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Eli's Rehab Report

Outpatient Outlook: Work Out the Kinks in Functional Limitations Reporting Now

CMS clarifies rules and exceptions in Transmittal 2622.

Ready to report your **Medicare** patients' functional limitations and goals? This requirement, due to a mandate from the Middle Class Tax Relief Act of 2012, has been in effect since Jan. 1, 2013.

The 2013 Medicare Physician Fee Schedule Final Rule lists specific G-codes and modifiers you must use to indicate a patient's functional status and goals. (See the December 2012 issue of **Eli's Rehab Report** for a list of these G-codes and modifiers.)

Saving grace: You have until July 1, 2013, to get up to speed. After that, however, Medicare will begin denying claims that do not include these G-codes.

The **Centers for Medicare & Medicaid Services** recently released Transmittal 2622 with final clarifications on functional limitations reporting.

Know the Exceptions to the Rule

CMS normally requires two G-codes on the claim at each reporting interval. The first code describes the patient's current status. The second describes the anticipated goals at discharge.

However, "there are two exceptions outlined in the transmittal that require you to submit additional G-codes," notes **Heather Smith, PT, MPH,** program director of quality for the American Physical Therapy Association:

1) Multiple plans of care. "For example, a patient is receiving therapy for lymphedema but is also being seen under another physician's plan of care for an orthopedic-related issue," Smith says. "In that situation, you would submit [the two appropriate] G-codes for each one of those plans."

Different scenario: If you are treating a patient for multiple issues on one plan of care, report only one set of G-codes. "You can continue to treat the multiple issues, but you must identify the primary issue and report functional limitation codes on that," Smith clarifies.

2) A one-time visit. "Suppose a patient comes in for a consultative visit, gets a home exercise program and that's it," Smith says. "In that instance, the therapist needs to report three G-codes the current functional limitation status code, the projected goal code, and a third code for the patient's discharge status."

The same rule would apply if you only see the patient once because you refer him to another therapist.

Clarification: A patient who's an unexpected no-show for a planned discharge session is a different ballgame. In this case, you would not report a discharge status code.

Get a Reporting Interval Refresher

You don't have to report functional limitation codes for every therapy visit, but the following instances do call for G-codes on the claim form:

The initial date of therapy services,

At least once every 10 treatment days,

Anytime you conduct an evaluation or re-evaluation,

At discharge,

If there's a need for further therapy after functional limitation reporting has ended, and

If you begin reporting a new or different functional limitation within the same episode of care.

Be sure to adjust the current status and projected goals G-codes according to your patient's progress for subsequent therapy sessions.

Important: In Transmittal 2622, "CMS has included a comprehensive list of CPT® codes for evaluations that will trigger 'mandatory' G-code reporting in the system," says **Lisa Satterfield, MS, CCC/A,** director of health care regulatory advocacy for the **American Speech-Language-Hearing Association.**

Good to know: CMS also updated the progress note requirement in the Medicare Benefits Policy Manual to coincide with functional limitation reporting intervals. "The manual used to state that the progress report had to be done at the 10th visit or every 30 days, whichever was shorter," Smith says. "Now the progress note is only required every 10 treatment days, so the 30-day piece has been struck."

Follow These Transition Tips

With a grace period until July 1, you have a great opportunity to get major issues ironed out before your claims can be denied.

Good idea: At the minimum, "begin documenting the G-codes and modifiers in the medical record now, even if electronic systems are not ready or the billing systems are not including the codes on the claim just yet," Satterfield suggests. "[Some of our members] with electronic health records are working with IT departments to get the changes into the system, which is challenging for everyone."

"I can't stress enough: don't wait until June," Smith says. "People really need to read through the available education materials more than once and create a process in their clinic that works for them."

Tip: Start documenting for all patients that may use Medicare Part B benefits, Satterfield recommends. "This includes patients on observation status, some inpatients that may exhaust Part A benefits, dual-eligible beneficiaries (Medicaid and Medicare), or private plans where Medicare Part B may be billed as a secondary insurance. Anytime Medicare Part B is billed, the functional outcome reporting requirements apply."

Resource: To view Transmittal 2622, go to www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2622CP.pdf.

To view the updates to the Medicare Benefits Policy Manual, go to www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R165BP.pdf.