

2013 Medicare Update: Therapy Claims Based Data Collection of Information Regarding Function

Frequently Asked Questions (FAQs)

The following questions were submitted by participants in several webinars sponsored by the Section on Health Policy & Administration and the Section on Geriatrics in April of 2013. The answers were provided by the webinar moderator, **Amit Mehta, PT, MBA**, and the presenter, **Ellen R. Strunk, PT, MS, GCS, CEEAA**.

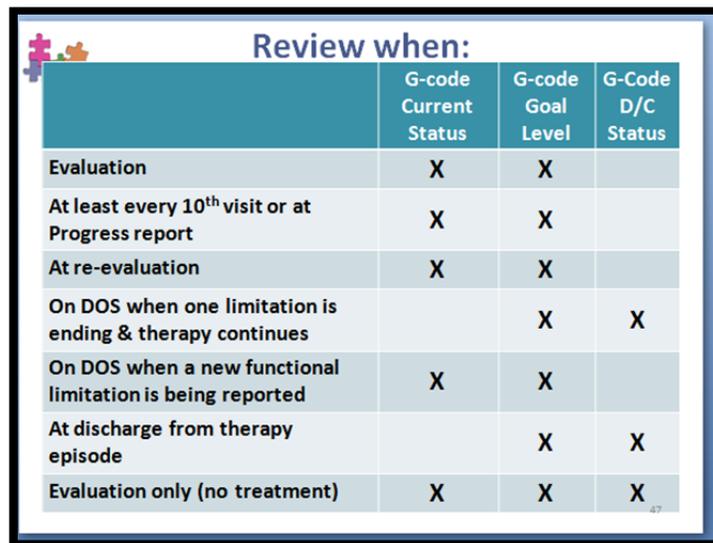
1. When did CMS begin using predictive modeling to choose which claims and providers to review?
 - Answer: 2011
2. What are the 11 states that fall under the Recovery Auditor (RA) pre-payment review for Medicare services delivered over \$3,700?
 - Answer: Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina and Missouri
3. Will there be an appeal process for the denials by the RAs?
 - Answer: Yes, you will want to contact your Medicare Administrative Contractor's website for specific information.
4. What is the time frame for prepayment appeals?
 - Answer: You will want to contact your Medicare Administrative Contractor's website for specific information.
5. On prepayment claims, will the RA approve the treatment on the claim or will they approve additional care as they did last year?
 - Answer: in 2013, there is no "pre-authorization process". The RAs will only be reviewing services that have been delivered and billed. They will not be approving any visits on a "go-forward" basis.
6. Are G codes required if Medicare part B is secondary insurance?

- Answer: There is no specific CMS guidance on this question, but they have told APTA in an email that G-codes will be required on all claims for services with Medicare as the secondary payer. Since many commercial payers may not accept claims with G-codes, it may require the provider to submit a separate claim to Medicare once the primary payer has paid rather than using the crossover claims system.
7. If the patient self discharges themselves from therapy, how do we report G codes
 - Answer: If the patient does not return for a discharge visit, then no G-codes can be reported. Clinical documentation should reflect the self discharge status.
 8. Do we report only one G code each time or more than one G code?
 - Answer: Only one Functional category is reported on at a time. However for each date of service, two G-codes must be reported for that Functional category
 9. How do you report initial if the patient is only going to be seen once i.e. goal was met?
 - Answer: In this instance, CMS has advised that all three G codes (current, goal and discharge status) should be reported for this single visit
 10. For Hospital based clinics, does it matter what revenue code you use when reporting the G codes?
 - Answer: The revenue code should reflect the respective therapy discipline of the service being billed
 11. In regards to the Medicare therapy cap and the \$3700 threshold, will 100% of claims be reviewed or a sample of claims?
 - Answer: All claims for Medicare part B services over \$3,700 of PT and SLP or over \$3,700 of OT will be reviewed
 12. Do G codes apply to Medicare and Medicare HMO payers?
 - Answer: Per current CMS guidelines, the G-codes must be reported on claims for traditional fee-for-service Medicare plans. Medicare HMO payers can determine for themselves whether to require the codes, so the provider will need to check with the individual plan.
 13. When evaluating or treating a multidisciplinary patient (PT/OT/ST), all disciplines will choose their G-code and modifier with goals. If claims are limited to 2 codes, which do we report?

