

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4214	Date: January 25, 2019
	Change Request 11120

SUBJECT: Updates to Reflect Removal of Functional Reporting Requirements and Therapy Provisions of the Bipartisan Budget Act of 2018

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update chapter 5 to reflect recent changes in outpatient therapy service billing instructions and payment policies related to the Bipartisan Budget Act of 2018 and the calendar year 2019 Medicare physician fee schedule final rule.

EFFECTIVE DATE: January 1, 2019

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: February 26, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/Table of Contents
R	5/10.2/The Financial Limitation Legislation
R	5/10.3/Application of Financial Limitations
R	5/10.3.3/Use of the KX Modifier
R	5/10.3.4/Manual Review Threshold to Ensure Appropriate Therapy
R	5/10.6/Functional Reporting

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4214	Date: January 25, 2019	Change Request: 11120
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EFFECTIVE DATE: January 1, 2019

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IMPLEMENTATION DATE: February 26, 2019

I. GENERAL INFORMATION

A. Background: Section 50202 of the Bipartisan Budget Act 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 modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record.

In the Calendar Year (CY) 2019 Physician Fee Schedule final rule, after a consideration of stakeholders' requests for burden reduction and a review of the Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA) requirements, CMS concluded that continued collection of functional reporting data through the same format would not yield additional information to inform future analyses. The rule ended the functional reporting requirements to reduce burden of reporting for providers of therapy services.

This change request updates the Medicare Claims Processing Manual to reflect these changes to law and regulation.

B. Policy: Effective for dates of service on or after January 1, 2018, providers of therapy services shall continue to report the KX modifier on claims as applicable. The modifier no longer represents an exception request but serves as a confirmation that services are medically necessary after the beneficiary has exceeded the threshold of incurred expenses.

Effective for dates of service on or after January 1, 2019, Healthcare Common Procedure Coding System (HCPCS) G-codes and severity modifiers for functional reporting are no longer required on claims for therapy services.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11120 - 04.1	The contractor shall be aware of the changes to Pub.100-04, chapter 5 contained in this CR.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11120 - 04.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Brian Reitz, brian.reitz@cms.hhs.gov (for professional claims) , Wil Gehne, wilfried.gehne@cms.hhs.gov (for institutional claims) , Pam West, pamela.west@cms.hhs.gov (for therapy payment policy)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Medicare Claims Processing Manual

Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

Table of Contents
(Rev.4214, Issued: 01-25-19)

Transmittals for Chapter 5

10.3.3 - Use of the KX Modifier

10.3.4 - Manual Review Threshold to Ensure Appropriate Therapy

10.2 - The Financial Limitation Legislation

(Rev. 4214, Issued: 01-25-19, Effective: 01-01-19, Implementation: 02-26-19)

A. Legislation on Limitations

The dollar amount of the limitations (caps) on outpatient therapy services is established by statute. The updated amount of the caps is released annually via Recurring Update Notifications and posted on the CMS Website www.cms.gov/TherapyServices, on contractor Websites, and on each beneficiary's Medicare Summary Notice. Medicare contractors shall publish the financial limitation amount in educational articles. It is also available at 1-800-Medicare.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P.L. 105-33) of 1997, which added [§1834\(k\)\(5\)](#) to the Act, required payment under a prospective payment system (PPS) for outpatient rehabilitation services (except those furnished by or under arrangements with a hospital). Outpatient rehabilitation services include the following services:

- Physical therapy
- Speech-language pathology; and
- Occupational therapy.

Section 4541(c) of the BBA required application of financial limitations to all outpatient rehabilitation services (except those furnished by or under arrangements with a hospital). In 1999, an annual per beneficiary limit of \$1,500 was applied, including all outpatient physical therapy services and speech-language pathology services. A separate limit applied to all occupational therapy services. The limits were based on incurred expenses and included applicable deductible and coinsurance. The BBA provided that the limits be indexed by the Medicare Economic Index (MEI) each year beginning in 2002.

Since the limitations apply to outpatient services, they do not apply to skilled nursing facility (SNF) residents in a covered Part A stay, including patients occupying swing beds. Rehabilitation services are included within the global Part A per diem payment that the SNF receives under the prospective payment system (PPS) for the covered stay. Also, limitations do not apply to any therapy services covered under prospective payment systems for home health or inpatient hospitals, including critical access hospitals.

The limitation is based on therapy services the Medicare beneficiary receives, not the type of practitioner who provides the service. Physical therapists, speech-language pathologists, and occupational therapists, as well as physicians and certain nonphysician practitioners, could render a therapy service.

