

**“Preparing for Therapy Functional Reporting Implementation in CY 2013”
National Provider Call
Moderator: Charlie Eleftheriou
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Operator: At this time I would like to welcome everyone to today's Preparing for Therapy Functional Reporting Implementation in CY 2013 National Provider Call. Our lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, he may disconnect at this time.

I will now turn the call over to Charlie Eleftheriou. Thank you sir, you may begin.

Announcements and Introduction

Charlie Eleftheriou: Hello, this is Charlie Eleftheriou from the provider communications group here at CMS, and I'll serve as your moderator today. I'd like to welcome everyone to today's National Provider Call to discuss preparing for therapy functional reporting implementation in calendar year 2013. This call is part of the Medicare learning network, your source for official CMS information for Medicare fee-for-service providers.

Today we'll cover the new functional reporting requirements for outpatient therapy services, including physical therapy, occupational therapy and speech language pathology services, effective January 1st, 2013. The presentation will be followed by a question-and-answer session giving participants an opportunity to provide input and ask questions of our subject matter experts.

Before we get started, there are a few items I'd like to cover. There is a slide presentation for this session. A link to the call materials for today were included in your registration reminder e-mails and was also e-mailed to all registrants today after the close of registration. If you did not receive these e-mails, please check your spam or junk mail folders. The presentation can be found at the following Web site: www.cms.gov/npc as in National Provider Call. That's www.cms.gov/npc and then click on the National Provider Calls, an events link on the left side navigation panel, and find today's call by date on the list.

In addition to the presentation, you'll also find a link to the MLN matters article MM8005 implementing the claims-based data collection requirements for outpatient therapy service and a document titled "Therapy Functional Reporting G Codes, Short Descriptors."

Next, we'd like to thank all of you who submitted questions when you registered for today's call. The questions were shared with the presenters to help prepare for the call. Please keep in mind that we may not be able to address every individual question during this call. Lastly, a reminder that the call is being recorded and transcribed. An audio recording and written transcript will be posted to the National Provider Call's webpage in approximately three weeks.

Now with that said, I'd like to turn the call over to Pamela West, health insurance specialist and lead policy analyst for outpatient therapy services in the CMS Division of Practitioner Services. Pam?

Presentation

Pam West: Thank you, Charlie. I'd like to begin today by telling you that our goal for today is to give a clear picture of our policy related to therapy function reporting. In the course of the presentation, I hope to answer many of the questions that were submitted when you registered for this call. I'm beginning on slide number three where I'll just go over the agenda.

First, we'll give an overview where we'll review the law, the regulations, and the rules for the new required functional reporting. Next, we will talk about the professional providers that are affected. The G-codes that are used to report the functional limitations we'll review next. After that, we'll talk about the modifiers that are used to report the severity of the functional limitations. And finally, the reporting requirements and documentation requirements will be explained. Finally, the question-and-answer session which I hope will be able to address all your unanswered questions that remain.

Slide four outlines the law that (INAUDIBLE) the functional reporting requirements in effect, and that is section 3005(g) of the Middle Class Tax Relief and Job Creation Act of 2012. I refer to this act as MCTRJCA. It was signed by President Obama on February 22nd, 2012. Section 3005 of MCTRJCA and then the Social Security Act for therapy services requires that a claims-based data collection system for outpatient therapy services include physical therapy, occupational therapy, and speech-language pathology services. The system will collect data on beneficiary functions during the course of therapy services in order to better understand beneficiary conditions and outcome and expenditures. CMS hopes to use this data to aid us in developing an improved payment system for outpatient therapy services.

On slide five, the MCTRJCA law requires CMS to implement this system by January 1st. In order to get this done, we had to include this as part of our physician fee schedule rulemaking. Our proposed rule was issued on July 6th of 2012. We received over 200 comments from therapists and therapy providers, as well as therapy organizations across the country. Some of the organizations represented members of therapists; others of therapy providers. And some organizations represented beneficiaries who benefit from the many outpatient therapy services. We carefully reviewed all your comments and considered them before crafting our final rule which was (INAUDIBLE) our rule which was issued on November 1st.

We implemented the functional reporting requirement with a six-month testing period so that claims—your claims for therapy services could—your systems could be tested during this period of from January 1st through June 30th, 2013. After the testing periods, claims will be returned or rejected that don't contain the applicable G codes and modifiers for dates of service on and after July 1st, 2013. The functional reporting requirement applies to beneficiaries receiving services under several benefits.

The first benefit, of course, is the Medicare Part B outpatient therapy benefit. The second is the comprehensive outpatient rehabilitation facility benefit and that applies to just the PT, OT, and SLP services provided there. And finally, the third is the therapy services

furnished personally by or incident to physician and non-physician practitioners delivering therapy services.

On slide six, I'll review the professionals and providers affected. For the professionals, first is the therapist enrolled as private practitioner. That includes all the physical therapists, occupational therapists, and speech language pathologists practicing as private practitioners. Second is physicians. That would include medical doctors, doctors of osteopathy, doctors of podiatric medicine, and doctors of optometry for low-vision services only. I'd like to note that chiropractors and dentists are not recognized under the Medicare—under Medicare to furnish therapy services or to refer or certify for outpatient therapy services.

The third group of professionals affected is the non-physician practitioners. And for purposes of outpatient therapy services, this would mean nurse practitioners, clinical nurse specialists, and physician assistants. The therapy providers affected at the bottom of the page include outpatients and inpatients of hospitals, those (INAUDIBLE) acute care hospitals, as well as for the inpatient rehabilitation facilities, rehabilitation agencies. Another provider is home health agencies. This would be for that beneficiary that is not home-bound and not under any other kind of home health plan of care. Of course, costs would be affected, and outpatient hospitals, including the emergency room department and critical access hospitals, are also affected by this provision.

