CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1775	**Date: January 27, 2017**
	Change Request 9933

SUBJECT: Updated Editing of Professional Therapy Services

I. SUMMARY OF CHANGES: This change request identifies new therapy Common Procedure Terminology (CPT) codes for physical and occupational therapy evaluations and instructs Medicare Administrative Contractors (MACs) on editing requirements.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2017

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
N/A	

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:
One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1775	Date: January 27, 2017	Change Request: 9933

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I. GENERAL INFORMATION

A. Background: Original Medicare claims processing systems contain edits to ensure claims for the evaluative procedures furnished by rehabilitative therapy clinicians – including physical therapists, occupational therapists and speech-language pathologists – are coded correctly. These edits ensure that when the codes for evaluative services are submitted, the therapy modifier (GP, GO or GN) that reports the type of therapy plan of care is consistent with the discipline described by the evaluation or re-evaluation code. The edits also ensure that Functional Reporting occurs, i.e., that functional G-codes, along with severity modifiers, always accompany codes for therapy evaluative services. These edits were applied to institutional claims in a recent issuance, Change Request (CR) 9698. This notification applies these edits to professional claims.

For calendar year (CY) 2017, eight new CPT codes (97161-97168) were created to replace existing codes (97001-97004) to report physical therapy (PT) and occupational therapy (OT) evaluations and reevaluations. The new CPT code descriptors include specific components that are required for reporting as well as the typical face-to-face times. In another recent issuance, CR 9782, we described the new PT and OT code sets, each comprised of three new codes for evaluation – stratified by low, moderate, and high complexity – and one code for re-evaluation. CR 9782 designated all eight new codes as "always therapy" (always require a therapy modifier) and added them to the 2017 therapy code list located on the CMS website at http://**www.cms.gov**/Medicare/Billing/TherapyServices/index.html. For a complete listing of the new codes, their CPT long descriptors, and related policies, please refer to CR 9782.

This notification applies the coding requirements for certain evaluative procedures that are currently outlined in Pub. 100-04, Medicare Claims Processing Manual (MCPM), Chapter 5 to the new codes for PT and OT evaluations and re-evaluations. These coding requirements include the payment policies for evaluative procedures that (a) require the application of discipline-specific therapy modifiers and (b) necessitate Functional Reporting using G-codes and severity modifiers. The new codes are also added to the list of evaluation codes that CMS will except from the caps after the therapy caps are reached when an evaluation is necessary, e.g., to determine if the current status of the beneficiary requires therapy services.

B. Policy: This notification implements the following payment policies related to professional claims for therapy services for the new codes for PT and OT evaluative procedures – claims without the required information will be returned/rejected:

Therapy modifiers. The new PT and OT codes are added to the current list of evaluative procedures that require a specific therapy modifier to identify the plan of care under which the services are delivered to be on the claim for therapy services. Therapy modifiers GP, GO or GN are required to report the type of therapy plan of care – PT, OT, or SLP, respectively. This payment policy requires that each new PT evaluative procedure code – 97161, 97162, 97163 or 97164 – to be accompanied by the GP modifier; and, (b) each new code for an OT evaluative procedure – 97165, 97166, 97167 or 97168 – be reported with the

GO modifier.

Functional Reporting (FR). In addition to other Functional Reporting requirements, current payment policy requires Functional Reporting, using G-codes and severity modifiers, when an evaluative procedure is furnished and billed. This notification adds the eight new codes for PT and OT evaluations and re-evaluations – 97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168 – to the procedure code list of evaluative procedures that necessitate Functional Reporting. A severity modifier (CH – CN) is required to accompany each functional G-code (G8978-G8999, G9158-9176, and G9186) on the same line of service.

For each evaluative procedure code, Functional Reporting requires either two or three functional G-codes and related severity modifiers be on the same claim. Two G-codes are typically reported on specified claims throughout the therapy episode. However, when an evaluative service is furnished that represents a one-time therapy visit, the therapy clinician reports all three G-codes in the functional limitation set – G-codes for Current Status, Goal Status and Discharge Status. For the documentation requirements related to Functional Reporting, please refer to Pub. 100-02, Medicare Benefits Policy Manual, chapter 15, section 220.4.

CMS coding requirements for Functional Reporting applied through this notification ensure that at least two G-codes in a functional set and their corresponding severity modifiers are present on the same claim with any one of the codes on this evaluative procedure code list. The required reporting of G-codes includes: (a) G-codes for Current Status and Goal Status; or, (b) G-codes for Discharge Status and Goal Status.

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	
9933.1	Contractors shall return/reject therapy evaluation/re-evaluation Healthcare Common Procedure Coding System (HCPCS) codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, and 97168 when not submitted with a functional current status G-code/functional severity modifier and paired functional goal status G-code/functional severity modifier OR appropriate paired functional goal status G-code/functional severity modifier and paired functional discharge status G-code/functional severity modifier.		X							
9933.1.1	Contractors shall return the following message when codes 97161, 97162 ,97163, 97164, 97165, 97166, 97167and 97168 are not submitted with a functional current status G-code/functional severity modifier and paired functional goal status G-code/functional severity modifier OR appropriate paired functional goal status G-code/functional severity modifier and		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	paired functional discharge status G-code/functional severity modifier CO CARC – 16: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication**.** RARC – N572: This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.									
9933.2	Contractors shall note the following new "always therapy" codes and return/reject claims reporting HCPCS codes 97161, 97162, 97163 and 97164, if modifier GP is not present.		X							
9933.2.1	Contractors shall return the following message when modifier GP is missing: CO CARC – 4: The procedure code is inconsistent with the modifier used or a required modifier is missing**.**		X							
9933.3	Contractors shall note the following new "always therapy" codes and return/reject claims reporting HCPCS codes 97165, 97166, 97167 and 97168, if modifier GO is not present.		X							
9933.3.1	Contractors shall return the following message when modifier GO is missing: CO CARC – 4: The procedure code is inconsistent with the modifier used or a required modifier is missing**.**		X							
9933.4	Contractors shall return/reject "always therapy" codes submitted without a therapy modifier.		X							
9933.4.1	Contractors shall return the following message when an "always therapy" code is submitted without a therapy modifier:		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	CO CARC – 4: The procedure code is inconsistent with the modifier used or a required modifier is missing**.**									
9933.5	Contractors shall be in compliance with the instructions found in Pub 100-04, Medicare Claims Processing Manual, chapter 5.		X							
9933.6	Contractors shall not search for claims that do not report new evaluation codes with dates of service on or after January 1, 2017 which were received before the implementation date, but contractors may adjust claims that are brought to their attention.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9933.7	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 5 business days after receipt of the notification from CMS announcing the availability of the 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 billing and administering the Medicare program correctly.		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, 410-786-5001 or brian.reitz@cms.hhs.gov , PAMELA WEST, 410-786-2302 or pamela.west@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0