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| CMS Manual System | Department of Health & Human Services (DHHS) |
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 2859 | Date: January 17, 2014 |
| | Change Request 8426 |

SUBJECT: Applying the Therapy Caps to Critical Access Hospitals

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to implement a regulation subjecting outpatient therapy services furnished by a CAH to the therapy cap and related policies, which include the exceptions process and the manual medical review of claims in excess of the therapy threshold when required by statute.

EFFECTIVE DATE: January 1, 2014

IMPLEMENTATION DATE: January 31, 2014

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 | 5/10.3/Application of Financial Limitations |
| R | 5/10.4/Claims Processing Requirements for Financial Limitations |
| 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 obliged 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**

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

Attachment - Business Requirements

| | | | |
|-------------|-------------------|------------------------|----------------------|
| Pub. 100-04 | Transmittal: 2859 | Date: January 17, 2014 | Change Request: 8426 |
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SUBJECT: Applying the Therapy Caps to Critical Access Hospitals

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I. GENERAL INFORMATION

A. Background: Section 4541(c) of the Balanced Budget Act of 1997 amended section 1833(g) of the Act to create annual limits on per beneficiary incurred expenses on therapy services known as “therapy caps.” This provision expressly applies the therapy caps to outpatient therapy services described under section 1861(p) of the Act, which also applies to therapy services described under sections 1861(g) and 1861(l)(2) of the Act, and exempts outpatient therapy services described under section 1833(a)(8)(B) of the Act, which is known as the “outpatient hospital services exemption.” When the therapy caps were implemented in CY 1999, CMS interpreted the outpatient hospital services exemption to include therapy services furnished by a critical access hospital (CAH).

The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA) temporarily removed the outpatient hospital services exemption from October 1, 2012 through December 31, 2012. CMS concluded that the MCTRJCA amendment only affected the outpatient hospital services described under section 1833(a)(8)(B) of the Act for which payment is made under section 1834(k)(1)(B) of the Act.

The American Taxpayer Relief Act of 2012 (ATRA) removed the outpatient hospital services exemption through December 31, 2013. The ATRA also amended the Act to count outpatient therapy services furnished between January 1, 2013 and December 31, 2013 by a CAH towards a beneficiary’s annual cap and threshold using the amount that would be payable if such services were paid under section 1834(k)(1)(B) of the Act instead of being paid under section 1834(g) of the Act. The ATRA amendment specifically does not change the method of payment for outpatient therapy services furnished by a CAH. CMS concluded that the ATRA amendment does not explicitly make the therapy caps applicable to services furnished by CAHs, but provides a methodology to count CAH services towards the caps using the Medicare Physician Fee Schedule rate. As a result, from October 1, 2012 to December 31, 2013, CAH services continued to be exempt from the therapy caps, whereas services furnished in outpatient hospital settings are subject to the cap policies.

In August 2012, CMS issued Change Request 7881, which created a mechanism to allow Medicare Administrative Contractors (MACs) both to count CAH services towards the cap amounts and to apply the caps to services furnished by CAHs, if necessary. In order to ensure that CAH services counted towards the cap amounts without being subject to the cap policy, CMS issued subsequent instructions for MACs to automatically apply the KX modifier to CAH services found to be over the caps, effective January 1, 2013.

B. Policy: This policy applies the therapy caps to therapy services furnished by a CAH as required by modifications to the regulation at §410.59 and §410.60. Beginning January 1, 2014, outpatient therapy services furnished by a CAH are subject to the therapy cap and related policies. If extended without modification the exceptions process, including the use of the KX modifier to attest the medical necessity of therapy services above the caps, will apply to services furnished by a CAH in CY 2014. If extended without modification the manual medical review of claims in excess of the \$3,700 threshold will apply to services furnished by a CAH in CY 2014. Accordingly, the requirements below instruct the MACs to no longer automatically apply the KX modifier to CAH services, effective January 1, 2014.