On slide seven, I want to talk about the non-table G codes that are used to report the functional limitations. And I wanted to call your attention to the short descriptors that were on the Web site today for this call. The long descriptors were not issued separately because we are trying to address some discrepancy in the speech language pathology long descriptors because they don't reflect all the information as those for the PT and OT codes. But that's why the Medlearn Matters article is there and you can reference the long descriptors in that publication.

And soon—we will be issuing a change to the long descriptors shortly. There are 42 G codes and these codes are non-payable as we've already said and they are always therapy code. What this mean is that they require therapy modifier, just as any of the other therapy codes do. So the GP modifier would indicate that the beneficiary is under a (TT) plan of care. A GO would include that they are under an OT plan of care and a GN indicates that the beneficiary is receiving services under a speech language pathology plan of care.

Each functional G code set contains a G code to represent the current status, the projected goal status, and the discharge status of the beneficiary's functional limitation that is being report. All told there are 42 functional G-codes, 14 sets of three codes each. Six of the code sets are used for PT and OT functional limitations and eight are used to report SLP functional limitations.

On slide eight, we describe the 42 functional G codes in two different ways. On the left hand side of the page, we have six sets that are typically reported for PT and OT. We

adapted four of the activities or tasks as they're defined by the International Classification of Functioning Disability and Health, to define the four sets of G codes that we—categorical G codes that we had proposed in rulemaking. The first is for mobility, which is walking and moving around. The second is for changing and maintaining body position. The third categorical of the G code set is for carrying, moving, and handling, and the fourth is for self-care.

There are two sets for other functional limitations. The first is other PT, OT primary, and the second is other PT, OT subsequent. These other codes are used to report a functional limitation that is not defined by one of the four categorical code sets that are listed above. We'll discuss more about how these other codes are used in a later slide.

Moving to the right hand side of the page we talk about the codes for—that are used to report for SLP services. We adopted these from the national outcome measurements system developed by ASLHA, the American Speech Language Hearing Association, and the seven categorical measures that are defined are swallowing, motor speech, spoken language comprehension, spoken language expression, and attention, memory, and voice.

We developed one set for other SLP functional limitations that are not defined by any of the above seven. There are eight—there are 15 of the (INAUDIBLE) measures in total. So it would be used to report one of the eight that are—one of the eight functional measures that are not defined above.

Moving to slide 9, I tried to put together some guidelines for selecting the G codes to report. The first is to select the G code for the functional limitation that most closely describes the functional limitation—the primary functional limitation being treated, or the one that is the primary reason for the treatment. We have this provision here that says without description by discipline, meaning that there was some confusion during rulemaking where the PTs and OTs were not clear as to whether they could report all four of the therapy measures that we had outlined, or the functional limitations reported by PTs and OTs.

So if you're choosing a functional limitation, if it most clearly defines what you're reporting, it doesn't matter what the description is. You would use the most appropriate one. 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, number one, most clinically relevant to a successful outcome for the beneficiary; number two, the one that would yield the quickest and/or greatest functional progress; or number three, the one that has the greatest priority for the beneficiary.

Under number two, I put a little example there where a beneficiary would have two functional limitations at the beginning of the therapy episode and the therapist could pick either of the functional limitations if they were both significant to report first. In this example, the patient has the self-care and mobility functional limitation.

So if the therapist could pick—would pick the self-care limitation to report first, knowing that it might be the quickest one to resolve. But the therapist could also keep the mobility one to report first, knowing that the patient's going to benefit from that and primarily would be reported probably a longer period of time. So we can use your judgment in determining which functional limitation is primary to report first.

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

On slide 10, we talk about how to use the other PT, OT functional G code sets. And these are used when none of the four categorical code sets describes the beneficiary functional limitations. So these will be used—another PT, OT code would be used when a beneficiary's functional limitation is not defined by one of the four categorical code sets; when a beneficiary to therapy services are not intended to treat a functional limitation.

An example of this would be when the therapy services are given primarily to address wound care or lymphedema after any of the self-care or mobility issues that might be—happen at the same time, after they've been resolved and just the wound care is left to address.

And the final one would be if a beneficiary's functional limitations 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 four categorical PT, OT code sets. One example that I could give for using one of the other PT, OT process would be when, for example, one of the other (ICFs) activities that we didn't create a code set for is the primary reason for treatment. Examples of these would be basic learning, which involves learning to read, write and acquiring skills; applying knowledge such as focusing attention, thinking, reading, writing, calculating, solving problems and decision-making; and general tasks and demands—the ability to perform simple or multiple-step tasks and carrying out a daily routine.

As far as the other SLP code sets, it would be used when the functional limitation being addressed is not represented by one of the seven categorical functional measures. And also possibly it would be used to report an overall composite or other score from a non-(NOM) assessment tool.

On slide 11, we talk about the modifiers used to report the severity of functional limitations. We have a table of 7 modifiers that are listed on the page and they range from CH, which is 0.0% impaired, to CN which is a 100% impaired, limited, or restricted. And for each non-payable G code, one of these 7 modifiers must be used to report the severity or complexity of the functional limitation.

I wanted to point out that this is a true disability scale where 100% means the beneficiary is 100% impaired, rather than a wellness or a health scale that is used in some functional measures, as well as outcome measures. A health scale would represent—100% would be you're in perfect health and you have no functional limitations. The severity modifiers

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

On slide 12, there's some guidelines for selecting the severity modifier. These modifiers would (INAUDIBLE)—with the first guideline, you would use the severity modifier that reflects the score from a functional or outcome assessment tool or other performance measurement instrument as appropriate. In cases where the therapist uses multiple assessment tools or measurements tool during the evaluative process to inform clinical decision-making, clinical judgment is used to combine these results to determine a functional limitation percentage. And the third bullet, the therapist can use their clinical judgment in the assignment of an appropriate modifier. Therapists will need to document in the medical record how they made this modifier selection so that the same process can be followed at succeeding assessment intervals.

