document the G-codes and modifiers in the beneficiary's medical record of therapy services.

Transitioning From the Testing Period

For beneficiaries whose therapy episode of care and Functional Reporting began prior to July 1, 2013, clinicians do not need to restart Functional Reporting on the first DOS on or after July 1, 2013. Simply, report at the next required reporting interval that occurs on or after July 1, 2013.

For beneficiaries whose therapy episode of care began prior to July 1, 2013 but for whom Functional Reporting information has not been submitted prior to July 1, 2013, clinicians must report on the first claim with a treatment DOS on or after July 1, 2013, and document the beneficiary's functional status for that DOS in a progress report.

Functional Reporting Codes

G-codes are used to report a beneficiary's functional limitation being treated and note whether the report is on the beneficiary's current status, projected goal status, or discharge status. Modifiers are used to indicate the severity/complexity level of the functional limitation being reported. By reporting G-codes and modifiers on a periodic basis, a beneficiary's functional limitation is tracked throughout the therapy episode of care.

The Functional Reporting G-codes:

- have a status code indicator of Q =Therapy functional information code, used for required reporting purposes only;
- have no payment amounts or relative value units; and
- are "always therapy" codes, which requires the use of a therapy modifier (GP, GO, or GN). A separate article (see MLN Matters® Article MM8126 at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8126.pdf**) was issued to alert providers/suppliers and contractors that these non-payable functional G-codes are "always therapy" codes on the therapy code list.

Functional Reporting G-codes—Short Descriptors

The following Healthcare Common Procedure Coding System (HCPCS) G-codes are used to report the status of a beneficiary's functional limitations:

Mobility G-code set:

- G8978 Mobility status
- G8979 Mobility goal status
- G8980 Mobility D/C status

Changing & Maintaining Body Position G-code set:

- G8981 Body pos current status
- G8982 Body pos goal status
- G8983 Body pos D/C status

Carrying, Moving & Handling Objects G-code set:

- G8984 Carry current status
- G8985 Carry goal status
- G8986 Carry D/C status

Self Care G-code Set:

- G8987 Self care current status
- G8988 Self care goal status
- G8989 Self care D/C status

Other PT/OT Primary G-code Set:

- G8990 Other PT/OT current status
- G8991 Other PT/OT goal status
- G8992 Other PT/OT D/C status

Other PT/OT Subsequent G-code Set:

- G8993 Sub PT/OT current status
- G8994 Sub PT/OT goal status
- G8995 Sub PT/OT D/C status

Swallowing G-code Set:

- G8996 Swallow current status
- G8997 Swallow goal status
- G8998 Swallow D/C status

Motor Speech G-code Set: (Note: Codes in this set are not sequentially numbered)

- G8999 Motor speech current status
- G9186 Motor speech goal status
- G9158 Motor speech D/C status

Spoken Language Comprehension G-code Set:

- G9159 Lang comp current status
- G9160 Lang comp goal status
- G9161 Lang comp D/C status

Spoken Language Expressive G-code Set:

- G9162 Lang express current status
- G9163 Lang express goal status
- G9164 Lang express D/C status

Attention G-code Set:

- G9165 Atten current status
- G9166 Atten goal status
- G9167 Atten D/C status

Memory G-code Set:

- G9168 Memory current status
- G9169 Memory goal status
- G9170 Memory D/C status

Voice G-code Set:

- G9171 Voice current status
- G9172 Voice goal status
- G9173 Voice D/C status

Other Speech Language Pathology G-code Set:

- G9174 Speech lang current status
- G9175 Speech lang goal status
- G9176 Speech lang D/C status

Severity/Complexity Modifiers

For each non-payable G-code, a modifier must be used to report the severity level for that functional limitation. The severity modifiers reflect the beneficiary's percentage of

functional impairment as determined by the clinician furnishing the therapy services. Therefore, the beneficiary's current status, projected goal status, and discharge status are reported via the appropriate severity modifiers. The following table includes the seven modifier's definitions.

Modifier	Impairment Limitation Restriction
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

Other Information

Remittance Advice Messages

Medicare will return a Claim Adjustment Reason Code 246 (This non-payable code is for required reporting only.) and a Group Code of CO (Contractual Obligation) assigning financial liability to the provider. In addition, beneficiaries will be informed via Medicare Summary Notice 36.7 that they are not responsible for any charge amount associated with one of these G-codes.

Additional Resources

There are related MLN Matters® Articles that you may want to review:

- MM8126 - "2013 Annual Update to the Therapy Code List," discusses the 42 "Always Therapy" Codes, which are non-payable and for use only in Functional Reporting, and is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8126.pdf** on the CMS website.
- MM8166 - "Outpatient Therapy Functional Reporting Non-Compliance Alerts" inform providers of alert messaging that conveys supplemental information regarding your claims for outpatient therapy during the 6-month Functional Reporting testing period of January 1, 2013, to June 30, 2013, to allow you to use the new G-codes to assure that your systems work. It is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8166.pdf** on the CMS website.

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

You are encouraged to go to the Therapy Services page at **http://www.cms.gov/Medicare/Billing/TherapyServices/index.html** on the CMS website for more information and links related to this article.

Document History

Date of Change	Description
March 4, 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.
August 29, 2017	The article was revised to add a reference to MLN Matters Article, MM10176. MM10176 clarifies "Always Therapy" and provides guidance on the correct modifiers to use.
July 24, 2013	Initial article released.