FUNCTIONAL LIMITATIONS REPORTING

Frequently Asked Questions for PT/OT

In General

- **What is Functional Limitations Reporting (FLR)?**

  The purpose of FLR is to collect information on patient function during the course of therapy to better understand patient conditions, outcomes and expenditures.

  Patient functional information is reported using non-payable G-codes and severity/complexity modifiers reporting the patient's functional status at the outset of therapy (including projected goal status), at specified points during treatment, and at the time of discharge.

- **What types of providers are subject to FLR?**

  Reporting applies to outpatient PT, OT and SLP provided by:

  - Private offices of therapists, physicians and non-physician practitioners
  - Hospitals (for Part B)
  - Home health agencies (see FAQ below re: home health claims)
  - Skilled nursing facilities (for Part B)
  - CORFs
  - Rehabilitation agencies

- **Which patients are subject to FLR?**

  Medicare patients.

- **Does FLR apply to Medicare Advantage patients?**

  CMS has stated that FLR does not apply to Medicare Advantage patients; however, plans can impose reporting requirements by contract/policy. Very few Medicare Advantage plans require FLR.

- **Does FLR apply if Medicare is primary or secondary?**

  FLR applies in either case

- **Does FLR apply to commercial, workers' compensation or Medicaid patients?**

  No.

- **Which home health claims are subject to FLR?**

  FLR applies to TOB 34X, which are home health claims for beneficiaries who are not under a home health plan of care, are not homebound, and whose therapy or other services are not paid under the home health prospective payment system. Medicare's outpatient therapy rules and regulations apply to TOB 34X claims, including the therapy caps, the exceptions process, and manual medical review.

- **Does FLR apply to a hospital inpatient with Part B coverage who has exhausted his/her Part A benefit?**

  If the patient is admitted as an inpatient to a hospital without Part A, but with Part B coverage, all functional reporting (including related documentation) requirements apply. In addition to FLR, all other outpatient therapy Part B rules and manual provisions apply.

G-Codes and Modifiers

- **What are the function-related G-codes?**

  There are 14 G-code sets of three codes each. Only six of the G-code sets are for PT and OT functional limitations. The other eight G-code sets are for SLP.

  The G-codes listed on the following table are for functional limitations typically seen in patients receiving PT or OT services. The first four of these sets describe categories of functional limitations and the final two sets describe "other" functional limitations which are used to report:

  - A patient's functional limitation that is not defined by one of the first four sets;
  - A patient whose therapy services are not intended to treat a functional limitation; or
  - A patient's functional limitation when an overall, composite or other score from a functional assessment tool is used and it does not clearly represent a functional limitation defined by one of the above four sets.

PT/OT G CODES			
Category	Current Status Report at therapy outset and at 10 visit reporting intervals	Projected Goal Report at therapy outset, at reporting intervals and at discharge or end reporting	Discharge Status Report at discharge or end reporting
Mobility: Walking & Moving Around	G8978	G8979	G8980
Changing & Maintaining Body Position	G8981	G8982	G8983
Carrying, Moving & Handling Objects	G8984	G8985	G8986
Self Care	G8987	G8988	G8989
Other PT/OT Primary Functional Limitation	G8990	G8991	G8992
Other PT/OT Subsequent Functional Limitation	G8993	G8994	G8995

- **What are the severity/complexity modifiers that must be used with the functional G-codes?**

  For each G-code, one of the modifiers listed below must be used to report the severity/complexity for that functional limitation.

SEVERITY/COMPLEXITY MODIFIERS	
Modifier	**Impairment Level**
CH	0%
CI	1-19%
CJ	20-39%
CK	40-59%
CL	60-79%
CM	80-99%
CN	100%

The severity modifiers reflect the patient's percentage of functional impairments as determined by the therapist furnishing the therapy services.