And the fourth bullet explains to use the CH modifier to reflect a 0.0% impairment when the therapy services being furnished are not intended to treat a functional limitation. So we've—I've already given you a couple of those examples, which was wound care or lymphedema after all functional limitations such as mobility or self-care have been addressed.

And the fifth bullet explains to use that in some cases for beneficiaries where improvement is expected to be limited, the same severity modifier may be used in reporting the current goal status and discharge status. In cases where the therapist does not expect improvement, such as those individuals receiving maintenance therapy, the modifier used for the projected goal status will be the same as the one for the current status, as well as for the discharge status.

On slide 13, this begins the first of five slides on the reporting requirement. Required functional reporting is a condition of coverage (INAUDIBLE). This came out of rulemaking where we created regulations at 42 CFR 410, 59 for OT, 60 for PT, and 62 for SLP, and we will be making changes to our manuals—our claims manuals, which is chapter five of pub. 100-04, sections 10.6 is the new section. So any claims that are submitted for outpatient and for PT, OT, and SLP services must contain information on beneficiary functional limitations.

The functional reporting is required on claims throughout the entire episode of care. So the first rule to follow here is that only one functional limitation shall be reported at a time. And while many beneficiaries will have just one functional limitation, many also will have two or more. So a second functional limitation can—will often be reported for some beneficiaries. This reporting of a second functional limitation is required when the beneficiary has reached his or her goal, or progress towards the goal has been maximized on the initially reported functional limitation, but the need for treatment continues. In these cases, reporting is required for a second functional limitation, using a different set of G codes, in these situations where two or more limitations will be reported for a beneficiary during one therapy episode of care.

It's actually possible that a third or a fourth functional limitation will be reported as well. Thus, reporting on more than one functional limitation may be required for some patients. This will not be required on a simultaneous basis.

The second reporting requirement, slide 14, we talk about reporting the G codes and modifiers that is required on specific, specified therapy claims. And the first is at the outset of a therapy episode of care that is on the claim for the date of service of the initial therapy service. The second bullet says that at least once every ten treatment days, the functional reporting is required. This matches the newly revised progress reporting period that is effective January 1st, 2013. The third bullet explains that the functional reporting is required when an evaluative procedure, including a re-evaluated one, is furnished and billed.

I've listed here the actual CPT code that this—that applies to this evaluative procedures, and you will note that for PT and OT services there are specific reevaluation codes, so—but those codes are not present for speech language pathology services. So that's why it's phrased in the manner it is. So anytime an evaluative procedure is billed or anytime a reevaluated procedure is billed, that will require the presence of the G code and modifier.

In the fourth bullet, I talked—it says that at the time of discharge from the therapy episode of care, so when the beneficiary is discharged from therapy, the functional reporting requirements must be on the claim.

Five, the fifth bullet, at the time the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary, that is before beginning reporting on the different functional limitations. And of course, the last bullet explains that at the time the reporting is begun on a different functional limitation within the same episode of care, the functional reporting is required.

On slide 15, the number of functional G codes required on a claim under one plan of care will be two at any given time. So this will be a combination of the current status and the goal status, or the discharge status and the goal status will be reported. I've noted here that it is possible to—for claim to have more than two (non-payable) G codes in cases where there is a beneficiary receiving therapy services under more than one plan of care for PT, OT and/or speech from the same therapy provider.

So for example a claim from rehab agency which is required to bill only once a month would likely have G codes and modifiers reported for a beneficiary where they were receiving both PT and SLP services or OT and SLP services. This could also happen to be reported on the same date of service, not just within the same (month).

On slide 16, each reported functional G code must also contain the following essential line of service information. Each G code must be accompanied by a functional severity modifier. One of the modifiers in the CH to CN range must be on the line of service. The line of service also must have the therapy modifier to indicate which therapy plan of care

the beneficiary is under—either the (GP) or PT, the (GO) or OT, or the JN or SLP services. The date of the related therapy service also goes on the line.

And lastly the nominal charge—for example, a penny—is required for institutional claims that are submitted to the FIs, or the—I'm sorry, the fiscal intermediaries, or the Medicare part A, Medicare administrative contractors, or the AMAC.

And for the professional claim, a zero charge is acceptable for the service line. However, if the billing—if your provider billing software requires an amount for professional claims, a nominal charge such as 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. Notice (one) page I've added because I received many questions about this, that neither the KX modifier nor the 59 modifier are applicable to the line of service for any of the non-payable functional G codes.

So the only modifiers required on the line of service is the severity modifier in the CH to the CN range and the therapy modifier either GN, GO, or GT. On slide 17, we talk about the last of the reporting requirements. The first one is that the functional reporting period matches exactly the progress reporting period and the progress reporting period was, frequency was changed effective January 1st, 2013. Currently the progress reporting period was once every tenth treatment day or every 30 calendar days, whichever is left. On January 1st, 2013, the only requirement would be that the tenth treatment day would be the last day that the progress report could occur. So the reporting frequency is first at the outset of the therapy episode and at the end of each progress or functional reporting period.

At the time an evaluation or re-evaluation is furnished and billed at this charge from the therapy episode to end a reporting of one functional limitation and to begin the reporting of a different functional limitation. I want us to make note about the change in the treatment, the progress reporting period to every tenth treatment day, we did hear from many commenters during our rule making after our rulemaking for the purposed rule and we heard that many therapist told us that they had sort of intervals for progress reporting and of course the frequency of the progress report would really depend upon the clinical appropriateness and maybe appropriate at the first or fourth or fifth treatment rather than the tenth treatment day, so the tenth treatment day's not [a] hard cutoff for the progress reporting and functional reporting period.