B. Moratoria and Exceptions for Therapy Claims

Since the creation of therapy caps, Congress has enacted several moratoria. The Deficit Reduction Act of 2005 directed CMS to develop exceptions to therapy caps for calendar year 2006 and the exceptions have been extended periodically. The cap exception for therapy services billed by outpatient hospitals was part of the original legislation and applies as long as caps are in effect. Exceptions to caps based on the medical necessity of the service are in effect only when Congress legislates the exceptions.

C. Repeal of Original Legislation and Replacement with Thresholds to Ensure Appropriate Therapy.

Section 50202 of the Bipartisan Budget Act 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 modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record. This is termed the KX modifier threshold.

Along with this KX modifier threshold, the new law retains the targeted medical review process but at a lower threshold amount of \$3,000. For more information about the medical review (MR) threshold see the below section 10.3.4.

10.3 - Application of Financial Limitations

(Rev. 4214, Issued: 01-25-19, Effective: 01-01-19, Implementation: 02-26-19)

(Additions, deletions or changes to the therapy code list are updated via a Recurring Update Notification)

Financial limitations on outpatient therapy services, as described above, began for therapy services rendered on or after on January 1, 2006. References and policies relevant to the exceptions process in this chapter apply only when exceptions to therapy caps are in effect. For dates of service before October 1, 2012, limits apply to outpatient Part B therapy services furnished in all settings except outpatient hospitals, including hospital emergency departments. These excluded hospital services are reported on types of bill 12x or 13x, or 85x. Effective for dates of service on or after October 1, 2012, the limits also apply to outpatient Part B therapy services furnished in outpatient hospitals other than CAHs and hospitals in Maryland. During this period, only type of bill 12x claims with a CMS certification number in the CAH range, type of bill 12x and 13x claims with a CMS certification number beginning with the State code for Maryland, and type of bill 85x claims are excluded.

Effective for dates of service on or after January 1, 2014, the limits also apply to CAHs. Effective for dates of service on or after January 1, 2016, the limits also apply to hospitals in Maryland. *Effective for dates of service on or after January 1, 2018, the KX modifier threshold applies to all the therapy provider types to which the limits applied.*

Contractors apply the financial limitations *or thresholds* to the MPFS amount (or the amount charged if it is smaller) for therapy services for each beneficiary.

As with any Medicare payment, beneficiaries pay the coinsurance (20 percent) and any deductible that may apply. Medicare will pay the remaining 80 percent of the limit after the deductible is met. These amounts will change each calendar year.

Medicare shall apply these financial limitations *or KX modifier thresholds* in order, according to the dates when the claims were received. When limitations *or KX modifier thresholds* apply, the Common Working File (CWF) tracks *them*. Shared system maintainers are not responsible for tracking the dollar amounts of incurred expenses.

In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount on to CWF as the amount applied to therapy limits *or KX modifier thresholds*.

10.3.3 - Use of the KX Modifier

(Rev. 4214, Issued: 01-25-19, Effective: 01-01-19, Implementation: 02-26-19)

NOTE: Effective for dates of service on or after January 1, 2018, the KX modifier continues to be used. It no longer represents an exception request but serves as a confirmation that services are medically necessary after the beneficiary has exceeded the KX modifier threshold of incurred expenses. Medicare claims systems process claims with and without the KX modifier in the same manner described below and in section 10.4.

When exceptions are in effect and the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS code subject to the cap limits. The KX modifier shall not be added to any line of service that is not a medically necessary service; this applies to services that, according to a local coverage determination by the contractor, are not medically necessary services.

The codes subject to the therapy cap tracking requirements for a given calendar year are listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

The GN, GO, or GP therapy modifiers are currently required to be appended to therapy services. In addition to the KX modifier, the GN, GP and GO modifiers shall continue to be used. Providers may report the modifiers on claims in any order. If there is insufficient room on a claim line for multiple modifiers, additional modifiers may be reported in the remarks field. Follow the routine procedure for placing HCPCS modifiers on a claim as described below.