- **When are the "Other PT/OT <u>Primary</u> Functional Limitation" Codes used?**

    - If a patient's functional limitations are not defined by one of the other four categories, or
    - If therapy is not intended to treat a functional limitation (e.g., lymphedema, wound care), or
    - If a patient's composite score from an assessment tool is used and does not clearly fall into one of four categories

- **Can you report more than one functional limitation at a time?**

    No, providers are not allowed to report on more than one functional limitation at a time. You should report on the patient's primary functional limitation that is the most clinically relevant functional limitation at the time of the initial evaluation and establishment of the plan of care (POC). You should use the G-code that best describes the functional limitation that is primary to the POC.

- **When do you use the "Other PT/OT <u>Subsequent</u> Functional Limitation" G-codes?**

    If treatment continues after the primary treatment goal is achieved and reporting ended on the primary functional limitation, reporting will be required for another functional limitation. If you need to report on a second condition after reporting on the first has ended, use the G-code set for "other subsequent" functional limitation (G8993, G8994, G8995).

<u>Frequency</u>

- **When do you need to report?**

    - At the outset of a therapy episode of care (i.e., on the claim for the date of service of the initial therapy service);

    - At least once every 10 treatment days, which corresponds with the progress reporting period;

    - When an evaluative procedure, including a re-evaluation (HCPCS/CPT codes 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168) is furnished and billed;

    - At the time of discharge from the therapy episode of care – (i.e., on the date services related to the discharge report are furnished;

    - At the time reporting of a particular functional limitation is ended in cases where the need for further therapy is necessary; and

    - At the time reporting is begun for a new or different functional limitation within the same episode of care (i.e., after the reporting of the prior functional limitation is ended).

Functional reporting is required on claims throughout the entire episode of care. When the patient has reached his or her goal or progress has been maximized on the initially selected functional limitation, but the need for treatment continues, reporting is required for a

second functional limitation using another set of G-codes. In these situations, two or more functional limitations will be reported for a patient during the therapy episode of care. So, reporting on more than one functional limitation may be required for some patients, but not simultaneously.

When a patient stops coming to therapy prior to discharge, the therapist should report the functional information on the last claim. If the therapist is unaware that the patient is not returning for therapy until after the last claim is submitted, the therapist cannot report the discharge status.

When functional reporting is required on a claim for therapy services, two G-codes will generally be required, but two exceptions exist which are for:

1. Therapy services under more than one therapy POC – Claims may contain more than two G-codes when a patient receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapist.

2. One-Time Therapy Visit – When a patient is seen and future therapy services are either not medically indicated or will be furnished by another provider, the therapist should report on the claim for the DOS of the visit all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.

- **Has the timing for progress reports changed to coincide with FLR?**

  Yes, CMS modified its rules to establish the same timing requirement for progress reports, so progress reports are now required every 10 treatment days. However, keep in mind that your state PT or OT Act may have a different progress reporting requirement. For example, if your PT Act requires a progress report every 30 days, then you will need to do a progress report at the lesser of every 30 days or every 10 visits to comply with both your PT Act and Medicare requirements. If you need to do a progress report at the 7th visit because this is when you meet the 30-day requirement, you will need to report the FLR G-codes and modifiers on or before visit 17 because that is 10 visits after visit 7.

- **Do you need to report if you are only doing a custom splint and not billing any therapy code?**

  No, you do not need to report if you are only providing a splint.

- **How do you report the functional information when you provide an evaluation only and determine that the patient does not need further therapy services?**

  For one-time visits, you report all three G-codes for the functional limitation being evaluated, along with the corresponding severity modifiers for each.

- **How do you report an evaluative procedure when it is for a different functional limitation than you are currently reporting?**

  You should report the evaluation 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 G-codes in the code set for the functional limitation that matches the evaluation). Your ongoing reporting of the primary functional limitation is not affected by reporting for this evaluation. The reporting of all three G-codes for the evaluation for a second functional limitation ***and*** the ongoing reporting of the primary functional limitation CAN both occur on the same date of service.