On slide 18, we begin five slides on documentation requirement. The documentation requirements are also a condition of coverage and payment. The beneficiary function limitations that are reported on claims is part of functional reporting must be consistent with the functional limitations identify as part of the therapy plan of care and express this part as beneficiary anticipated long-term goal.

During rule making, we established confirming regulation at 42 CFR 410.61 for the plan of care for outpatient therapy service and at 42 CFR 410.105 for the course plan of care also changing the—and adding to our plain prophecy manual on Chapter Five, a new

section 10.6, and and/or benefits policy manual Chapter Twelve for the course benefits and Chapter 15 for the outpatient therapy benefit.

On slide 19 again on documentation requirements, the documentation and G codes and severity modifiers using compliment requirement for functional reporting must be included in the beneficiary's medical record of therapy services for each required reporting. The documentation must be completed by the clinician furnishing the services that is the qualify therapist furnishing the therapy services, the physician or a non-physician practitioner who is personally furnishing the therapy services. The qualified therapist furnishing clinician services infinite to the physician or non-physician practitioner. And the physician or a non-physician practitioner for infinite to services furnished by qualified personnel who are not qualified therapists.

CMS is required to permit the a qualified person to provide incident to services, but these individuals must meet all of the educational and training requirements as section 44.4 of this Social Security Act, 42 CFR, so that we have all the definitions of education and training for therapists and therapy assistant at that location. And so the qualified personnel—really auxiliary personnel, but they have qualification—CMS cannot require them to have licenses. So when they don't meet all the qualifications that 44.4—they are considered qualified personnel for purposes of incident to services, and lastly the qualified therapist who furnishes the PT, OT, or SLP services in a CORF must document in the medical record.

On slide 20, documentation of information used in reporting, functional reporting is required, at the time the functional reporting is required, and just recapping from the above reporting requirement section, this is at the time of the outset of therapy episode of care at least once every 10 treatment days, when an evaluated procedure is furnished and billed including the reevaluated one, at the time of discharge from the therapy episode of care and at the time reporting of a particular functional limitation is ended, and further therapy is necessary and finally at the time reporting is begun on a second or different functional limitation.

The clinician documents on the applicable dates of service of specific non-payable G codes and severity modifiers used in the required reporting of the beneficiary's functional limitation on the claims for therapy services. So it's important to note that, how the modifier selection was made, should also be included. And this would be used when the therapist uses a single functional assessment tool or uses more than one functional assessment tool or measurement instrument to determine the severity modifier that was used or uses a clinical judgment to determine the severity modifier is suggested that the therapist include that information in the medical record.

So then slide 21 and talk about where to document in the medical record. The G codes and modifiers that are used in reporting are also required to be documented in the medical record of therapy services at the time of required reporting on the same date of service. This documentation required at the outside of the office or care or initial therapy services.

Here, you would document in the evaluation the plan of care or the treatment note related to that an example would be when evaluation and plan of care are non-established by clinician during therapy services and so you would document in this case and the treatment note from the initial therapy service.

Another example would be where there is no therapy evaluation and plan of care as applicable such as line of physician conduct and evaluation and management service and develops the therapy plan of care complete with the long-term goal, but a qualify therapy furnishes the services. Therapist documents in this case in the treatment not for the first treatment day.

The clinician would document in the progress report at the end of each progress reporting period or in cases where also related treatment note that information can be documented in that notice well. When reevaluation is necessitated and (filmed) such as one as prompted by significant change in the beneficiary's function condition the therapist could document in the reevaluation or in a related treatment note.

At the time of discharge from the therapy episode or to end reporting of particular functional limitation before the reporting of different one, the therapist would document in the discharge note or summary when the patient is being discharged and document in the progress note that related to the end of the functional limitation or the treatment note that all related to that service as well.

Last bullet on page 22, talks about at the first treatment day after the progress report that ended the previously reported functional limitation, so therapist(s) would document in the treatment note as initial service at the time the reporting of new functional limitation began.

On the last two pages, we have an example of required reporting and an example for the G codes and timing of—for documentation purposes. The charts are very similar and I will just walk you through the chart on, the table on slide 23 and it's just an example of required reporting and the G codes that would be used for beneficiaries who have two functional limitations at the outset of a therapy episode. The therapist determined that the mobility functional limitation would be reported first and the second functional limitation, which is not defined by any of the other three categorical G code sets used for PT and OT services, so the other TT, OT primary G code set is used to report this. So, the G codes for mobility are listed for the current (INAUDIBLE) and discharge status and those obviously fall across on the table you'll see at the time at the outset of the episode of therapy, involves a current status and (goal) G codes are reported and at the end of reporting of mobility at the first progress reporting period, the current status and (goal) status are also reported. The third column is, relates to the beginning of the new reporting period, which is the next treatment day after the progress report was due and this is here to indicate that there is no functional reporting required if any of you followed our rule making process we had actually proposed that a probe would be reported at times when the other, at the times when there was not required reporting, but that is no longer the case.

We do not; we only require that as specified claims that the functional reporting is required. So the next time it would be, required would not be until the end of the second progress reporting period, and the current status and gold status is reported at that time. Moving to the next to last column the gold status and the discharge status G codes are submitted (submitted) on the (claim) when the end, for the end of the reporting of that mobility functional limitation.

