Preparing for Therapy Required Functional Reporting Implementation in CY 2013

National Provider Call

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Preparing for Therapy Functional Reporting Implementation in CY 2013

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Preparing for Therapy Functional Reporting Implementation in CY 2013

Agenda

- Overview
- Professionals and providers affected
- Nonpayable G-codes used to report functional limitations
- Modifiers used to report the severity of functional limitations
- Reporting requirements
- Documentation requirements
- Question and answer session

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Overview of the Functional Reporting Requirement

The Law: Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012

Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) amended Section 1833(g) of the Social Security Act to require a claims-based data collection system for outpatient therapy services, including physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. The system will collect data on beneficiary function during the course of therapy services in order to better understand beneficiary conditions, outcomes, and expenditures. This data will be used in developing an improved payment system.

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Overview of the Functional Reporting Requirement

Requires CMS to implement by January 1, 2013:

- Part of the Medicare Physician Fee Schedule rulemaking
  - Notice of Proposed Rulemaking (NPRM) – issued July 6, 2012
  - Final Rule – issued November 1, 2012
- Implemented Functional Reporting with a 6-month testing period
  - January 1 through June 30, 2013
- Claims will be returned/rejected without applicable G-codes and modifiers for dates of services on and after:
  - July 1, 2013

Functional Reporting Applies to:

- Medicare Part B outpatient (OP) therapy benefit
- PT, OT, SLP Services in Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Therapy services furnished personally and incident to physicians and certain nonphysician practitioners (NPPs)

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Professionals and Providers Affected

Professionals:

- Therapists in Private Practice: Physical Therapists, Occupational Therapists & Speech Language Pathologists
- Physicians: Medical Doctors (MDs), Doctors of Osteopathy (DOs), Doctors of Podiatric Medicine (DPMs), & Doctors of Optometry (ODs)
- NPPs: Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), & Physician Assistants (PAs)

Providers:

- Outpatients (OPs) and inpatients (IPs) receiving Part B therapy services
- Rehabilitation Agencies
- Home Health Agencies (HHAs)
- CORFs
- Outpatient Hospitals, including Emergency Departments
- Critical Access Hospitals

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Nonpayable G-codes Used to Report Functional Limitations

G-codes are "Always Therapy" Codes

- Require a therapy modifier:
  - GP – under a PT plan of care (POC)
  - GO – under an OT POC
  - GN – under an SLP POC

Each functional G-code set contains:

- Current status
- Projected Goal Status
- Discharge Status

There are 42 functional G-codes, 14 sets of 3 codes each. Generally, 6 of the G-code sets are used for PT and OT functional limitations and eight of the G-code sets are for SLP functional limitations.

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42 Functional G-codes, 14 Sets of 3 Codes Each

The 6 sets typically reported for PT or OT:

- *4 sets are for categorical functional limitations:*
  - Mobility: Walking & Moving Around
  - Changing & Maintaining Body Position
  - Carrying, Moving and Handling Objects
  - Self Care
- *2 sets are for "Other" functional limitations:*
  - Other PT/OT Primary
  - Other PT/OT Subsequent

The 8 sets typically reported for SLP:

- *7 sets are for categorical measures:*
  - Swallow
  - Motor Speech
  - Spoken Language Comprehension
  - Spoken Language Expression
  - Attention
  - Memory
  - Voice
- *1 set is for "Other":*
  - Other SLP

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Guidelines for Selecting the G-codes to Report

Select the G-code set for the functional limitation that most closely relates to the primary functional limitation being treated or the one that is the primary reason for treatment.

- Without restriction by discipline.

When the beneficiary has more than one functional limitation, the therapist may need to make a determination as to which functional limitation is primary. In these cases, the therapist may choose the functional limitation that is:

1) Most clinically relevant to a successful outcome for the beneficiary;
2) The one that would yield the quickest and/or greatest functional progress (e.g., select mobility over self-care even though both are addressed simultaneously and therapist expects beneficiary will attain self care goals before mobility goal); or
3) The one that is the greatest priority for the beneficiary.

In all cases, this primary functional limitation should reflect the predominant limitation that the furnished therapy services are intended to address.

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Guidelines for Selecting the G-codes to Report

The "Other PT/OT" functional G-codes are used when one of the four PT/OT categorical code sets does not describe the beneficiary's functional limitation, as follows:

- a beneficiary's functional limitation that is not defined by one of the four categories;
- a beneficiary whose therapy services are not intended to treat a functional limitation; or
- a beneficiary's functional limitation where an overall, composite, or other score from a functional assessment tool is used and does not clearly represent a functional limitation defined by one of the above four categorical PT/OT code sets.

