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Part A/B Outpatient Therapy Claims-Based Data Collection Reporting and Manual Medical Review Ask-the-Contractor Teleconference

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Claims-Based Data Collection Requirement for Outpatient Therapy Services

This reporting and collection system requires claims for therapy services to include non-payable HCPCS G-codes and related modifiers. These non-payable G-codes and severity/complexity modifiers provide information about the beneficiary's functional status at:

- The outset of the therapy episode of care,
- Specified points during treatment, and
- The time of discharge

This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013. However, a testing period will be in effect from January 1, 2013, through June 30, 2013, to allow providers to use the new coding requirements in order to assure that their systems work. During this time period, claims without G-codes and modifiers will be processed.

Because these are non-payable G-codes, there will be no Relative Value Units or payment amounts for these codes.

Services Affected Applies to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services furnished under the Comprehensive Outpatient Rehabilitation Facility (CORF) benefit. They also apply to the therapy services furnished incident to the service of a physician and certain Non-Physician Practitioners (NPPs), including, Nurse Practitioners (NPs), Certified Nurse Specialists (CNSs), and Physician Assistants (PAs).

Providers and Practitioners Affected These reporting requirements apply to the therapy services furnished by the following providers and practitioners:

- Hospitals
- Critical Access Hospitals (CAHs)
- Skilled Nursing Facilities (SNFs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Rehabilitation agencies
- Home Health Agencies (HHAs) (when the beneficiary is not under a home health plan of care)
- Therapists in Private Practice (TPPs)
- Physicians
- Non-Physician Practitioners (NPPs)

Function-Related G-Codes

The following Healthcare Common Procedure Coding System (HCPCS) G-codes are used to report the status of a beneficiary's functional limitations:

G-Code Set	HCPCS Code	Description
Mobility G-code set	G8978	Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals
	G8979	Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
	G8980	Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting
Changing & Maintaining Body Position G-code set	G8981	Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals
	G8982	Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
	G8983	Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting
Carrying, Moving & Handling Objects G-code set	G8984	Carrying, moving & handling objects functional 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
	G8986	Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting

G-Code Set	HCPCS Code	Description
Self Care G-code Set	G8987	Self care functional limitation, current status, at therapy episode outset and at reporting intervals
	G8988	Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
	G8989	Self care functional limitation, discharge status, at discharge from therapy or to end reporting
Other PT/OT Primary G-code Set	G8990	Other physical or occupational primary functional limitation, current status, at therapy episode outset and at reporting intervals
	G8991	Other physical or occupational primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
	G8992	Other physical or occupational primary functional limitation, discharge status, at discharge from therapy or to end reporting
Other PT/OT Subsequent G-code Set	G8993	Other physical or occupational subsequent functional limitation, current status, at therapy episode outset and at reporting intervals
	G8994	Other physical or occupational subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting
	G8995	Other physical or occupational subsequent functional limitation, discharge status, at discharge from therapy or to end reporting
Swallowing G-code Set	G8996	Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
	G8997	Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy
	G8998	Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation

G-Code Set	HCPCS Code	Description
Motor Speech G-code Set	G8999	Motor speech functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
	G9186	Motor speech functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
	G9158	Motor speech functional limitation, discharge status at discharge from therapy/end of reporting on limitation
Spoken Language Comprehension G-code Set	G9159	Spoken language comprehension functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
	G9160	Spoken language comprehension functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
	G9161	Spoken language comprehension functional limitation, discharge status at discharge from therapy/end of reporting on limitation
Spoken Language Expressive G-code Set	G9162	Spoken language expression functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
	G9163	Spoken language expression functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
	G9164	Spoken language expression functional limitation, discharge status at discharge from therapy/end of reporting on limitation
Attention G-code Set	G9165	Attention functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
	G9166	Attention functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
	G9167	Attention functional limitation, discharge status at discharge from therapy/end of reporting on limitation

G-Code Set	HCPCS Code	Description
Memory G-code Set	G9168	Memory functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
	G9169	Memory functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
	G9170	Memory functional limitation, discharge status at discharge from therapy/end of reporting on limitation
Voice G-code Set	G9171	Voice functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
	G9172	Voice functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
	G9173	Voice functional limitation, discharge status at discharge from therapy/end of reporting on limitation
Other Speech Language Pathology G-code Set	G9174	Other speech language pathology functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals
	G9175	Other speech language pathology functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy
	G9176	Other speech language pathology functional limitation, discharge status at discharge from therapy/end of reporting on limitation

Severity/Complexity Modifiers

For each non-payable G-code shown above, a modifier must be used to report the severity/complexity for that functional measure. The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the therapist, physician, or NPP furnishing the therapy services. The beneficiary's current status, the anticipated goal status, and the discharge status are reported via the appropriate severity modifiers.