In this case, the beneficiary had another condition functional limitation to be reported and the primary OTPT other code is used to begin the reporting period of that, that first progress report following the reporting of the mobility would be that first treatment day following the ending of the mobility so treatment day number would you would report the current status and the goal status of the second functional limitation in this case the other PT, OT primary decode sets, so the information on the slide 24 uses the same set of decode and the same reporting requirement and the same reporting examples, so you can see that how you determine which two codes to report at which required reporting period.

With that, that ends the prepared presentation, and I'll turn the call back over to Charlie.

Charlie Eleftheriou: All right, thank you. Before we move into our question-and-answer session I just like to conduct keypad polling in order to obtain estimate of the numbers of participants in attendance to better document how many members of the provider community are receiving this valuable information probably related to start polling now.

Polling

Operator: CMS greatly appreciate that many of you minimize the government teleconference expense by listening to these calls together in your office using only one mind. At this time, please us your telephone keypad and enter the number of participants that are currently listening in. If you're the only person in the room, enter one. If there are between two and (eight) they're listening in, enter corresponding number between 2 and 8. If there are nine or more of you in the room, enter 9. Again, if you're the only person in the room, enter one. If there are between two and eight of you listening in enter the corresponding number 2 and 8. If there are nine or more of you in the room enter 9. Please hold while we complete the polling.

Charlie Eleftheriou: While we are holding, I would like to take a time so remind everyone this call has been recorded and transcribed. Before you ask your question, please state your name and the name of your organization, and then in (an) effort to get to as many questions as possible, we ask that you limit your questions to one at a time. If you have more than one question, press star one after your first question has been answered.

Operator: Again, please continue to hold while we complete the polling, and this does conclude the polling session for today's call.

Question-and-Answer Session

Charlie Eleftheriou: All right, thank you and we're now to begin our question-and-answer session portion of today's call. During Q&A we ask that you limit your questions or comments to those related only to the new functional reporting requirements for outpatient therapy services as our subject matter experts will only be addressing those questions and we're ready to take our first question.

Operator: To ask a question press star, followed by the number one on your touchtone phone, to remove yourself from the queue please press the pound key, remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your questions, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster. And your first question comes from the line of Nancy Beckley.

Nancy Beckley: Hi, Pam, this is a question regarding part B services in an inpatient hospital, and if a patient has been determined to have been part B services at a time that the therapist did not know, for example, a upon appeal with the recovery audit contract or an ALJ remand to the quick level for an order for part B services or observation that was four days and the therapy department had no way of knowing it, how was that handled with respect to the G code?

Pam West: I am actually trying to understand your complete question, but I do think that it's really a special situation, which would have to be dealt with separately. If the therapist did not know the status of an inpatient then that they were actually covered and paid under part B rather than under part A, then that would have to be addressed at the time of the circumstances that you said, the ALG and from that point of view. You have mentioned also about an outpatient status and observation status, I believe and that I think people will be more cognizant of when beneficiaries are being covered under part B rather than under part A so it's an observation status and an outpatient hospital would be considered encompassed by the functional reporting requirement.

Nancy Beckley: And Pam the thing had to do specifically with CMS' part A to part B demonstration project too that's going on. These are all new things but I appreciate your answer and I hope that as the rules continue to come up, due consideration will be given for these unique situations in the hospital.

Pam West: Thank you.

Charlie Eleftheriou: Thank you.

Operator: Your next question comes from the line of (Barb Grossman).

Charlie Eleftheriou: Hello, (Barb).

Operator: (Barb), your line is open. And that question has been withdrawn. Your next question comes from the line of Patti Heflin.

Patti Heflin: We were wondering is there software that we could purchase that would help us determine what G codes we should be using.

Pam West: Software, CMS is not affiliated with the software vendors so we would not be able to recommend the software vendor to you.

Pam West: OK is there anything else, Patty?

Patti Heflin: Not at this time. OK, thank you.

Charlie Eleftheriou: Thank you. We'll take the next question.

Operator: Your next question comes from the line of William Malm.

William Malm: Yes good afternoon. I just want to confirm that the revenue codes on the UBO4 would remain the same as PTOT and speech for 24, 34, 40 and you'll use the CPT code with the GNGOGP and then the modifiers, so the revenue codes will be addressed with the functional modifiers.

Pam West: Yes the revenue codes used on institutional plans will not be changing. They are still required on the claims, however CMS actually uses the therapy modifiers when researching and looking and applying therapy caps and everything that's related to therapy services. But yes, you are correct. Those revenue codes 42, 43, and 44 are not changing. They are still required on the claims.

William Malm: Thank you.

Operator: And your next question comes from the line of Salli Crawford.

Salli Crawford: Hi, thank you for taking the question. I just want a clarification please as far as the inpatient services, such as swing bed in part A, they are not going to be subject to this recording, I mean, reporting?

Pam West: That is correct, anything, any services, therapy services paid under our part A benefits do not apply to outpatient functional reporting.

Salli Crawford: Thank you.

Operator: And your next question comes from the line of Amber Krueger.

Amber Krueger: Yes, we just want to clarify that the reporting requirements for the patient that is just been for an evaluation in a home program so one time visit, would you just view the current status and discharge status all in one claim?

Pam West: We are still on developing response for those specific one time therapy episodes, so we will be sending this information out in our next release forum CRA 005

as well as putting responses to this and other questions on our therapy Web site in a couple of weeks for—at listing for FAQs.

Amber Krueger: What's the Web site? I am sorry.

Pam West: The therapy Web site is actually on the last slide of today's presentation.

Amber Krueger: OK.

Pam West: And it is the therapy services Web site which is found on the Medicare webpage under billing and therapy services.