The "Other SLP" functional G-code is used to report any other functional limitation not represented by one of the other 7 categorical SLP functional measures.

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Modifiers Used to Report the Severity of Functional Limitations

For each nonpayable functional G-code, one of the modifiers listed below must be used to report the severity/complexity for that functional limitation:

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

- The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the therapist, physician, or NPP furnishing the therapy services.
- Severity modifiers are required to be reported with each functional G-code

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Guidelines for Selecting the Severity Modifier

- Use the severity modifier that reflects the score from a functional assessment tool or other performance measurement instrument, as appropriate.
- In cases where the therapist uses multiple measurement tools during the evaluative process to inform clinical decision making, clinical judgment is used to combine these results to determine a functional limitation percentage.
- Therapists can use their clinical judgment in the assignment of the appropriate modifier. Therapists will need to document in the medical record how they made the modifier selection so that the same process can be followed at succeeding assessment intervals.
- Use the CH modifier to reflect a zero percent impairment when the therapy services being furnished are not intended to treat a functional limitation.
- In some cases for beneficiaries where improvement is expected to be limited, the same severity modifier may be used in reporting the current and goal status.
- In cases where the therapist does not expect improvement, such as for those individuals receiving maintenance therapy, the modifier used for projected goal status will be the same as the one for current status.

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Reporting Requirements

Condition of coverage and payment – Required Reporting

- Claims submitted for outpatient (and CORF) PT, OT, and SLP services must contain the information on beneficiary functional limitations.
  - 42CFR410.59, 60, and 62
  - Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6

Functional reporting is required on claims throughout the entire episode of care:

- Only one functional limitation shall be reported at a time
- However, a second functional limitation will be reported for some beneficiaries:
  - When the beneficiary has reached his or her goal or progress has been maximized on the initially reported functional limitation, but the need for treatment continues, reporting is required for a second functional limitation using another set of G-codes.
  - In these situations two or more functional limitations will be reported for a beneficiary during one therapy episode of care.
  - Thus, reporting on more than one functional limitation may be required for some patients, but not simultaneously.

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Reporting Requirements

Reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims:

- At the outset of a therapy episode of care (i.e., on the claim for the date of service (DOS) of the initial therapy service);
- At least once every 10 treatment days, which corresponds with the newly-revised progress reporting period;
- When an evaluative procedure, including a re-evaluative one, is furnished and billed
  - Applies to: Current Procedural Terminology (CPT) codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 97001, 97002, 97003, & 97004;
- At the time of discharge from the therapy episode of care–(i.e., on the date services related to the discharge report are furnished);
- At the time reporting of a particular functional limitation is ended in cases where the need for further therapy is necessary (i.e., before reporting on a different functional limitation begins); and
- At the time reporting is begun on a different (second, third, etc.) functional limitation within the same episode of care

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Reporting Requirements

The number of functional G-codes required on a claim under one therapy POC will be two:

- Current status and goal status
- Discharge Status and goal status

It is possible, however, for a claim to contain more than 2 nonpayable G-codes in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.

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Reporting Requirements

Each reported functional G-code must also contain the following essential line of service information:

- Functional severity modifier
- Therapy modifier indicating the related discipline/POC – GP, GO or GN – for PT, OT, and SLP services, respectively
- Date of the related therapy service
- Nominal charge, e.g., a penny, for institutional claims submitted to the Fiscal Intermediaries (FIs) and Medicare Part A Medicare Administrative Contractors (A/MACs). For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.

In addition, claims containing any of these functional G-codes must also contain another billable and separately payable (non-bundled) service.

Note: The KX and 59 modifiers are not applicable to the line of service for the functional G-codes.

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Reporting Requirements

Reporting Frequency:

- The functional reporting period matches the progress reporting period
- Progress reporting period frequency is changed, effective January 1, 2013.
  - Currently: Once every 10th treatment day or every 30 calendar days, whichever is less
  - January 1, 2013: Once on or before the 10th treatment day
- Reporting frequency:
  - Outset of therapy episode
  - At the end of progress/functional reporting period
  - At the time an evaluation or re-evaluation is furnished & billed
  - At discharge
  - To end reporting of one functional limitation
  - To begin reporting of a different functional limitation

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Documentation Requirements

Condition of coverage and payment:

- The beneficiary functional limitations(s) reported on claims, as part of the functional reporting, must be consistent with the functional limitations identified as part of the therapy plan of care and expressed as part of the beneficiary's anticipated long term goals
    - 42CFR410.61 and 42CFR410.105
    - Pub. 100-04, Medicare Claims Processing Manual, chapter 5, section 10.6

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Documentation Requirements

Documentation of the G-codes and severity modifiers used in complying with the requirements for Functional Reporting must be included in the beneficiary's medical record of therapy services for each required reporting.

