Questions & Answers

Question: It is my understanding that CGS medical review has determined that additional documentation requests (ADRs) were erroneously sent to physical therapists and that the ADR requests do not have to be fulfilled. Is that correct?

Answer: That is correct. CGS mailed ADR letters to Ohio Physical Therapists (specialty 65) in error. These letters were mailed from May 8-22, 2013. Physical Therapists (specialty 65) who received one of these letters do not need to respond. CGS is currently identifying the affected claims and will release them for routine processing whether or not a response has been received. We sincerely apologize for this inconvenience.

Question: When an ADR request is sent by the Recovery Auditors, will providers be able to return documentation via fax or does it have to be mailed?

Answer: The Recovery Auditor ADRs identify how documentation is to be returned. The ADR sample letter on the CGI website indicates mail or fax is acceptable: http://rach.cgi.com/Docs/Letters/ADRDUAL-Additional_Documentation_Letter_Dual_Sample_02122013.pdf

Question: We are an LTCH facility, so our patients are all inpatients. However, there are times when the patient’s benefit days have exhausted and we bill for the Part B ancillary services. Do we have to report these functional therapy codes?

Answer: Yes, the edits for the functional G-codes and severity/complexity modifiers will be applied to claims with type of bill 12X.

Question: After July 1, 2013, if a therapy service is submitted without the G-codes, will there be an opportunity to resubmit it later?

Answer: Yes. If, after July 1, 2013, your therapy service is submitted without the G-code, the therapy service will be rejected (Part B). The only way to correct a rejected service is to correct the error causing the rejection and resubmit as a new claim. Part A claims will Return to Provider (RTP). The claim can be corrected via the Direct Data Entry (DDE) system or a new claim may be submitted.

Question: Speech pathology is the one discipline that has multiple evaluation codes. Here is the scenario: I am addressing language and report the G-codes for language. Two weeks into treatment, I decide to evaluate swallowing while still treating language. When an evaluation is
performed, the G-codes are required. In this scenario, I was told to report all three G-codes for swallowing, or the second evaluation, until the language, or first evaluation, is discharged. Once discharged, begin reporting on the second evaluation as normal. Is that correct?

**Answer:** No. Only one functional limitation shall be reported at a time. A second functional limitation will be reported with a different set of G-codes when the beneficiary has reached his or her goal, or progress has been maximized, on the initially reported functional limitation, but the need for treatment continues. Therefore, more than one functional limitation may be reported during one therapy episode of care, but not simultaneously.

In your scenario, we recommend you report the G-codes for language until the goal is reached or progress is maximized. Then, perform and report the evaluation for swallowing with the new set of G-codes.

Note: The discharge status reported for the first functional limitation only applies to that functional limitation. It does not discharge the patient from the entire therapy episode of care when the need for treatment continues.

**Question:** We are still confused about how to use the goal status on subsequent visits. We believe we understand that on the first visit, your goal status will be what you hope to accomplish, where you want that patient to end up. But on subsequent visits, is it how they progress toward that overall goal?

**Answer:** You would be reporting the goal - your ultimate goal - every time, but then your current status should change as it relates to that goal.

**Question:** For Recovery Auditor ADRs we receive when the $3,700 threshold is exceeded, the RAC representatives are telling me that the entire claim is being reviewed and not just the disciplines that have exceeded the threshold. Is that correct?

**Answer:** It is our understanding that the Recovery Auditor reviews the services on the claim that actually exceed the cap. To do this, they may require documentation that supports the entire billing period.

**Question:** Does functional reporting apply to just traditional Medicare or do the Medicare Advantage Plans require this as well?

**Answer:** This call is specific to traditional Medicare. Please check with the specific plan.
Question: Would there be an issue with the PT and OT using the same objective measurement test to determine the correct G-code to use?

Answer: We do not foresee problems with this. Please be sure to document the method or tool used in the patient’s medical record.

Question: If someone is progressing better than you thought when the original goal was established, is it assumed that you can increase the goal at the time of the progress note?

Answer: Yes. Ensure the progress report meets all documentation requirements and includes the functional G-code and severity/complexity modifier that will be reported on the claim with the rationale. A re-evaluation should not be required before every progress report routinely, but may be appropriate when assessment suggests changes not anticipated in the original plan of care.


Question: I understand that you can’t report a discharge status for one functional limitation and the current status for a new functional limitation on the same day. If the PT documents the assessment, G-code, and modifier for the new functional limitation on the same day as the discharge summary for the first functional limitation, is it acceptable for the PTA to perform services at the next visit based on the previous assessment?

Answer: Yes, this is acceptable.

Question: I heard that there were some issues with claims being held up during this testing period for the functional G-codes. Do you have any information on that?

Answer: We are unaware of any claims processing issues.

Question: Patients are being seen multiple times per week and approaching their threshold of $3,700. Is there an easy way to track it so that we know exactly when they hit that threshold?