Charlie Eleftheriou: That would be found on slide 28 of today's presentation. The URL is [cms.gov/medicare/billing/therapyservices/index.html](https://www.cms.gov/medicare/billing/therapyservices/index.html). Again, that's www.cms.gov/medicare/billing/therapyservices. Next question please.

Operator: And your next question comes from the line of Elena Kurth.

Elena Kurth: Hi, thanks for taking my call. On slide 21 you referenced that the codes and severity modifiers are to be documented to the medical record. I just want to clarify whether or not the actual alphanumeric code and modifier sequence need to be in the medical record or could just a description of it be in the record?

Charlie Eleftheriou: Hold please, we are going to confirm, hi, we're just going to confer quickly among us. Hold one second please.

Elena Kurth: OK.

Pam West: The point for putting the documentation in the record is to make sure that we can match up what in the record we select what's being reported. So it's probably just as easy to write down the numeric for the code than it is to write out the entire, or you can do both—write out the entire description.

Elena Kurth: Because that's currently not our practice for everything else we do. When we do evaluation we don't also write out 97001.

Pam West: That is correct. This is a separate initiative.

Elena Kurth: So you are recommending that we do both at this time?

Pam West: I'm recommending that the alphanumerics for the functional reporting codes be recorded in the medical record not the other codes that you would just for example you would not want to receive—you need to report that 97001 and evaluation for PT was done on that day.

Elena Kurth: OK, thank you very much.

Operator: And your next question comes from the line of Philip Yuson.

Philip Yuson: Do the functional reporting codes need to be entered for only patients with Medicare as the primary insurance or for patients with Medicare as secondary or replacement policies?

Pam West: At the moment we believe that the answer to that is that only one when Medicare is the primary payer should these codes be reported.

Philip Yuson: OK, thank you.

Operator: And your next question comes from the line of Matthew Mesibov.

Matthew Mesibov: Hi, this is Matthew Mesibov from (Sops) rehabilitation. Is the clinician using the composite functional tool—meaning it's a multiple function tool? My understanding according to what you said today is you're billed with the G code that's described as "Other." However, if you continue on the episode of care with other functional deficits and you're still using that same tool, would you continue to report the G code which is described as "Other" as you continue along in the episode.

Pam West: Yes, you—you are correct. If you have—if (your) beneficiary has two conditions, functional limitations that are not described by, say for the PT—OT is not described by one of the four categorical functional limitations, then the first reported other would be for the primary and the second reported other would be for the subsequent.

Matthew Mesibov: Right. And—and just to clarify, it's not so much that the other G code with—there are G codes that wouldn't describe the functional limitation, but my understanding is because we are using a composite functional tool, we are required to use the G code described as "Other." Is that correct?

Pam West: It is correct. If that composite for or for that assessment tool, when you are using it, that you have not identified a functional limitation as primary. That's defined by one of the categorical codes.

For example, if you are using the impact tool, then—but your patient, you have identified that you are treating your patient primarily for a mobility functional limitation, then it is—it is preferred that you report the categorical code because it identifies that you are, you know, working with somebody that has a mobility restriction. Even though the assessment tool, you know, looked at other indicators such as their ability to carry out their routine and their quality of life.

Matthew Mesibov: OK, that—that explains it clearly. Thanks a lot.

Charlie Eleftheriou: Thank you.

Operator: And your next question comes from the line of Aaron Weg.

Aaron Weg: Yes, you mentioned that the KX modifier is not required. Would there be a problem if the KX modifier was included together with the G codes?

Pam West: Yes it is—not only is it not required, we do not want it and [don't] expect it to be reported with these codes.

Aaron Weg: Thank you.

Operator: All right. And your next question comes from the line of Beth Ann Muthig.

(Lindsey Casey): Hello, this is (Lindsey Casey) at Health Medx. Do you have a requirement as to which comes first, the severity modifier or the therapy modifier? And does the penny need to be included in the total charge amount on the total charge line?

Pam West: OK, the answer to the first part of the question, there is no order required for the modifiers, so the therapy modifier could go first, and the severity modifier could go second.

As far as the penny charge, could you repeat that part of question for us?

(Lindsey Casey): Yes. On these new functional limitation reporting you are wanting on the institutional claim, a penny in the charge column. And I'm wondering if the penny needs to be added into the grand total of the total charges?

Charlie Eleftheriou: Quick—one second, please.

Pam West: OK, well, just wanted to point out, we do not have someone here from the institutional claim side, but it makes sense to us that the charge would be included, because you would want to compare the total -- the total charges.

(Lindsey Casey): Right. OK, do you know if they will be having a sample claim out there for us to look at?

Pam West: We do not have plans here to have a sample claim posted online. You're asking that, you think that you would like us to do that?

(Lindsey Casey): Well, it may help with people not getting rejections in case they don't interpret this right.

Charlie Eleftheriou: Could you repeat that? I'm sorry.

(Lindsey Casey): It may help with for any claim or EBI rejections in case they're not interpreting all of this information that the way it presents on the claim properly.

Pam West: We will have to look into that to see whether or not we can post a sample claim as part of the therapy Web site. I'm not sure that sample claim might address all aspects of your question.

(Lindsey Casey): I understand. At least you guys have the testing period so maybe that will help alleviate that.

Pam West: OK.

(Lindsey Casey): Thank you.

Charlie Eleftheriou: All right. Thank you. We will take the next question.

Operator: Your next question comes from a line of Carol Carlson.

Carol Carlson: Hi, good afternoon. We're wondering for phasing this in, do we start with just our new referrals after January 1st?

Charlie Eleftheriou: We had a little bit hard time hearing you. Could you repeat that please?

Carol Carlson: Yes, the phase this in, do we start with our new referrals after January 1st?