- For professional claims, sent to the A/B MAC(B), refer to:
 - Pub.100-04, Medicare Claims Processing Manual, chapter 26, for more detail regarding completing Form CMS 1500, including the placement of HCPCS modifiers. **NOTE:** The Form CMS 1500 currently has space for providing four modifiers in block 24D, but, if the provider has more than four to report, he/she can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.
 - The ASC X12N 837 Health Care Claim: Professional Implementation Guide for more detail regarding how to electronically submit a health care claim transaction, including the placement of HCPCS modifiers. The ASC X12N 837 implementation guides are the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for submitting health care claims electronically. The 837 professional transaction currently permits the placement of up to four modifiers, in the 2400 loop, SV1 segment, and data elements SV101-3, SV101-4, SV101-5, and SV101-6. Copies of the ASC X12N 837 implementation guides may be obtained from the Washington Publishing Company.
 - For claims paid by a carrier or an A/B MAC(B), it is only appropriate to append the KX modifier to a service that reasonably may exceed the cap. Use of the KX modifier when there is no indication that the cap is likely to be exceeded is abusive. For example, use of the KX modifier for low cost services early in an episode when there is no evidence of a previous episode that might have exceeded the cap is inappropriate.
- For institutional claims, sent to the A/B MAC(A):
 - When the cap is exceeded by at least one line on the claim, use the KX modifier on all of the lines on that institutional claim that refer to the same therapy cap (PT/SLP or OT), regardless of whether the other services exceed the cap. For example, if one PT service line exceeds the cap, use the KX modifier on all the PT and SLP service lines (also identified with the GP or GN modifier) for that claim. When the PT/SLP cap is exceeded by PT services, the SLP lines on the claim may meet the requirements for an exception due to the complexity of two episodes of service.
 - Use the KX modifier on either all or none of the SLP lines on the claim, as appropriate. In contrast, if all the OT lines on the claim are below the cap, do not use the KX modifier on any of the OT lines, even when the KX modifier is appropriately used on all of the PT lines. Refer to Pub.100-04, Medicare Claims Processing Manual, chapter 25, for more detail.

By appending the KX modifier, the provider is attesting that the services billed:

- Are reasonable and necessary services that require the skills of a therapist; (See Pub. 100-02, chapter 15, section 220.2); and
- Are justified by appropriate documentation in the medical record, (See Pub. 100-02, chapter 15, section 220.3); and
- Qualify for an exception using the automatic process exception.

If this attestation is determined to be inaccurate, the provider/supplier is subject to sanctions resulting from providing inaccurate information on a claim.

When the KX modifier is appended to a therapy HCPCS code, the contractor will override the CWF system reject for services that exceed the caps and pay the claim if it is otherwise payable.

Providers and suppliers shall continue to append correct coding initiative (CCI) HCPCS modifiers under current instructions.

If a claim is submitted without KX modifiers and the cap is exceeded, those services will be denied. In cases where appending the KX modifier would have been appropriate, contractors may reopen and/or adjust the claim, if it is brought to their attention.

Services billed after the cap has been exceeded which are not eligible for exceptions may be billed for the purpose of obtaining a denial using condition code 21.

10.3.4 - Manual Review Threshold to *Ensure Appropriate* Therapy *(Rev. 4214, Issued: 01-25-19, Effective: 01-01-19, Implementation: 02-26-19)*

Section 50202 of the Bipartisan Budget Act of 2018 retains the targeted medical review (MR) process (first established through Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)), but at a lower threshold amount of \$3,000. For CY 2018 (and each calendar year until 2028 at which time it is indexed annually by the MEI), the MR threshold is \$3,000 for PT and SLP services and \$3,000 for OT services. The targeted MR process means that not all claims exceeding the MR threshold amount are subject to review as they once were. For a general overview of the MR process, go to the Medical Review and Education website at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/index.html>

10.6 - Functional Reporting

(Rev. 4214, Issued: 01-25-19, Effective: 01-01-19, Implementation: 02-26-19)

A. General

Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) amended Section 1833(g) of the 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. 42 CFR 410.59, 410.60, 410.61, 410.62 and 410.105 implement this requirement. The system will collect data on beneficiary function during the course of therapy services in order to better understand beneficiary conditions, outcomes, and expenditures.

Beneficiary function information is reported using 42 nonpayable functional G-codes and seven severity/complexity modifiers on claims for PT, OT, and SLP services. Functional reporting on one functional limitation at a time is required periodically throughout an entire PT, OT, or SLP therapy episode of care.

The nonpayable G-codes and severity modifiers provide information about the beneficiary’s functional status at the outset of the therapy episode of care, including projected goal status, at specified points during treatment, and at the time of discharge. These G-codes, along with the associated modifiers, are required at specified intervals on all claims for outpatient therapy services – not just those over the cap.

