Outpatient Therapy G-Code Edit Findings
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Mary Sue Gardner, RN/BSN Senior Nurse Analyst

Background
Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) amended Section 1833(g) of the Social Security Act to require a claims-based data collection system for outpatient therapy services, including physical therapy, occupational therapy and speech-language pathology services. The system will collect data on beneficiary function during the course of therapy services in order to better understand beneficiary conditions, outcomes, and expenditures. This data will be used in developing an improved payment system.

Agenda
- Background information on the G-code regulations
- Edit findings

Application of New Code Requirements
- Effective for therapy services with dates of service, on or after January 1, 2013
- Testing period: January 1, 2013 - June 30, 2013
- Required compliance July 1, 2013
- New status indicator of “Q” created for Medicare Physician Fee Schedule Database (MPFSDB)
  - Informational code, reporting purposes only

Services Affected
- Applies to all claims for services furnished under the Medicare Part B outpatient therapy benefit
- Applies to services furnished personally by and incident to service of a physician or Non physician Practitioner (NPP); Nurse Practitioner (NP), Certified Nurse Specialist (CNS), and Physician Assistant (PA)

Providers and Practitioners Affected
- Providers
  - Hospitals
  - Critical Access Hospitals (CAH)
  - Skilled Nursing Facilities (SNF)
  - Comprehensive Outpatient Rehabilitation Facilities (CORF)
Rehabilitation agencies
- Home Health (HH) agencies
  - When beneficiary is not under HH plan of care

Professionals
- Therapists in private practice
  - Physical Therapist (PT), Occupational Therapist (OT), Speech Language Pathologist (SLP)
- Physicians
  - Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctors of Podiatric Medicine (DPM) and Doctor of Optometry (OD)
- NPPs (NP, CNS, PA)

Function Related G-code Sets
- G-codes are “Always Therapy” codes
  - Require a therapy modifier:
    - GP - under a PT Plan of Care (POC)
    - GO - under and OT POC
    - GN - under an SLP POC
- Each functional G-code set contains:
  - Current status
  - Projected goal status
  - Discharge status
- There are 42 functional G-codes, 14 sets of 3 codes
- Generally, 6 of the G-code sets are used for PT and OT functional limitations and 8 for SLP

Severity/Complexity Modifiers
- Each G-code must have 1 severity/complexity modifier which reflects a percentage of functional impairment as determined by the therapist, physician or NPP furnishing the service

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Impairment Limitation Restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>0 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CI</td>
<td>At least 1 percent but less than 20 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CJ</td>
<td>At least 20 percent but less than 40 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CK</td>
<td>At least 40 percent but less than 60 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CL</td>
<td>At least 60 percent but less than 80 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CM</td>
<td>At least 80 percent but less than 100 percent impaired, limited or restricted</td>
</tr>
<tr>
<td>CN</td>
<td>100 percent impaired, limited or restricted</td>
</tr>
</tbody>
</table>

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Required Reporting of Functional G-codes and Severity Modifiers

- Used in required reporting for certain dates of service
  - At the outset of a therapy episode of care (date of service (DOS) for initial therapy services)
  - At least once every 10 treatment days (on or before the 10th treatment day, which matches new progress reporting effective January 1, 2013)
  - When evaluation or re-evaluation is furnished and billed
  - At time of discharge from therapy episode of care
  - On the same DOS the reporting of a particular functional limitation is ended, in cases where there is need for further therapy
  - At the time reporting is begun on a different (second, third) functional limitation within the same episode of care

- Only 1 functional limitation shall be reported at a given time for each related therapy POC

- Functional reporting is required on claims throughout the entire episode of care

- Under one therapy plan of care the minimum number of functional G-codes required on a claim will be two
  - Current status and goal status
  - Discharge status and goal status

- Two exceptions exist to the number of functional G-codes required on a claim
  - Therapy services under more than one therapy POC
    - PT, OT and/or SLP from same therapy provider
  - One-time therapy visit
    - Further therapy services not medically indicated
    - Further therapy services will be furnished by another provider
  - Report all 3 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 essential line of service information
  - Functional severity modifier
  - Therapy modifier indicating the related discipline/POC (GP, GO or GN)
  - Date of service
  - Nominal charge
    - A penny for institutional claims submitted to Part A
    - Zero charge for professional claims to Part B
      - If billing software requires an amount for professional claims, a penny may be included

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Claims containing any of these functional G-codes must also contain another billable and separately payable (non-bundled) service

- The KX and 59 modifiers are not applicable to the line of service for the functional G-codes

## Edit Findings

Recent denial reports show increasing errors with Therapy Functional Reporting G-codes. The following reason codes contain examples of the most common errors.