II. BUSINESS REQUIREMENTS TABLE

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

| Number | Requirement | Responsibility | | | | | | | | |
|--------|--|----------------|---|-------------|----------------------------|---------------------------|-------------|-------------|-------------|-------|
| | | A/B MAC | | | D M E M A C | Shared-System Maintainers | | | | Other |
| | | A | B | H H H | | F I S S | M C S | V M S | C W F | |
| 8426.1 | Medicare contractors shall update the legislation effective screen for legislation effective indicator B so that the effective through date is 12/31/2015. | X | | | | | | | | |
| 8426.2 | Medicare contractors shall ensure that if a claim with type of bill 12x and a CAH provider number, or type of bill 85x receives one of the therapy cap edits from CWF, the contractor automatically places a KX modifier on the identified claim lines only if the dates of service are between January 1, 2013 and December 31, 2013. | X | | | | | | | | |
| 8426.3 | Medicare contractors shall ensure that if a claim with type of bill 12x and a CAH provider number, or type of bill 85x is rejected by CWF due to the \$3,700 threshold, the contractor automatically applies the CWF override code only if the dates of service are between January 1, 2013 and December 31, 2013. | X | | | | | | | | |

III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|--------|--|----------------|---|-------------|----------------------------|------------------|
| | | A/B MAC | | | D M E M A C | C E D I |
| | | A | B | H H H | | |
| 8426.4 | MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in | X | | | | |

| Number | Requirement | Responsibility | | | | |
|--------|---|----------------|---|-------------|-------------|------------------|
| | | A/B MAC | | | D M E | C E D I |
| | | A | B | H H H | | |
| | billing and administering the Medicare program correctly. | | | | | |

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

| X-Ref Requirement Number | Recommendations or other supporting information: |
|--------------------------|---|
| 8426.2 & 8426.3 | These requirements revise the conditions of Expert Claims Processing System (ECPS) events created by previous instructions. |

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

V. CONTACTS

Pre-Implementation Contact(s): Simone Dennis, Simone.Dennis@cms.hhs.gov (Policy Contact) , Wil Gehne, Wilfried.Gehne@cms.hhs.gov (Institutional Claims Contact)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

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 do 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.

10.3 - Application of Financial Limitations

(Rev. 2859, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-31-14)

(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 Critical Access Hospitals. During this period, only *type of bill* 12x claims with a CMS certification number in the *Critical Access Hospital* range and *type of bill* 85x claims are excluded. *Effective for dates of service on or after January 1, 2014, the limits also apply to Critical Access Hospitals.*

Contractors apply the financial limitations 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 in order, according to the dates when the claims were received. When limitations apply, the Common Working File (CWF) tracks the limits. Shared system maintainers are not responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limit.

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.

A. Exceptions to Therapy Caps - General

The following policies concerning exceptions to caps due to medical necessity apply only when the exceptions process is in effect. With the exception of the use of the KX modifier, the guidance in this section concerning medical necessity applies as well to services provided before caps are reached.

Provider and supplier information concerning exceptions is in this chapter and in Pub. 100-02, Chapter 15, section 220.3. Exceptions shall be identified by a modifier on the claim and supported by documentation.

The beneficiary may qualify for use of the cap exceptions at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception are in the form of a KX modifier added to claim lines. (See subsection D. for use of the KX modifier.)

Use of the exception process does not exempt services from manual or other medical review processes as described in Pub. 100-08. Rather, atypical use of the automatic exception process may invite contractor scrutiny. Particular care should be taken to document improvement and avoid billing for services that do not meet the requirements for skilled services, or for services which are maintenance rather than rehabilitative treatment (see Pub. 100-02, Chapter 15, sections 220.2, 220.3, and 230).

The KX modifier, described in subsection D., is added to claim lines to indicate that the clinician attests that services are medically necessary and justification is documented in the medical record.

B. Exceptions Process

An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve their prior functional status or maximum expected functional status within a reasonable amount of time.

No special documentation is submitted to the contractor for exceptions. The clinician is responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary may qualify for the exception because documentation justifies medically necessary services above the caps. The clinician's opinion is not binding on the Medicare contractor who makes the final determination concerning whether the claim is payable.

Documentation justifying the services shall be submitted in response to any Additional Documentation Request (ADR) for claims that are selected for medical review. Follow the documentation requirements in Pub. 100-02, Chapter 15, section 220.3. If medical records are requested for review, clinicians may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception.

In making a decision about whether to utilize the exception, clinicians shall consider, for example, whether services are appropriate to--

- The patient's condition, including the diagnosis, complexities, and severity;
- The services provided, including their type, frequency, and duration; and
- The interaction of current active conditions and complexities that directly and significantly influence the treatment such that it causes services to exceed caps.