In the CY 2019 Physician Fee Schedule final rule, CMS-1693-F, after consideration of stakeholders’ requests for burden reduction, a review of all of the MCTRJCA requirements, and in light of the statutory amendments to section 1833(g) of the Act, via section 50202 of Bipartisan Budget Act of 2018 to repeal the therapy caps, CMS concluded that continued collection of functional reporting data through the same format would not yield additional information to inform future analyses or to serve as a basis for reforms to the payment system for therapy services. The rule ended the functional reporting requirements to reduce burden of reporting for providers of therapy services and revised regulation text at 42 CFR 410.59, 410.60, 410.61, 410.62, 410.105, accordingly.

The instructions below apply only to dates of service when the reporting requirement was effective, January 1, 2013 through December 31, 2018.

B. Application of Coding Requirements

This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013 *and before January 1, 2019.*

C. Services Affected

These requirements apply to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the PT, OT, and SLP services furnished under the CORF benefit. They also apply to the therapy services furnished personally by and incident to the service of a physician or a nonphysician practitioner (NPP), including a nurse practitioner (NP), a certified nurse specialist (CNS), or a physician assistant (PA), as applicable.

D. Providers and Practitioners Affected.

The functional reporting requirements apply to the therapy services furnished by the following providers: hospitals, CAHs, SNFs, CORFs, rehabilitation agencies, and HHAs (when the beneficiary is not under a home health plan of care). It applies to the following practitioners: physical therapists, occupational therapists, and speech-language pathologists in private practice (TPPs), physicians, and NPPs as noted above. The term “clinician” is applied to these practitioners throughout this manual section. (See definition section of Pub. 100-02, Chapter 15, section 220.)

E. Function-related G-codes

There are 42 functional G-codes, 14 sets of three codes each. Six of the G-code sets are generally for PT and OT functional limitations and eight sets of G-codes are for SLP functional limitations.

The following G-codes are for functional limitations typically seen in beneficiaries receiving PT or OT services. The first four of these sets describe categories of functional limitations and the final two sets describe “other” functional limitations, which are to be used for functional limitations not described by one of the four categories.

NONPAYABLE G-CODES FOR FUNCTIONAL LIMITATIONS

Code	Long Descriptor	Short Descriptor
Mobility G-code Set		
G8978	Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals	Mobility current status

G8979	Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Mobility goal status
G8980	Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting	Mobility D/C status
Changing & Maintaining Body Position G-code Set		
G8981	Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals	Body pos current status
G8982	Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Body pos goal status
G8983	Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting	Body pos D/C status
Carrying, Moving & Handling Objects G-code Set		
G8984	Carrying, moving & handling objects functional limitation, current status, at therapy episode outset and at reporting intervals	Carry current status
G8985	Carrying, moving & handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Carry goal status
G8986	Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting	Carry D/C status
Self Care G-code Set		
G8987	Self care functional limitation, current status, at therapy episode outset and at reporting intervals	Self care current status
G8988	Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Self care goal status
G8989	Self care functional limitation, discharge status, at discharge from therapy or to end reporting	Self care D/C status

The following “other PT/OT” functional G-codes are used to report:

- a beneficiary’s functional limitation that is not defined by one of the above four categories;
- a beneficiary whose therapy services are not intended to treat a functional limitation;
- or a beneficiary’s functional limitation when an overall, composite or other score from a functional assessment too is used and it does not clearly represent a functional limitation defined by one of the above four code sets.

Code	Long Descriptor	Short Descriptor
Other PT/OT Primary G-code Set		
G8990	Other physical or occupational therapy primary functional limitation, current status, at therapy episode outset and at reporting intervals	Other PT/OT current status

Code	Long Descriptor	Short Descriptor
G8991	Other physical or occupational therapy primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Other PT/OT goal status
G8992	Other physical or occupational therapy primary functional limitation, discharge status, at discharge from therapy or to end reporting	Other PT/OT D/C status
Other PT/OT Subsequent G-code Set		
G8993	Other physical or occupational therapy subsequent functional limitation, current status, at therapy episode outset and at reporting intervals	Sub PT/OT current status
G8994	Other physical or occupational therapy subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Sub PT/OT goal status
G8995	Other physical or occupational subsequent functional limitation, discharge from therapy or end reporting.	Sub PT/OT D/C status

The following G-codes are for functional limitations typically seen in beneficiaries receiving SLP services. Seven are for specific functional communication measures, which are modeled after the National Outcomes Measurement System (NOMS), and one is for any “other” measure not described by one of the other seven.