- **Reason Code: E6104** – The current and goal OR goal and discharge functional G-codes are not appropriately paired from the same functional G-code set. The claim must have functional G-codes from the same functional group set.
  - **Example #1:**
    - Current Status: Mobility Current (G8978)
    - Discharge Status: Mobility Discharge (G8980)
    - No Goal Status listed
  - **Examples #2:**
    - 10/2/13:
      - Self-Care Current (G8987)
      - Self-Care Goal (G8988)
    - 10/3/13:
      - Mobility Current (G8978)
      - Self-Care Goal (G8988)

- **Reason Code: U5452** – The therapy claim has a different functional G-code set than the posted reporting episode which has not been discharged and has the same billing provider National Provider Identifier (NPI) and same discipline.
  - **Example #1:**
    - PT 42X 10/1/13
      - Other PT/OT Current (G8990) CMGP
      - Other PT/OT Goal (G8991) CKGP
    - PT 42X 10/14/13
      - Other PT/OT Goal (G8991) CKGP
      - Other PT/OT Discharge (G8992) CLGP
    - OT 43X 10/1/13
      - Self-Care Current (G8987) CJGP

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• Self-Care Goal (G8988) CIGP
  o The incorrect therapy modifier was appended, making the G-codes appear as if the patient was admitted to Other PT/OT and Self Care on the same date.
  o **Example # 2:**
    ▪ OT 43X 10/29/13
      - Body Position Goal (G8982)
      - Body Position Discharge (G8983)
      - Self-Care Current (G8987)
      - Self-Care Goal (G8988)
  o Cannot report discharge from 1 G-code set and start of new G-code set on the same date of service.

  ➢ **Reason Code 31816** – Evaluation/Re-evaluation codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003 or 97004 not submitted with Current Status and Goal Status plus severity modifiers OR evaluation codes not submitted with appropriately paired G-codes/severity modifiers.
  o **Example # 1:**
    ▪ SLP 44X 10/2/13
      - Dysphagia Evaluation, Treatment (92611)
      - Swallowing Current (89996)
      - Swallowing Discharge (G8998)
  o Therapy evaluation code with G-codes that are not appropriately paired (Current and Goal)

  ➢ **Reason Code U5453** – Claims with paired goal/discharge G-codes were received out of sequence and there is an open or discharged reporting period in the history.
  o **Example #1:**
    ▪ Claim dates 10/23/13 – 10/30/13 received and processed prior to the 10/02/13 – 10/21/136 dates of service
    ▪ The 10/23/13 – 10/30/13 claim contained new therapy evaluation and new G-codes with a new current status and goal status
    ▪ Since the dates of service of 10/02/13 – 10/21/13 were received and processed after 10/23 – 10/30 the system did not recognize that the prior reported G-codes contained a reported discharge

  ➢ **Reason Code U5451** – The 10th therapy service with dates of service on or after 10/01/13 is missing:
    ▪ Current Status and Goal Status/severity modifiers OR
    ▪ Goal Status and Discharge Status/severity modifiers
  o **Edit Issue**

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Mass adjustment on the claims is currently in place
Edit being worked
Claims should no longer reject for this edit until further notice

- **Reason Code U5450** – The initial therapy service with dates of service on or after 10/1/13 must be billed with the functional current status G-code/severity modifier and paired functional goal status G-code/severity modifier. (Services after 10/1/13 with an initial evaluation or re-evaluation, must also contain current status and goal status G-codes)

- **Reason Code U5454** – There is an open reporting period, for the same discipline, and the incoming claim has a FROM date that is 60 or more calendar days since the last THRU date.
  - **Example # 1**
    - Claims that process out of sequence will hit the system edit as it may not appear that a specific G-code was discharged prior to admitting to a new G-code set.
  - **Example # 2**
    - Claims that do not contain a discharge from a prior reported G-code set (patient self-discharges and no G-codes are reported) and then the patient returns to the same therapy provider, same NPI for the same discipline of service. Claims will hit the edit because there is a prior open reporting period for the same NPI, same provider in the same discipline.