Pam West: Your question is about the functional reporting. If it's about a functional reporting, then, yes, you can phase that in for your—your beneficiaries that we received services, or new beneficiaries starting after January 1st. That's one way to do it. That gives you the opportunity to see how you would take a patient all the way through from the beginning of the episode to the last—or, because this is a testing period, you could do that either way.

You could—you could apply to all of your patients, which for documentation purposes you should be doing anyway, as January 1st, 2013. So—but you need to establish your—you know, your protocols and procedures. We want you just to report as—as much as possible on the beneficiaries during the testing period.

Carol Carlson: Medicare HMOs?

Pam West: This reporting requirement is not applicable to our advantage plan.

Carol Carlson: Thank you.

Charlie Eleftheriou: We'll take the next question.

Operator: Your next question comes from the line of Amy Johnson.

Amy Johnson: My question was already asked. Thank you.

Charlie Eleftheriou: Thank you.

Operator: And your next question comes from the line of Patrice Baldwin. Patrice, your line is open.

Patrice Baldwin: I'm sorry, I was on mute. If a patient—I'm not still clear. If a patient is receiving two or more disciplines, does each discipline use its own coding or just—say if it's physical therapy and occupational therapy that are seeing the patient, do those two therapists have to come together to decide one G code to use?

Pam West: The functional reporting requirements are—are specific to each therapy discipline.

Patrice Baldwin: OK. And my second question is I'm still not clear on where these codes are placed. Do the coders use these codes at the end of each month when they do the claim, or are we putting this solely in the documentation that we're doing, or is it both?

Pam West: The answer—the short answer is it is both.

Patrice Baldwin: OK.

Thank you.

Pam West: You're welcome.

Operator: And your next comes from the line of Michelle Marlow.

Michelle Marlow: I'm sorry. Thank you. My answer—my question's been answered. Thank you.

Charlie Eleftheriou: Thank you.

Operator: Your next question comes from the line of Marla Hunt.

Marla Hunt: Yes, Marla Hunt from Superior Medical Billing Solutions. I was wondering: is there an article or a listing of all the codes that I can give to my therapists so that they have all the different codes that they need to pick from?

Pam West: You could actually use the—the list of short descriptors that appears on the national call page at the Web site that you are viewing the presentation from.

Marla Hunt: OK.

Charlie Eleftheriou: The link to that file is available underneath the link that you used to open up today's presentation—on today's calls detail page.

Marla Hunt: OK.

Charlie Eleftheriou: Thank you.

Marla Hunt: All right, thank you very much.

Charlie Eleftheriou: We'll take the next question.

Operator: Your next question comes from the line of Denise Bouderau.

Denise Bouderau: Hi. If the testing for a facility is not completed till late June and the patient is discharged from physical therapy on July 3rd of next year that would mean that potentially only the discharge G code gets submitted on the claim for the one month of services. Will the claims be denied because the complete length of stay was not submitted or no because it's only effective for data service 07/01/2013?

Pam West: The answer is no, it should not be rejected or denied.

Denise Bouderau: Thank you.

Charlie Eleftheriou: Before we take our next call, I just want to make a quick announcement that we do have a lot of callers in queue, so to get as many in as we can we ask again that you limit your question to one at a time. If you have a second question, press star one after your first has been answered. Thank you.

We'll take the next call.

Operator: Your next question comes from the line of (Lisa Biden).

(Todd Adelson): Thanks for taking my call. This is for clarification. My name is (Todd Adelson).

So the second functional limitation needs to be documented on the initial evaluation and a modifier used in billing?

Pam West: To answer that particular question, no, the—the coding and functional limitation does not have to be specifically addressed at the beginning of the episode of care.

(Todd Adelson): Thank you very much.

Operator: And your next question comes from the line of Marlene Kranz.

(Debbie Ashcraft): Hi, this is (Debbie Ashcraft) from Holton, Kansas. On—kind of a follow-up to the last question, if we have more than one functional modifier that we have identified, are we to select one only to go on the paper work and the billing process

although we maybe treating more than one? Or is this saying we need to treat one functional limitation until it's met before we can start on a second?

Pam West: Medicare does not want to tell the therapist how to practice. The answer is that—that while a therapist is going to be treating the functional limitations that are—that the patient presents with from the beginning of the episode, only one can be reported at a time.

Charlie Eleftheriou: Thank you.

Operator: And your next question comes from the line of Lori Riddick.

Lori Riddick: My question is when billing on a HCFA 1500 form, do you bill—just for example, if I bill 97110, then I have to bill a G code also?

Pam West: When a 97001, which is the physical therapy evaluation code, you would also have to submit the two G codes, functional G codes. So the current status and the (gold) status would be reported as time and (evaluated) procedure is reported on the claim.

Lori Riddick: So the G codes are like (CPT) codes. So it would just be like another (CPT) code that we are putting on each client form?

Pam West: Correct, it's an alphanumeric or a HCPCS code, the G codes are—are known as that. Yes, they though on the same—in the same column that the procedure code goes in.

Lori Riddick: So each code needs two—each code bill needs two G codes the follow?

Pam West: Each evaluated procedure code needs two—two functional reporting G codes.

Lori Riddick: In addition to the (GT) or the GLs. And they would have two G codes and then the severity modifier all together?

Pam West: Yes, each—each G code or HCPCS G code would be required to have the therapy modifier, the (GP) in this case for physical therapy, and the severity modifier that relates to the current status or the goal status that's being reported.

Lori Riddick: And then the two G functional codes. So it would be (GP), two G codes for functional status, and then the severity modifier. Does it matter which order?

Pam West: I'm not certain I followed what you just said.

Lori Riddick: So if I bill the evaluation, I would bill the 97110-GP-GXXX, GXXX and then the (CH) or a (CN) all together on one line?