Answer: The best way is to utilize either the myCGS web portal or the Interactive Voice Response (IVR) at the initiation of treatment and track the services you provide.

Question: When we receive an ADR letter from the Recovery Auditor, do we have to return all four pages of the ADR letter with the documentation?

Answer: We suggest you check with the Recovery Auditor.
Question: Can the documentation we send in response to CGS’ ADRs be faxed?

Answer: Yes, for Part A requests. The Part A Faxgate number is 1.803.462.2596.

Question: We are a Critical Access Hospital in Kentucky that provides outpatient therapy. Does the $3,700 cap apply to us?

Answer: The services that you provide are applied toward the cap; however, your claims are not subject to the manual medical review process.

References:

Question: We bill Part A claims and noticed the G-codes are being rejected stating that they are not accepted. Is this an error?

Answer: The G-codes should reject as non-covered since they are non-payable codes. We have received inquiries regarding the message code used on the remittance advice indicating the codes are invalid. A separate Change Request (CR) will be implemented on July 1, 2013, to apply the system edits to the G-codes and modifiers. We believe the correct message will be applied then.

Question: Once a patient reaches the threshold, what is the patient financially responsible for? Is it just the services over the threshold or the entire episode of care?

Answer: The Centers for Medicare & Medicaid Services (CMS) recently released guidance on this. The services beyond the cap are provider liability, not patient liability. The only time the patient would be liable is if the patient was issued an Advance Beneficiary Notice of Non-Coverage (ABN) and the appropriate modifier was applied. For more details, please refer to the Change to Payment Liability for Therapy Cap Denials section of the May 23, 2013, edition of CMS’ e-News located at [https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-23-Enews.pdf](https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-05-23-Enews.pdf).

Question: We submit claims to Part A. Patients who have reached the cap are waiting for CGS to make a decision on their claims before they receive more therapy. Is there a delay in processed ADRs? How do we find out the status of those that have been returned?
Answer: We are not aware of any delays. CGS was instructed to review claims above the $3,700 threshold for dates of service October 1, 2012, through December 31, 2012, and claims above the $3,700 threshold that processed between January 1, 2013, and March 31, 2013. If you have pending claims that meet these criteria, please call the provider contact center to check the status. The Recovery Auditor, CGI Federal, was instructed to review claims above the $3,700 threshold that processed April 1, 2013, and after. Please contact the Recovery Auditor to obtain the status.

Question: When the patient completes an assessment which shows them to be at 12% impairment; however, I can look at the patient and, from my own experience, know the percentage is much higher, do I submit the modifier based on the patient’s own assessment?

Answer: The modifier you select should be based on your own clinical judgment or an objective evaluative tool. In any case, be sure the method you use is documented in the patient’s medical record.

Question: We have a provider here that is a DO that does osteopathic manipulation treatment. Do the G-codes apply to this provider?

Answer: Since their services would not fall under a therapy plan of care, the G-codes do not apply.

Question: We submit CPT code 95992 with CPT modifier 59. How will this affect the G-codes?

Answer: CPT modifier 59 would be used if an exception to the National Correct Coding Initiative (NCCI) edits exists. Since the G-codes are non-payable, CPT modifier 59 is not applicable to that line and there should be no effect on the other reportable service. Please be sure to reference the CCI files, which can change on a quarterly basis, located at: http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html.

Question: Which modifier do I use if I am seeing the patient only once?

Answer: When a patient is seen and future therapy services are either not medically indicated or will be furnished by another provider, report all three G-codes in the appropriate code set (current status, goal status, discharge status) with the corresponding severity modifier. Use the severity modifier that reflects the score from a functional assessment tool or other performance measurement instrument and/or the therapist’s clinical judgment. Ensure the therapist documents how they made the modifier selection in the medical record.
**Question:** Since the Medicare Therapy CAP Exception Form is no longer used, are we to wait until Medicare sends us an ADR letter requesting records once the patient is over the $3,700 threshold?

**Answer:** Correct.

**Question:** In Ohio, what do you mean by prepayment review?

**Answer:** Prepayment review means the ADR letter requesting documentation and the activities of the Recovery Auditor are all performed prior to the claim being processed and paid.

**Question:** If we do a recertification on visit seven and report a G-code, will that be considered too early?

**Answer:** No. You are to report a G-code at least once every ten days, so reporting early is acceptable.

**Question:** Is a patient’s therapy cap and threshold amount tracked by the Multiple Procedure Payment Reduction (MPPR) amount or the non-MPPR amount?

**Answer:** The MPPR amount is applied.


**Question:** How does the hospital assign a discharge functional G-code and modifier when the patient stops therapy or doesn’t come back for their final treatment?

**Answer:** Document that the patient refused further treatment or didn’t return. The clinician may then base any judgments required to write the discharge summary and assign a discharge functional code on the documentation available (i.e., treatment notes and verbal reports of the assistant or qualified personnel).