Code	Long Descriptor	Short Descriptor
Swallowing G-code Set		
G8996	Swallowing functional limitation, current status, at therapy episode outset and at reporting intervals	Swallow current status
G8997	Swallowing functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Swallow goal status
G8998	Swallowing functional limitation, discharge status, at discharge from therapy or to end reporting	Swallow D/C status
Motor Speech G-code Set (Note: These codes are not sequentially numbered)		
G8999	Motor speech functional limitation, current status, at therapy episode outset and at reporting intervals	Motor speech current status
G9186	Motor speech functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Motor speech goal status
G9158	Motor speech functional limitation, discharge status, at discharge from therapy or to end reporting	Motor speech D/C status
Spoken Language Comprehension G-code Set		
G9159	Spoken language comprehension functional limitation, current status, at therapy episode outset and at reporting intervals	Lang comp current status
G9160	Spoken language comprehension functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Lang comp goal status
G9161	Spoken language comprehension functional limitation, discharge status, at discharge from therapy or to end reporting	Lang comp D/C status
Spoken Language Expressive G-code Set		

Code	Long Descriptor	Short Descriptor
G9162	Spoken language expression functional limitation, current status, at therapy episode outset and at reporting intervals	Lang express current status
G9163	Spoken language expression functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Lang press goal status
G9164	Spoken language expression functional limitation, discharge status, at discharge from therapy or to end reporting	Lang express D/C status
Attention G-code Set		
G9165	Attention functional limitation, current status, at therapy episode outset and at reporting intervals	Atten current status
G9166	Attention functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Atten goal status
G9167	Attention functional limitation, discharge status, at discharge from therapy or to end reporting	Atten D/C status
Memory G-code Set		
G9168	Memory functional limitation, current status, at therapy episode outset and at reporting intervals	Memory current status
G9169	Memory functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Memory goal status
G9170	Memory functional limitation, discharge status, at discharge from therapy or to end reporting	Memory D/C status
Voice G-code Set		
G9171	Voice functional limitation, current status, at therapy episode outset and at reporting intervals	Voice current status
G9172	Voice functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Voice goal status
G9173	Voice functional limitation, discharge status, at discharge from therapy or to end reporting	Voice D/C status

The following “other SLP” G-code set is used to report:

- on one of the other eight NOMS-defined functional measures not described by the above code sets; or
- to report an overall, composite or other score from assessment tool that does not clearly represent one of the above seven categorical SLP functional measures.

Code	Long Descriptor	Short Descriptor
Other Speech Language Pathology G-code Set		
G9174	Other speech language pathology functional limitation, current status, at therapy episode outset and at reporting intervals	Speech lang current status
G9175	Other speech language pathology functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting	Speech lang goal status
G9176	Other speech language pathology functional limitation, discharge status, at discharge from therapy or to end reporting	Speech lang D/C status

F. Severity/Complexity Modifiers

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 clinician furnishing the therapy services.

G. Required Reporting of Functional G-codes and Severity Modifiers

The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims at certain specified points during therapy episodes of care. Claims containing these functional G-codes must also contain another billable and separately payable (non-bundled) service. Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC).

Functional 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 progress reporting period;
- When an evaluative procedure, including a re-evaluative one, (HCPCS/CPT codes 92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97161, 97162 ,97163, 97164, 97165, 97166, 97167, 97168) is furnished and billed;
- At the time of discharge from the therapy episode of care–(i.e., on the date services related to the discharge [progress] report are furnished); and
- At the time reporting of a particular functional limitation is ended in cases where the need for further therapy is necessary.
- At the time reporting is begun for a new or different functional limitation within the same episode of care (i.e., after the reporting of the prior functional limitation is ended)

Functional reporting is required on claims throughout the entire episode of care. When the beneficiary has reached his or her goal or progress has been maximized on the initially selected 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 the therapy episode of care. Thus, reporting on more than one functional limitation may be required for some beneficiaries but not simultaneously.

When the beneficiary stops coming to therapy prior to discharge, the clinician should report the functional information on the last claim. If the clinician is unaware that the beneficiary is not returning for therapy until after the last claim is submitted, the clinician cannot report the discharge status.

When functional reporting is required on a claim for therapy services, two G-codes will generally be required.

Two exceptions exist:

1. Therapy services under more than one therapy POC-- Claims may contain more than two nonpayable functional G-codes when in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.
2. One-Time Therapy Visit-- When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, 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.

Each reported functional G-code must also contain the following 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 A/B MACs (A). 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.