- **How do you report functional information when the patient has two plans of care from two different physicians for separate conditions?**

  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 which POC functional reporting is most appropriate. Treatment days for both conditions are counted towards the reporting frequency – counting each treatment day towards the total number of days the patient received services under both POCs. When services are received on the same date of service under both POCs, this counts as one treatment day.

- **Do you need to report for each discipline?**

  Yes. If, for example, a patient is receiving both PT and OT, the providers will need to report G-codes and modifiers for both PT and OT.

- **Can therapists use any of the G-code sets or are they limited to those corresponding to their discipline?**

  The G-code sets are not discipline specific. The G-code set that best describes the functional limitation being treated should be used, regardless of the provider's discipline.

- **If improvement is expected to be limited, can current function and goal be reported using the same modifier?**

  Yes.

Reporting on Second/Subsequent Functional Limitations

- **Can you document the G-codes and modifiers for the end of the primary functional limitation and those to begin the start of the second functional limitation in the progress report for the same visit or do the G-codes and modifiers for the second functional limitation need to be documented in the daily treatment note on the same day they are reported on the claim?**

  You can document the G-codes and modifiers used to end the reporting period of the first (primary) functional limitation and those for the second functional limitation in the same progress report. For the next treatment day, you can simply note where the G-

codes and modifiers for the second functional limitation are located in the medical record. For example, you can state the following in the daily treatment note for the next treatment date: "The G-codes and modifiers used in today's functional reporting are found in the progress report dated [date of progress note]."

- **In the above scenario, can a therapy assistant furnish the therapy services on the day that the second functional limitation is reported on the claim?**

  Yes, the therapy assistant who furnished the services can report the G-codes and modifiers to begin reporting for a second functional limitation when a therapist previously determined the functional information.

- **When you begin reporting on your patient's second functional limitation, how do you report the severity of its current status? Do you use the severity modifier that reflected the current status at the time of the initial evaluation or the one from the time you began reporting?**

  The severity modifier used to indicate the patient's current status reflects the severity of the functional limitation at the time of the visit for which reporting occurred. You should note that the severity modifier used to report the goal status of the second (or other subsequent functional limitation) would be the same as that established in the plan of care unless the goal has been modified as a result of a significant change in the patient's condition.

- **Do you need to end reporting of the current primary functional limitation when a new functional limitation develops, e.g. a new condition, before reporting on the second functional limitation?**

  Yes, you need to end reporting on the first functional limitation by reporting the appropriate goal and discharge status codes before reporting on a second functional limitation can begin. Discharge reporting applies in all situations, except when the patient unexpectedly does not return to therapy and discharge information is not available.

- **How do you report when a patient stops therapy without a discharge and then resumes therapy?**

  A discharge status G-code is required at the end of the reporting period and prior to reporting another medically necessary functional limitation. When the patient ends therapy without notice, prior to the therapist's assessment, CMS encourages the inclusion of a discharge status G-code, whenever possible for the final services.

  The functional reporting data is tracked per patient, per therapy discipline and per billing provider NPI during the treatment dates of service. Functional reporting is required throughout the entire episode of care. The reporting period begins with the first therapy discipline (PT, OT or SP) initiated until the date of discharge (if one occurs). A reporting period will automatically end when it has been 60 or more calendar days since the last recorded date of service.

  When the reporting period is less than 60 calendar days and further therapy is medically necessary for the same therapy discipline and at the same billing provider NPI, then

providers/therapists need to continue tracking the progress to ensure that the 10th treatment day functional reporting requirement is met. After the patient attains the goal for the first reported functional limitation, the therapist would end reporting of the first functional limitation by using the discharge G-code and appropriate severity modifier. The reporting period for a different or new functional limitation will begin on the next treatment day.

The therapist is required to report progress every 10 treatment days. The reporting period for functional G-codes and severity modifiers begins with the first reported functional code until the 10th treatment day. Therapists can submit G-code(s) and modifier(s) prior to the 10th treatment day. The 10-day count restarts the next treatment day.