This documentation must be completed by:

- The qualified therapist furnishing the therapy services
- The physician/NPP personally furnishing the therapy services
- The qualified therapist furnishing services incident to the physician/NPP
- The physician/NPP for incident to services furnished by "qualified personnel" who are not qualified therapists.
- The qualified therapist furnishing the PT, OT, or SLP services in a CORF

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Documentation Requirements

Documentation of information used in functional reporting is required at each time functional reporting is required (recap from above):

- At the outset of a therapy episode of care
- At least once every 10 treatment days
- When an evaluative procedure is furnished and billed
- At the time of discharge from the therapy episode of care
- At the time reporting of a particular functional limitation is ended (and further therapy is necessary)
- At the time reporting is begun on a different (second, third, etc.) functional limitation

The clinician documents, on the applicable dates of service, the specific nonpayable G-codes and severity modifiers used in the required reporting of the beneficiary's functional limitation on the claim for services– including how the modifier selection was made – such as, where the therapist:

- uses a single functional assessment tool;
- uses more than one functional assessment tool/measurement instrument to determine the severity modifier used; or
- uses clinical judgment to determine the severity modifier.

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Documentation Requirements

Where to document in the medical record?

The G-codes and severity modifiers used in functional reporting are also required to be documented in the beneficiary's medical record of therapy services at the time of each required reporting, on the same date of service. This documentation is required:

- **At the outset of the episode of care, i.e., the initial therapy service**
  - Document in the evaluation, plan of care, or treatment note.
    - ❖ Example: When the evaluation and POC are not established by the clinician delivering the therapy services, document in the treatment note from the initial therapy service.
  - Where no therapy evaluation and POC are applicable -- such as when a physician conducts an evaluation and management (E/M) service and develops the therapy plan of care, complete with the long term goals; but, a qualified therapist furnishes the therapy services, the therapist documents, appropriately, in the treatment note for the first treatment day.

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Documentation Requirements

Where to document in the medical record?

- **At the end of each progress reporting period**
  - Document in the progress report
- **When a re-evaluation is necessitated and billed (such as when prompted by a significant change in the beneficiary's functional condition)**
  - Document in the re-evaluation or related treatment note
- **At the time of discharge from the therapy episode, or, to end reporting on a particular functional limitation before the reporting on a different functional limitation is begun**
  - Document in the discharge note or summary
  - Document in the progress note related to the end of that functional limitation
- **At the first treatment day after the progress report that ended the previous functional limitation**
  - Document in the treatment note of the initial service at the time the reporting of a new functional limitation begins.

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Chart 1. Example of Required Reporting

The chart below illustrates when reporting is required and what G-codes would be used for the scenario in which a beneficiary has two functional limitations at the outset of the therapy episode. The therapist reports the mobility one first. The second functional limitation is not defined by any of the other 3 categorical G-code sets.

Key: Reporting Period (RP)	Begin RP #1 for Mobility at Episode Outset	End RP#1for Mobility at Progress Report	Mobility RP #2 Begins Next Treatment Day	End RP #2 for Mobility at Progress Report	Mobility RP #3 Begins Next Treatment Day	D/C or End Reporting for Mobility	Begin RP #1 for Other PT/OT Primary
Mobility: Walking & Moving Around							
G8978 – Current Status	X	X		X			
G 8979– Goal Status	X	X		X		X	
G8980 – Discharge Status						X	
Other PT/OT Primary							
G8990 – Current Status							X
G8991 – Goal Status							X
G8992 – Discharge Status							
No Functional Reporting Required			X		X		

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Chart 2. Timing and G-codes Used in Documentation

Example: The chart below indicates the timing and the G-codes that are used to document in the beneficiary's medical record of therapy services. In this example of a PT episode of care, the "Mobility" G-code set is used to illustrate the first reported functional limitation and the G-code set for "Other PT/OT Primary" is used for the second reported functional limitation.

Documenting Functional G-codes & Severity Modifiers	Outset Therapy Episode or the Initial Service	At the End of Each Progress Reporting Period	At the Time of Discharge from Therapy Episode	When an Evaluation or a Re-eval is Furnished & Billed	When Ending the Reporting of a Functional Limitation	At the Time a New Functional Limitation is Reported. Initial Service of New Progress Reporting Period
G8978 Mobility	X	X		X		
G8979 Mobility	X	X	X	X	X	
G8980 Mobility			X		X	
G8990 Other PT/OT						X
G8991 Other PT/OT						X
G8992 Other PT/OT						

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Thank you!

Question & Answer Session

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