### Summary of G-code Findings

- If a therapy evaluation or re-evaluation is billed, G-codes/severity modifiers must be reported on the same day (Current Status and Goal Status or Goal and Discharge)
- A minimum of 2 G-codes from 1 G-code set must be reported at each required reporting interval
  - Current and Goal
  - Goal and Discharge
  - Only report all 3 for one time treatment visits
- The G-codes must be reported at least every 10 treatment days
- Claims that process out of sequence may cause a claim to hit a G-code edit and require subsequent bills to be cancelled and then rebilled in sequence
- Be sure to report the severity modifier as well as the proper therapy modifier with the G-codes
  - PT = GP
  - OT = GO
  - SLP = GN
- When changing from one G-code set to another, providers cannot report both sets on the same date of service. The first G-code set would be billed with goal status and discharge status on the day the

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therapist determines the need for the change and on the very next treatment day the provider would report the current status and goal status of the next G-code set.

- G-codes must be appropriately paired from the same G-code set
- Providers are encouraged to close a reported G-code set (goal status and discharge status), even if a patient self-discharges from therapy services. This will help to avoid future edits if that patient returns for the same discipline of service from the same provider

### References


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Q. How do I report an evaluative procedure when it is for a different functional limitation than I am currently reporting?
   A. You should report the evaluative procedure furnished for a second/different functional limitation other than the primary functional limitation for which ongoing reporting is occurring as a one-time visit (i.e., report all three (3) G-codes in the code set for the functional limitation that most closely matches that for which the evaluative procedure was furnished). The ongoing reporting of a primary functional limitation is not affected when all three (3) G-codes in a code set are reported for the evaluative procedure for a second functional limitation. Note: The reporting of all 3 G-codes for the evaluative procedure for a second functional limitation and the ongoing reporting of a primary functional limitation CAN both occur on the same date of service.

Q. How do I report functional information when the beneficiary has two plans of care from two different physicians for separate conditions?
   A. Assuming the same provider submits the claim for services under both POCs, only one functional limitation can be reported at a time per discipline. You will need to decide upon which POC Functional Reporting will occur. Treatment days for both conditions are counted towards the reporting frequency – counting each treatment day towards the total number of days the beneficiary received services, under both POCs. Note: It counts as one treatment day when services are received on the same date of service under both POCs.

Q. If the patient self-discharges from therapy, how do we report G-codes?
   A. There are several options the provider can take when a patient self-discharges:

   1. If a patient self-discharges prior to the bill being submitted to Medicare, the provider can append the Goal and Discharge G-codes/modifiers to the last billable date of service, if the therapist has a reasonable estimate of their progress.
   2. In the event that the patient self-discharges and the facility has already submitted the last bill to Medicare, providers would not have to supply the discharge G-codes if the therapist did not have a reasonable estimate of the patient’s progress.
   3. If the patient self-discharges and no discharge G-codes/modifiers were reported, then the episode of care will remain open for 60 days. If the patient returns to the same therapy provider (same provider number, same facility NPI) prior to 60 days, the facility will need to discharge from the prior reported G-code set before reporting a new G-code set. (Report the Goal and Discharge of the prior reported G-code set on the evaluation day. On the very next treatment day, report the Current and Goal of the new G-code set.) If the G-code set will remain the same, the provider can continue reporting the Current Status and Goal Status (from the prior reported G-code set) at the time of the evaluation. If the patient does not return within 60 days, the system will automatically end the episode of care.
   4. Providers cannot submit G-codes without another billable service on the claim. So the Goal and Discharge Status/modifiers either have to be appended to the last treatment day, or left as not reported. The provider always has the option of adjusting the last bill to Medicare and adding the Goal and Discharge to the last date of service. This would be dependent on if the therapist had a reasonable estimate of the patient’s progress, and the facility’s internal policy to adjust prior submitted claims.
Q. Does it make a difference which modifier initially follows the functional G-code: severity/complexity or therapy modifier when billing?
A. No. The therapy modifier and the severity modifier may be reported in any order.

Q. When we count the 10 treatment visits, does the evaluation count as day one or is it the next treatment visit after the evaluation day one in the counting series?
A. The minimum progress report period shall be at least once every 10 treatment days. The day beginning the first reporting period is the first day of the episode of treatment regardless of whether the service provided on that day is an evaluation, re-evaluation or treatment. Regardless of the date on which the report is actually written (and dated), the end of the progress report period is either a date chosen by the clinician or the 10th treatment day, whichever is shorter. The next treatment day begins the next reporting period. The progress report period requirements are complete when both the elements of the progress report and the clinician’s active participation in treatment have been documented. For example, for a patient evaluated on Monday, October 1, and being treated five times a week, on weekdays: On October 5, (before it is required), the clinician may choose to write a progress report for the last week’s treatment (from October 1 to October 5). October 5 ends the reporting period and the next treatment on Monday, October 8, begins the next reporting period. If the clinician does not choose to write a report for the next week, the next report is required to cover October 8 through October 19, which would be 10 treatment days.