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Updated Editing of Always Therapy Services - MCS

MLN Matters Number: MM10176 Revised
Related Change Request (CR) Number: 10176
Related CR Release Date: December 21, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3936CP
Implementation Date: January 2, 2018

This article was revised on December 21, 2017, to reflect an updated CR10176. The CR was revised to delete HCPCS code 97532 from the list of therapy codes in the attachment to the CR. That code is also removed from the list of those codes in this article. Also, in the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for therapists, physicians, and certain other practitioners billing Medicare Administrative Contractors (MACs) for therapy services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 10176 implements revised editing of Part B “Always Therapy” services to require the appropriate therapy modifier in order for the service to be accurately applied to the therapy cap. CR10176 contains no new policy. Instead, the guidelines presented in the CR improve the enforcement of longstanding, existing instructions. Make sure your billing staffs are aware of these revisions.

BACKGROUND

Services furnished under the Outpatient Therapy (OPT) services benefit – including Speech-Language Pathology (SLP), Occupational Therapy (OT), and Physical Therapy (PT) – are subject to the financial limitations, known as therapy caps, originally required under Section 4541 of the Balanced Budget Act (1997).

There are two such caps. One cap is for PT and SLP services combined and another cap is for OT services. In order to accrue incurred expenses to the correct therapy cap; the use of one of the three therapy modifiers (GN, GO, or GP) is required on a certain set of Healthcare Common Procedure Coding System (HCPCS) codes in order to identify when each OPT service is furnished under an SLP, OT, or PT plan of care, respectively.

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Medicare recognizes the services furnished under the OPT services benefit as either “always” or “sometimes” therapy and publishes this list as an Annual Update on the Therapy Services Billing page at https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate.html.

On professional claims, each code designated as “always therapy”:

- Must always be furnished under an SLP, OT, or PT plan of care, regardless of who furnishes them; and, as such,
- Must always be accompanied by one of the GN, GO, or GP therapy modifiers.

In addition, several “always therapy” codes have been identified as discipline-specific – requiring the GN modifier for six codes, the GO modifier for four codes, and the GP modifier for four codes, as illustrated in Tables 1-3.

Table 1: Codes Requiring the “GN” Therapy Modifier

Code	CPT Short Descriptor	Therapy Modifier Required
92521	Evaluation of speech fluency	GN
92522	Evaluate speech production	GN
92523	Speech sound lang comprehend	GN
92524	Behavral quality analys voice	GN
92597	Oral speech device eval	GN
92607	Ex for speech device rx 1hr	GN

Table 2: Codes Requiring the “GO” Therapy Modifier

Code	CPT Short Descriptor	Therapy Modifier Required
97165	Ot eval low complex 30 min	GO
97166	Ot eval mod complex 45 min	GO
97167	Ot eval high complex 60 min	GO
97168	Ot re-eval est plan care	GO

Table 3: Codes Requiring the "GP" Therapy Modifier

Code	CPT Short Descriptor	Therapy Modifier Required
97161	Pt eval low complex 20 min	GP
97162	Pt eval mod complex 30 min	GP
97163	Pt eval high complex 45 min	GP
97164	Pt re-eval est plan care	GP

The following "Always Therapy" HCPCS codes require a GN, GO, or GP modifier, as appropriate. Descriptors for these codes are included as an attachment to CR 10176.

92507 92508 92526 92608 92609 96125 97012 97016 97018 97022 97024
97026 97028 97032 97033 97034 97035 97036 97039 97110 97112 97113
97116 97124 97139 97140 97150 97530 97533 97535 97537 97542
97750 97755 97760 97761 97762 97799 G0281 G0283 G0329

In addition to Therapists in Private Practice (TPPs) – including physical therapists, occupational therapists, and speech-language pathologists – professional claims for OPT services may be furnished by physicians and certain Non-Physician Practitioners (NPPs) – specifically, physician assistants, nurse practitioners, and certified nurse specialists.

All OPT services furnished by TPPs are always considered therapy services, regardless of whether they are designated as "always therapy" or "sometimes therapy." As such, the appropriate therapy modifier must be included on the claim. However, it may be clinically appropriate for physicians and NPPs to furnish OPT services that have been designated "sometimes therapy" codes outside a therapy plan of care - in these cases, therapy modifiers are not required and claims may be processed without them.

During analyses of Medicare claims data for OPT services, the Centers for Medicare & Medicaid Services (CMS) found that these "always therapy" codes and modifiers are not always used in a correct and consistent manner. CMS found OPT professional claims for "always therapy" codes without the required modifiers. Also, CMS found claims that reported more than one therapy modifier for the same therapy service; for example, both a GP and GO modifier, when only one modifier was allowed.

These claims represent non-compliant billing by TPPs, physicians, and NPPs, and hamper CMS' ability to properly track the therapy caps and analyze claims data for purposes of Medicare program improvements. The requirements in CR10176 will create new edits for Medicare professional claims processing systems to return claims when "always therapy" codes and the associated therapy modifiers are improperly reported.

Providers should expect the following:

- MACs will return/reject claims which contain an “always therapy” procedure code, but do not also contain the appropriate discipline-specific therapy modifier of GN, GO, or GP.
- MACs will also return/reject claims if any service line on the claim contains more than one occurrence of a GN, GO, or GP therapy modifier.
- MACs who are returning/rejecting such claims will use Group Code CO and Claim Adjustment Reason Code (CARC) 4 on the related remittance advice.

ADDITIONAL INFORMATION

The official instruction, CR10176, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3936CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/.

DOCUMENT HISTORY

Date of Change	Description
December 21, 2017	The article was revised to reflect an updated CR. The CR was revised to remove HCPCS code 97532 from the list of always therapy codes in the attachment to the CR. That code is also removed from the list of those codes in this article. Also, in the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.
September 15, 2017	The article was revised to reflect an updated CR. In the article, the CR release date, transmittal, number and link to the transmittal changed. All other information is unchanged.
July 31, 2017	Initial article released.