- **Does FLR apply to patients in observation status in the hospital?**

  Yes. Observation services are, by Medicare's definition, outpatient services in the hospital. As such, FLR applies. Once the decision is made to admit the patient to the inpatient hospital, FLR no longer applies. If the patient's treatment was furnished on only one date of service, the therapist would report all three G-codes in the set for the functional limitation being reported.

Assessment Tools

- **Does CMS recommend any assessment tools?**

  No. CMS does not have a list of approved or endorsed functional assessment tools.

- **Are you required to use an assessment tool?**

  No. CMS is not requiring the use of a particular functional assessment tool or even the use of any tool to determine the severity/complexity modifier. When assessment tools are not used, CMS requires the use of objective measures to document functional status.

- **What do you need to do if you use a functional assessment tool where 100 means no disability and zero (0) means totally disabled to obtain the severity modifier? Can you directly crosswalk the score from the tool to the CMS severity modifier scale to select the modifier?**

  You will need to convert the score from the "wellness" scale, a scale in which 100 means no disability, to the CMS "disability" scale in which zero (0) means no disability. For example, if a patient scored 60 (out of 100) where 100% means no disability), this score converts to a 40 on a scale where 100% means totally disabled. To make this conversion, the wellness score of 60 is subtracted from 100 to yield a score of 40 on the disability scale.

- **Should you report the "other" PT/OT G-codes when using a functional assessment tool that yields a "composite" score?**

  A PT/OT categorical G-code set should be reported when it best describes the functional limitation being treated – even though the assessment tool used surveyed the patient's overall functional abilities, such as the ability to carry out his/her daily routine and

other quality of life measures. There may be times, however, that the "other" PT/OT G-code sets will be appropriate, especially when the patient's functional limitation is not described by one of the four categories of functional limitations or the patient is not being treated for a functional limitation.

Documentation

- **Do providers need to note the FLR G-codes and modifiers in the patient's medical record?**

  Yes. Documentation of the G-codes and severity modifiers must be included in the patient's chart for each required reporting.

Billing/Claims Submission

- **What needs to be added to the claims?**

  For each visit that requires FLR G-codes, the claim form should include a line that includes each reportable FLR G-code, the associated severity modifier, the corresponding GP or G0 modifier, DOS and nominal charge.

- **Should you include a charge on the G-code line?**

  Yes. A charge of $0 or $0.01 should be added, depending on the Medicare carrier. Palmetto-$0; NGS-$0.01; Noridian-$0.01

- **What if the claim is for an amount above the therapy cap and qualifies for an exception to the cap?**

  The KX modifier should be included on the line with the CPT codes that result in charges above the cap, not on the FLR line.

- **Does the -59 modifier go on the G-code line?**

  No.

- **Do claims for dates of service that do not require FLR G-codes need to include a code, modifier or any other signal that reporting is not required?**

  No.

- **Does the "units" field need to be completed for the functional G-code line of service?**

  Yes. The "units" field is required to be completed. Use "1" to complete the "units" field.

- **Do the FLR G-codes and other lines need to be in any specific order?**

  No. G-codes and other information can be listed on the claim in any order.

- **Are there any other claim requirements?**

  No. Except for the addition of the G-codes and modifiers as noted above, the FLR rules do not modify requirements for the submission of therapy claims.

Sources

- Medicare Claims Processing Manual, Ch 5, Section 10.6-Functional Reporting.
- Medicare Benefits Policy Manual, Ch 15, Section 220.4 – Functional Reporting.
- Functional Reporting: PT, OT, and SLP Services-Frequently Asked Questions (FAQs) https://www.cms.gov/Medicare/Billing/TherapyServices/Downloads/Functional-Reporting-PT-OT-SLP-Services-FAQ.pdf, accessed 8/30/2017).