HCPCS 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*

Reporting Tips

- Functional reporting is required for certain dates of service
  - At the outset of a therapy episode of care
  - At least once every 10 treatment days
  - The same date of service of an evaluative/re-evaluative procedure

CPT Codes Requiring Functional G-codes and Modifiers				
92506	92597	92607	92608	92610
92611	92612	92614	92616	96105
96125	97001	97002	97003	97004

  - At the time of discharge from the therapy episode of care
  - On the same date of service the reporting of a particular functional limitation in ended, in cases where the need for further therapy is necessary

    - Only one functional limitation shall be reported at a given time
    - Reporting on more than one functional limitation may be required if more than one plan of care is established, but not simultaneously.
        - Report on the second functional limitation using another set of G-codes after the first reported functional limitation is complete.
- Two G-codes will generally be reported
    - One for current status
    - One for projected goal status
        - Exception:
            - May report more than two G-codes when a patient is receiving therapy services under multiple plans of care from the same provider
            - One-time therapy where future therapy is not medically indicated or going to be furnished by a different provider. In this case, all three G-codes (current/goal/discharge status) and a corresponding modifier are reported.
- All G-codes and modifiers reported must be supported in the medical record
- Outpatient therapy services submitted April 1, 2013 and after for dates of service January 1, 2013 and after, without G-codes will be processed through June 30, 2013, but will include a reminder message to include them on future specified claims.
- G-codes captured and processed will show CO-246 (This non-payable code is for required reporting only) on the remittance advice (RA).

Manual Medical Review of Outpatient Therapy Claims – Medicare Part A

Effective April 1, 2013, Recovery Auditors will begin the process of reviewing all therapy claims, which have exceeded the $3,700 threshold cap for the year.

Service Affected There are two separate thresholds triggering manual medical reviews (MMRs) and build upon the separate therapy caps as follows:

- One for occupational therapy (OT) services
- One for physical therapy (PT) and speech language pathology (SLP) services combined
    - Although PT and SLP services are combined for triggering the threshold, the medical review will be conducted separately by discipline.
    - The National Provider Identifier (NPI) of the physician (or non-physician practitioner where applicable) who is responsible for reviewing the therapy plan of care must be identified on the claim.

Types of Recovery Auditor Reviews

- **Prepayment Review**
    - Eleven states will be participating in the Recovery Audit Prepayment Review Demonstration (FL, CA, MI, TX, NY, LA, IL, PA, **OH**, NC and MO).

- All therapy claims that have exceeded the $3,700 therapy cap threshold for the year will be reviewed and compared to the medical record before the claim is processed for payment.
- If the Recovery Auditors determine an improper claim has been submitted, a review results letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the Recovery Auditors findings and detailed description of the Medicare policy or rule that was violated.
- Typical Additional Documentation Requests (ADR) limits will not apply.
  - All therapy claims at or above the $3,700 threshold cap will trigger the MMR process and will need to be reviewed by the Recovery Auditors.
  - The ADR will be sent to the provider by CGS with instructions to send the records to the Recovery Auditor
  - The Recovery Auditors will conduct prepayment review within 10 business days of receiving the medical record

- **Post Payment Review**
  - In the remaining states, the Recovery Auditors shall conduct immediate post-pay reviews
  - All therapy claims that have exceeded the $3,700 therapy cap threshold for the year will be reviewed and compared to the medical record after the claim has been processed for payment
  - If the Recovery Auditors determine an improper payment has resulted, a demand letter will be sent to the provider, which clearly documents the rationale for the determination. The letter provides vital information to the provider regarding the Recovery Auditors findings and detailed description of the Medicare policy or rule that was violated.
  - Typical ADR limits will not apply.
    - All therapy claims at or above the $3,700 threshold cap will trigger the manual medical review process and will need to be reviewed by the Recovery Auditors.
    - The ADR will be sent to the provider immediately after the claim is paid.
    - The ADR will be sent by CGS to the provider with instructions to send the records to the Recovery Auditor.

The threshold cap will accrue for claims with dates of service from January 1 through December 31, 2013. The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Private Practices
- Part B Skilled Nursing Facilities
- Home Health Agencies (TOB 34X)
- Outpatient Rehabilitation Facilities (ORFs)
- Rehabilitation Agencies (Comprehensive Outpatient Rehabilitation Facilities)
- Outpatient Hospitals

Reference Material:

- Change Request 8005: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R165BP.pdf
- MLN Matters MM8005: http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/MM8005.pdf
- Manual Medical Review Process: http://www.cgsmedicare.com/parta/pubs/news/2013/0313/1020.html
- Change Request 8278: http://cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1216OTN.pdf
- MLN Matters MM8278: http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8278.pdf