In addition, the following should be considered before using the exception process:

1. Exceptions for Evaluation Services

Evaluation-- The CMS will except therapy evaluations from caps after the therapy caps are reached when evaluation is necessary, e.g., to determine if the current status of the beneficiary requires therapy services. For example, the following CPT codes for evaluation procedures may be appropriate:

92521, 92522, 92523, 92524, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004.

These codes will continue to be reported as outpatient therapy procedures as listed in the Annual Therapy Update for the current year at:

http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

They are not diagnostic tests. Definitions of evaluations and documentation are found in Pub. 100-02, sections 220 and 230.

Other Services-- There are a number of sources that suggest the amount of certain services that may be typical, either per service, per episode, per condition, or per discipline. For example, see the CSC - Therapy Cap Report, 3/21/2008, and CSC - Therapy Edits Tables 4/14/2008 at www.cms.hhs.gov/TherapyServices (Studies and Reports), or more recent utilization reports. Professional literature and guidelines from professional associations also provide a basis on which to estimate whether the type, frequency, and intensity of services are appropriate to an individual. Clinicians and contractors should utilize available evidence related to the patient's condition to justify provision of medically necessary services to individual beneficiaries, especially when they exceed caps. Contractors shall not limit medically necessary services that are justified by scientific research applicable to the beneficiary. Neither contractors nor clinicians shall utilize professional literature and scientific reports to justify payment for continued services after an individual's goals have been met earlier than is typical. Conversely, professional literature and scientific

reports shall not be used as justification to deny payment to patients whose needs are greater than is typical or when the patient's condition is not represented by the literature.

2. Exceptions for Medically Necessary Services

Clinicians may utilize the process for exception for any diagnosis or condition for which they can justify services exceeding the cap. Regardless of the diagnosis or condition, the patient must also meet other requirements for coverage.

Bill the most relevant diagnosis-- As always, when billing for therapy services, the ICD-9 code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason to report another diagnosis code. For example, when a patient with diabetes is being treated with therapy for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment). Where it is possible in accordance with State and local laws and the contractors' local coverage determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy diagnosis code in the primary position. In that case, the relevant diagnosis code should, if possible, be on the claim in another position.

Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code.

The condition or complexity that caused treatment to exceed caps must be related to the therapy goals and must either be the condition that is being treated or a complexity that directly and significantly impacts the rate of recovery of the condition being treated such that it is appropriate to exceed the caps. Documentation for an exception should indicate how the complexity (or combination of complexities) directly and significantly affects treatment for a therapy condition.

If the contractor has determined that certain codes do not characterize patients who require medically necessary services, providers/suppliers may not use those codes, but must utilize a billable diagnosis code allowed by their contractor to describe the patient's condition. Contractors shall not apply therapy caps to services based on the patient's condition, but only on the medical necessity of the service for the condition. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted.

Contact your contractor for interpretation if you are not sure that a service is applicable for exception.

It is very important to recognize that most conditions would not ordinarily result in services exceeding the cap. Use the KX modifier only in cases where the condition of the individual patient is such that services are APPROPRIATELY provided in an episode that exceeds the cap. Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry. Be sure that documentation is sufficiently detailed to support the use of the modifier.

In justifying exceptions for therapy caps, clinicians and contractors should not only consider the medical diagnoses and medical complications that might directly and significantly influence the amount of treatment required. Other variables (such as the availability of a caregiver at home) that affect appropriate treatment shall also be considered. Factors that influence the need for treatment should be supportable by published research, clinical guidelines from professional sources, and/or clinical or common sense. See Pub. 100-02, Chapter 15, section 220.3 for information related to documentation of the evaluation, and section 220.2 on medical necessity for some factors that complicate treatment.

NOTE: The patient's lack of access to outpatient hospital therapy services alone, when outpatient hospital therapy services are excluded from the limitation, does not justify excepted services. Residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for

whom transportation to the hospital is a physical hardship, or lack of therapy services at hospitals in the beneficiary's county may or may not qualify as justification for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not. For dates of service on or after October 1, 2012, therapy services furnished in an outpatient hospital are not excluded from the limitation.