NOTE: The KX modifier is not required on the claim line for nonpayable G-codes, but would be required with the procedure code for medically necessary therapy services furnished once the beneficiary's annual cap has been reached.

The following example demonstrates how the G-codes and modifiers are used. In this example, the clinician determines that the beneficiary's mobility restriction is the most clinically relevant functional limitation and selects the Mobility G-code set (G8978 – G8980) to represent the beneficiary's functional limitation. The clinician also determines the severity/complexity of the beneficiary's functional limitation and selects the appropriate modifier. In this example, the clinician determines that the beneficiary has a 75 percent mobility restriction for which the CL modifier is applicable. The clinician expects that at the end of therapy the beneficiaries will have only a 15 percent mobility restriction for which the CI modifier is applicable. When the beneficiary attains the mobility goal, therapy continues to be medically necessary to address a functional limitation for which there is no categorical G-code. The clinician reports this using (G8990 – G8992).

At the outset of therapy-- On the DOS for which the initial evaluative procedure is furnished or the initial treatment day of a therapy POC, the claim for the service will also include two G-codes as shown below.

- G8978-CL to report the functional limitation (Mobility with current mobility limitation of “at least 60 percent but less than 80 percent impaired, limited or restricted”)
- G8979-CI to report the projected goal for a mobility restriction of “at least 1 percent but less than 20 percent impaired, limited or restricted.”

At the end of each progress reporting period-- On the claim for the DOS when the services related to the progress report (which must be done at least once each 10 treatment days) are furnished, the clinician will report the same two G-codes but the modifier for the current status may be different.

- G8978 with the appropriate modifier are reported to show the beneficiary's current status as of this DOS. So if the beneficiary has made no progress, this claim will include G8978-CL. If the beneficiary made progress and now has a mobility restriction of 65 percent CL would still be the appropriate modifier for 65 percent, and G8978-CL would be reported in this case. If the beneficiary now has a mobility restriction of 45 percent, G8978-CK would be reported.
- G8979-CI would be reported to show the projected goal. This severity modifier would not change unless the clinician adjusts the beneficiary's goal.

This step is repeated as necessary and clinically appropriate, adjusting the current status modifier used as the beneficiary progresses through therapy.

At the time the beneficiary is discharged from the therapy episode. The final claim for therapy episode will include two G-codes.

- G8979-CI would be reported to show the projected goal. G8980-CI would be reported if the beneficiary attained the 15 percent mobility goal. Alternatively, if the beneficiary's mobility restriction only reached 25 percent; G8980-CJ would be reported.

To end reporting of one functional limitation-- As noted above, functional reporting is required to continue throughout the entire episode of care. Accordingly, when further therapy is medically necessary after the beneficiary attains the goal for the first reported functional limitation, the clinician would end reporting of the first functional limitation by using the same G-codes and modifiers that would be used at the time of discharge. Using the mobility example, to end reporting of the mobility functional limitation, G8979-CI and G8980-CI would be reported on the same DOS that coincides with end of that progress reporting period.

To begin reporting of a second functional limitation. At the time reporting is begun for a new and different functional limitation, within the same episode of care (i.e., after the reporting of the prior functional limitation is ended). Reporting on the second functional limitation, however, is not begun until the DOS of the next treatment day -- which is day one of the new progress reporting period. When the next functional limitation to be reported is NOT defined by one of the other three PT/OT categorical codes, the G-code set (G8990 - G8992) for the "other PT/OT primary" functional limitation is used, rather than the G-code set for the "other PT/OT subsequent" because it is the first reported "other PT/OT" functional limitation. This reporting begins on the DOS of the first treatment day following the mobility "discharge" reporting, which is counted as the initial service for the "other PT/OT primary" functional limitation and the first treatment day of the new progress reporting period. In this case, G8990 and G8991, along with the corresponding modifiers, are reported on the claim for therapy services.

The table below illustrates when reporting is required using this example and what G-codes would be used.

Example of Required Reporting

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		

H. Required Tracking and Documentation of Functional G-codes and Severity Modifiers

The clinician who furnishes the services must not only report the functional information on the therapy claim, but, he/she must track and document the G-codes and severity modifiers used for this reporting in the beneficiary's medical record of therapy services.

For details related to the documentation requirements, refer to, Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, section 220.4 - Functional Reporting. For coverage rules related to MCTRJCA and therapy goals, refer to Pub. 100-02: a) for outpatient therapy services, see Chapter 15, section 220.1.2 B and b) for instructions specific to PT, OT, and SLP services in the CORF, see Chapter 12, section 10.