- Answer: If the patient is being seen by all three disciplines, you can potentially have 3 functional categories being reported on a claim (represented by six G-codes (two per discipline). This is especially true for providers billing on a UB-04 claim since they are required to bill monthly
14. What about OBV (observation) patients seen in a hospital setting who may only be seen for one or two visits?
- Answer: if a hospital is going to bill for services provided to observation patients and outpatient surgery patients under their Medicare Part B plan, the claim will have to include the functional G-codes and appropriate modifiers.
15. Is the Medicare therapy cap threshold of \$3700 calculated based on the amount “billed by the provider” or on the “amount paid to the provider”?
- Answer: The Medicare therapy cap threshold of \$3700 is calculated based on the 2013 Medicare physician fee schedule allowable charges. The Multiple Procedure Payment Reduction should also be accounted for, since it reduces the amount of allowable charge.
16. What if my patient has made no progress over the course of therapy and the G-codes show no change? Will I still get paid?
- Answer: Payment is not linked to improvements in severity modifiers; it is based on need for skilled therapy services.
17. Is the Medicare beneficiary responsible for services over the Medicare therapy cap if the claim is denied?
- Answer: No, the American Taxpayer Relief Act of 2013 shifted the liability of services from the patient to the provider. A provider may only issue an Advanced Beneficiary Notice for services if he/she believes the therapy services are not medically necessary.
18. Does the Recovery Auditor’s review of therapy claims trigger at \$1,900 of PT/SLP and \$1,900 of OT or \$3,700 of PT/SLP and \$3,700 of OT?
- Answer: \$3,700 of PT/SLP and \$3,700 of OT
19. What happens if I don’t apply the Functional G-codes to my claim because the patient’s primary insurance is not Medicare, but this payer denies coverage and Medicare is then the primary payer?

- Answer: the G codes should be chosen for all patients with Medicare as the primary or the secondary payer.
20. Is the interim progress reporting required at the 10th visit or the visit that occurs within 30 days of last reporting?
- Answer: G-code reporting is required on at least every 10th visit, when a re-evaluation is required, when one functional category is being discharged and another one begins, and/or as often as the clinician thinks necessary
21. If the patient is being treated by both PT and OT during the same claim period, can they both report the SAME category?
- Answer: Yes. The codes will be reported under separate revenue modifiers on the claim, but the documentation must support the choice of the same category.
22. If my patient does better than was initially expected, can you change your goal?
- Answer: Yes
23. How do you charge for time spent administering a standardized test on the 10th visit or discharge visits?
- Answer: The choice of the CPT to bill for treatment should be based upon the skilled service provided.
24. What is the necessary documentation on treatment notes?
- Answer: Please see CMS requirements in the Medicare Benefit Policy Manual 100-2; Chapter 15 for daily documentation. Documentation of the choice of functional G-code, the severity modifier, and the rationale used in choosing both should be documented in the notes corresponding to the visit on which any G-code is reported.
25. If we start seeing a Medicare patient on June 15, what G-codes are required after July 1?
- Answer: CMS has not yet clarified what they will expect to see on claims that crossover between June and July 2013. It is highly recommended that all providers begin reporting G-codes on claims prior to July 1, 2013.
26. Does documentation of the choice of the G code have to be included in the body of the note as well as on the billing sheet?
- Answer: Yes, the G-code and its severity modifier should be documented in the body of a clinical record. The method used by the provider to transfer that information to the claim is up to each provider.

27. Corrected slide from the Handout (#47)



Review when:

	G-code Current Status	G-code Goal Level	G-Code D/C Status
Evaluation	X	X	
At least every 10 th visit or at Progress report	X	X	
At re-evaluation	X	X	
On DOS when one limitation is ending & therapy continues		X	X
On DOS when a new functional limitation is being reported	X	X	
At discharge from therapy episode		X	X
Evaluation only (no treatment)	X	X	X

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