C. Appeals Related to Disapproval of Cap Exceptions

Disapproval of Exception from Caps-- When a service beyond the cap is determined to be medically necessary, it is covered and payable. But, when a service provided beyond the cap (outside the benefit) is determined to be NOT medically necessary, it is denied as a benefit category denial. Contractors may review claims with KX modifiers to determine whether the services are medically necessary, or for other reasons. Services that exceed therapy caps but do not meet Medicare criteria for medically necessary services are not payable even when clinicians recommend and furnish these services.

Services without a Medicare benefit may be billed to Medicare with a GY modifier for the purpose of obtaining a denial that can be used with other insurers. See Pub. 100-04, Chapter 1, section 60.4 for appropriate use of modifiers.

APPEALS –If a beneficiary whose excepted services do not meet the Medicare criteria for medical necessity elects to receive such services and a claim is submitted for such services, the resulting determination would be subject to the administrative appeals process. Further details concerning appeals are found in Pub. 100-04, Chapter 29.

D. Use of the KX Modifier for Therapy Cap Exceptions

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 carrier or A/B MAC, refer to:
 - Medicare Claims Processing Manual, Pub.100-04, Chapter 26, for more detail regarding completing the CMS-Form 1500 claim form, including the placement of HCPCS modifiers. **NOTE:** The CMS-Form 1500 currently has space for providing two modifiers in block 24D, but, if the provider has more than two 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 A/B MAC, 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 FI or A/B MAC:
 - 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 Medicare Claims Processing Manual, Pub.100-04, 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.

E. Therapy Cap Manual Review Threshold

For calendar year 2012, there shall be two total therapy service thresholds of \$3700 per year: one annual threshold each for

(1) Occupational therapy services.

(2) Physical therapy services and speech-language pathology services combined.

Services shall accrue toward the thresholds beginning with claims with dates of service on and after January 1, 2012. The thresholds shall apply to both services showing the KX modifier and those without the modifier. Beginning with claims with dates of service on and after October 1, 2012, contractors shall apply the thresholds to claims exceeding it by suspending the claim for manual review. Instructions regarding the manual review process may be found in the Program Integrity Manual.

F. Identifying the Certifying Physician

Therapy plans of care must be certified by a physician or non-physician practitioner (NPP), per the requirements in the Medicare Benefit Policy Manual, Pub.100-02, Chapter 15, section 220.1.3. Further, the National Provider Identifier (NPI) of the certifying physician/NPP identified for a therapy plan of care must be included on the therapy claim.

For the purposes of processing professional claims, the certifying physician/NPP is considered a referring provider. At the time the certifying physician/NPP is identified for a therapy plan of care, private practice therapists (PPTs), physicians or NPPs, as appropriate, submitting therapy claims, are to treat it as if a referral has occurred for purposes of completing the claim and to follow the instructions in the appropriate ASC X12 837 Professional Health Care Claim Technical Report 3 (TR3) for reporting a referring provider (for paper claims, they are to follow the instructions for identifying referring providers per Chapter 26 of this IOM). These instructions include requirements for reporting NPIs.

Currently, in the 5010 version of the ASC X12 837 Professional Health Care Claim TR3, referring providers are first reported at the claim level; additional referring providers are reported at the line level only when they are different from that identified at the claim level. Therefore, there will be at least one referring provider identified at the claim level on the ASC X12 837 Professional claim for therapy services. However, because of the hierarchical nature of the ASC X12 837 health care claim transaction, and the possibility of other types of referrals applying to the claim, the number of referring providers identified on a professional claim may vary. For example, on a claim where one physician/NPP has certified all the therapy plans of care, and there are no other referrals, there would be only one referring provider identified at the claim level and none at the line levels. Conversely, on a claim also containing a non-therapy referral made by a different physician/NPP than the one certifying the therapy plan of care, the billing provider may elect to identify either the nontherapy or the therapy referral at the claim level, with the other referral(s) at the line levels. Similarly, on a claim having different certifying physician/NPPs for different therapy plans of care, only one of these physician/NPPs will be identified at the claim level, with the remainder identified at the line levels. These scenarios are only examples: there may be other patterns of representing referring providers at the claim and line levels depending upon the circumstances of the care and the manner in which the provider applies the requirements of the ASC X12 837 Professional Health Care Claim TR3.