Pam West: No.

Lori Riddick: Or one column?

(Female): No.

Pam West: No, that is not correct. And each—each CPT code or HCPCS code, each code has to go into the procedure code column.

(Female): Right.

Pam West: ... Not followed by another G code. Each C code is...

(Female): ... Completely separate codes.

Lori Riddick: Thank you.

Charlie Eleftheriou: Thank you. We will take the next call please.

Operator: Your next question comes from the line of (Elaine Teres).

(Elaine Teres): Our question has already been answered. Thank you.

Charlie Eleftheriou: Thank you.

Operator: And your next question comes from the line of Martin Ugarte.

Martin Ugarte: Yes, thank you.

Just want to get clarification on when we use these (other) primary functional limitation code and the other subsequent functional limitation code. I think this was addressed earlier. If I'm using, say, one of the four categorical codes as the primary functional limitation, a patient's discharged from that. They're treated for another functional limitation that's not a categorical code—we would then use the other primary functional limitation code?

Pam West: Yes, the other primary functional limitation code for PT/OT would be used in a situation when it's the first reported other code. So the subsequent other PT/OT code would only be used after a primary PT/OT code was reported.

Martin Ugarte: So that primary code (INAUDIBLE) first time would have to be the other primary functional limitation code?

Pam West: Correct.

Martin Ugarte: And then we would use the subsequent functional limitation code after that? That's the only time you would use it?

Pam West: That's the only time that you would use the subsequent in the same episode of care would be after the primary other code was—was reported.

Martin Ugarte: So you would never use that subsequent functional limitation code with one of the four categorical codes?

Pam West: Not as the first reported other code.

Martin Ugarte: Wanted to make sure I understood that. Thank you.

Charlie Eleftheriou: Thank you. We'll take the next call please.

Operator: Your next question comes from the line of Herbert Weiss.

Herbert Weiss: Hi. I understand that you need to have a—you need to report on function at the time of discharge and you have tie it to your functional assessment tools documented in your chart. Very often, we don't know when our patient is going to be seen for the last time. They may discharge themselves, go to their physician and not return his recommendation, or for other reasons be unable—we are unable to know that they are being discharged or that it is their last date of service. Can we submit a final claim and not have a functional score and not have it rejected if we are audited?

Pam West: The—there is—there's a couple of things about your question that I—I would need to address. Number one is the requirement that any time one of these non-payable G codes, the functional G codes is reported on a claim it has to be reported with another billable service. So if you—if the claim for the last service has already been submitted, then you would not be able to submit an additional claim for that—for the reporting of that discharge.

If, on the other hand, you had already done an assessment and that you had for the last treatment that the beneficiary did have, if that were available and if that were current—in other words not, you know, from four or five treatments before and you just didn't have the opportunity to present it, you could—you could put that on the bill for the last treatment day that the patient was there.

But we—we realize that this does happen and when that information is not there, it is not—and you have already submitted a claim, it is not required on the claim for the (file) service.

Herbert Weiss: And if we're asked for—you know, if you ask for records and it's not there, will an additional communication be necessary, some additional note to a reviewer or auditor?

Pam West: I—I would suspect that you would be documenting in your—in the medical records for the therapy services that beneficiary received that the—the beneficiary did not show for their last treatment, so that—that would explain—you could explain that that’s why, you know, assessment was done and no (C-codes) and modifiers were present.

Herbert Weiss: Thank you very much.

Charlie Eleftheriou: All right. And this will be our last call.

Operator: And your next—or your final question, rather, comes from the line of Parveen Khan.

Parveen Khan: Yes, hi. I couldn’t quite make out if this was asked before, but I’ll ask it again. Is the sequencing of the modifier, is it your expectation that the severity modifier go first or the therapy, the (GPG NGO), or does it matter?

Pam West: It does matter what sequence a modifier is in. There are (spaces) for four modifiers on the claim and you can submit either one first.

Parveen Khan: OK. Thank you.

Charlie Eleftheriou: Alright. Thank you.

Additional Information

Charlie Eleftheriou: Unfortunately, that is all the time we have for today. We did create a resource mailbox to accept e-mailed questions directly related to today’s call. It’s important to note, though, that we will only accept questions that are directly related to the new functional reporting requirements for outpatient therapy services to this e-mail box. So please do not submit unrelated questions as they will not be considered.

If you do have a question directly related to today’s National Provider Call, you can e-mail them to therapyservicesnpc. That’s therapy services, “N” as in “Nancy,” “P” as in “Paul,” “C” as in “Charlie.” Again, therapyservicesnpc@cms.hhs.gov.

Also note that while we will—may not be able to dress every single question directly, we’ll review them all to help develop frequently asked questions on functional reporting, related educational products, and future calls, and messaging.

On slide 26 of the presentation today you’ll find information and a URL to evaluate your experience with today’s NPC. Evaluations are anonymous and strictly confidential.

I should also point out that all registrants for today’s call will receive a remainder e-mail from the CMS National Provider Calls resource box within two days regarding the opportunity to evaluate the call. Please disregard this e-mail if you have already completed the evaluation.

We appreciate the feedback.

I would like to thank everyone who participated in today's National Provider Call. And also—I'm sorry—remind you that that e-mail address that I gave out to accept callers [questions] from today, therapyservicesnpc@cms.hhs.gov –will only be accepting questions from today's call until close of business December 31st.

As I was saying, an audio recording and written transcript of this call will be posted to the National Provider Calls webpage on the CMS Web site within approximately three weeks.

That concludes today's National Provider Call. Thanks for all the callers and the presenters.

And have a great day, and happy holidays.

Operator: Thank for participating in today's National Provider Call.

You may now disconnect.

Speakers please hold the line.

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