For situations where the physician/NPP is both the certifier of the plan of care and furnishes the therapy service, he/she supplies his/her own information, including the NPI, in the appropriate referring provider loop (or, appropriate block on the 1500 form). This is applicable to those therapy services that are personally furnished by the physician/NPP as well as to those services that are furnished incident to their own and delivered by "qualified personnel" (see section 230.5 of this manual for qualifications for incident to personnel).

Contractors shall edit to ensure that there is at least one claim-level referring provider identified on professional therapy claims, and shall use the presence of the therapy modifiers (GN, GP, GO) to identify those claims subject to this requirement.

For the purposes of processing institutional claims, the certifying physician/NPP and their NPI are reported in the Attending Provider fields on institutional claim formats. Since the physician/NPP is certifying the

therapy plan of care for the services on the claim, this is consistent with the National Uniform Billing Committee definition of the Attending Provider as “the individual who has overall responsibility for the patient’s medical care and treatment” that is reported on the claim. In cases where a patient is receiving care under more than one therapy plan of care (OT, PT, or SLP) with different certifying physicians/NPPs, the second certifying physicians/NPP and their NPI are reported in the Referring Physician fields on institutional claim formats.

G. MSN Messages

Existing MSN messages 38.18, 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this manual. Contractors add the applied amount for individual beneficiaries and the generic limit amount to all MSNs that require them. For details of these MSNs, see: http://www.cms.gov/MSN/02_MSN%20Messages.asp

10.4 - Claims Processing Requirements for Financial Limitations

(Rev. 2859, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-31-14)

A. Requirements – Institutional Claims

Regardless of financial limits on therapy services, CMS requires modifiers (See section 20.1 of this chapter) on specific codes for the purpose of data analysis. Beneficiaries may not be simultaneously covered by Medicare as an outpatient of a hospital and as a patient in another facility. When outpatient hospital therapy services are excluded from the limitation, the beneficiary must be discharged from the other setting and registered as a hospital outpatient in order to receive payment for outpatient rehabilitation services in a hospital outpatient setting after the limitation has been reached.

A hospital may bill for services of a facility as hospital outpatient services if that facility meets the requirements of a department of the provider (hospital) under 42 CFR 413.65. Facilities that do not meet those requirements are not considered to be part of the hospital and may not bill under the hospital’s provider number, even if they are owned by the hospital. For example, services of a Comprehensive Outpatient Rehabilitation Facility (CORF) must be billed as CORF services and not as hospital outpatient services, even if the CORF is owned by the hospital.

The CWF applies the financial limitation to the following bill types 22X, 23X, 34X, 74X and 75X using the MPFS allowed amount (before adjustment for beneficiary liability).

For SNFs, the financial limitation does apply to rehabilitation services furnished to those SNF residents in noncovered stays (bill type 22X) who are in a Medicare-certified section of the facility—i.e., one that is either certified by Medicare alone, or is dually certified by Medicare as a SNF and by Medicaid as a nursing facility (NF). For SNF residents, consolidated billing requires all outpatient rehabilitation services be billed to Part B by the SNF. If a resident has reached the financial limitation, and remains in the Medicare-certified section of the SNF, no further payment will be made to the SNF or any other entity. Therefore, SNF residents who are subject to consolidated billing may not obtain services from an outpatient hospital after the cap has been exceeded.

Once the financial limitation has been reached, services furnished to SNF residents who are in a non-Medicare certified section of the facility—i.e., one that is certified only by Medicaid as a NF or that is not certified at all by either program—use bill type 23X. For SNF residents in non-Medicare certified portions of the facility and SNF nonresidents who go to the SNF for outpatient treatment (bill type 23X), medically necessary outpatient therapy may be covered at an outpatient hospital facility after the financial limitation has been exceeded when outpatient hospital therapy services are excluded from the limitation.

B. Requirements - Professional Claims

Claims containing any of the “always therapy” codes should have one of the therapy modifiers appended (GN, GO, GP). When any code on the list of therapy codes is submitted with specialty codes “65” (physical therapist in private practice), “67” (occupational therapist in private practice), or “15” (speech-language pathologist in private practice) they always represent therapy services, because they are provided by therapists. Contractors shall return claims for these services when they do not contain therapy modifiers for the applicable HCPCS codes.

The CMS identifies certain codes listed at:

http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage as “sometimes therapy” services, regardless of the presence of a financial limitation. Claims from physicians (all specialty codes) and nonphysician practitioners, including specialty codes “50” (Nurse Practitioner), “89,” (Clinical Nurse Specialist), and “97,” (Physician Assistant) may be processed without therapy modifiers when they are not therapy services. On review of these claims, “sometimes therapy” services that are not accompanied by a therapy modifier must be documented, reasonable and necessary, and payable as physician or nonphysician practitioner services, and not services that the contractor interprets as therapy services.

The CWF will capture the amount and apply it to the limitation whenever a service is billed using the GN, GO, or GP modifier.

C. Contractor Action Based on CWF Trailer

Upon receipt of the CWF error code/trailer, contractors are responsible for assuring that payment does not exceed the financial limitations, when the limits are in effect, except as noted below.

In cases where a claim line partially exceeds the limit, the contractor must adjust the line based on information contained in the CWF trailer. For example, where the MPFS allowed amount is greater than the financial limitation available, always report the MPFS allowed amount in the “Financial Limitation” field of the CWF record and include the CWF override code. See example below for situations where the claim contains multiple lines that exceed the limit.

EXAMPLE:

Services received to date are \$15 under the limit. There is a \$15 allowed amount remaining that Medicare will cover before the cap is reached.

Incoming claim: Line 1 MPFS allowed amount is \$50.
Line 2 MPFS allowed amount is \$25.
Line 3, MPFS allowed amount is \$30.

Based on this example, lines 1 and 3 are denied and line 2 is paid. The contractor reports in the “Financial Limitation” field of the CWF record “\$25.00 along with the CWF override code. The contractor always applies the amount that would least exceed the limit. Since institutional claims systems cannot split the payment on a line, CWF will allow payment on the line that least exceeds the limit and deny other lines.

D. Additional Information for Contractors During the Time Financial Limits Are in Effect With or Without Exceptions

Once the limit is reached, if a claim is submitted, CWF returns an error code stating the financial limitation has been met. Over applied lines will be identified at the line level. The outpatient rehabilitation therapy services that exceed the limit should be denied. The contractors use claim adjustment reason code 119 - Benefit maximum for this time period or occurrence has been reached- in the provider remittance advice to

establish the reason for denial. Provider liability (group code CO) or beneficiary liability (group code PR) are reported on the remittance advice as defined by section 10.5.

In situations where a beneficiary is close to reaching the financial limitation and a particular claim might exceed the limitation, the provider/supplier should bill the usual and customary charges for the services furnished even though such charges might exceed the limit. The CWF will return an error code/trailer that will identify the line that exceeds the limitation.

Because CWF applies the financial limitation according to the date when the claim was received (when the date of service is within the effective date range for the limitation), it is possible that the financial limitation will have been met before the date of service of a given claim. Such claims will prompt the CWF error code and subsequent contractor denial.

When the provider/supplier knows that the limit has been reached, and exceptions are either not appropriate or not available, further billing should not occur. The provider/supplier should inform the beneficiary of the limit and their option of receiving further covered services from an outpatient hospital when outpatient hospital therapy services are excluded from the limitation (unless consolidated billing rules prevent the use of the outpatient hospital setting). If the beneficiary chooses to continue treatment at a setting other than the outpatient hospital where medically necessary services may be covered, the services may be billed at the rate the provider/supplier determines. Services provided in a capped setting after the limitation has been reached are not Medicare benefits and are not governed by Medicare policies.

If a beneficiary elects to receive services that exceed the cap limitation and a claim is submitted for such services, the resulting determination is subject to the administrative appeals process as described in subsection C. of section 10.3 and Pub. 100-04, Chapter 29.

10.6 - Functional Reporting

(Rev. 2859, Issued: 01-17-14, Effective: 01-01-14, Implementation: 01-31-14)

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.

B. Application of New Coding Requirements

This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013. A testing period will be in effect from January 1, 2013, until July 1, 2013, to allow providers and practitioners to use the new coding requirements to assure that systems work. Claims for therapy services furnished on and after July 1, 2013, that do not contain the required functional G-code/modifier information will be returned or rejected, as applicable.

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

| | 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 | Carry current status |

| | | |
|-----------------------------|---|--------------------------|
| | limitation, current status, at therapy episode outset and at reporting intervals | |
| 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.

| | 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 |
| 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 |

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.

| | 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 | | |
| 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.

| | 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, 97001, 97002, 97003, 97004) 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 FIs and A/MACs. For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.

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#1 for 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.