CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1196	**Date: March 8, 2013**
	Change Request 8166

SUBJECT: Outpatient Therapy Functional Reporting Non-Compliance Alerts

I. SUMMARY OF CHANGES: This Change Request implements alert messaging, effective April 1, 2013, that conveys supplemental information to the provider submitting claims for outpatient therapy from April 1, 2013 through June 30, 2013.

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
	N/A

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1196	Date: March 8, 2013	Change Request: 8166

SUBJECT: Outpatient Therapy Functional Reporting Non-Compliance Alerts

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

I. GENERAL INFORMATION

A. Background: Change Request (CR) 8005, Pub 100-04, Transmittal 2622 Dated December 21, 2012 Implementing the Claims-Based Data Collection Requirement for Outpatient Therapy Services−Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012, implements a new claims-based data collection requirement for outpatient therapy services by requiring reporting functional limitations with 42 new nonpayable G-codes and seven new modifiers on specified claims for physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. The claims-based data collection system is effective for outpatient therapy services with dates of service, on and after January 1, 2013. A testing period is in effect from January 1, 2013 through June 30, 2013, during which claims without the required G-codes and modifiers will be processed to allow providers to use the new coding requirements in order to assure that their systems work. This CR implements alert messaging, effective April 1, 2013, that conveys supplemental information to the provider submitting claims, with dates of service on and after January 1, 2013, for outpatient therapy services from April 1, 2013 through June 30, 2013.

B. Policy: Section 3005(g) of MCTRJCA says, " The Secretary of Health and Human Services shall implement, beginning on January 1, 2013, a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)). Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes."

A testing period is in effect from January 1, 2013 through June 30, 2013, during which claims without the required G-codes and modifiers will be processed to allow providers to use the new codes to assure that their systems work. For therapy claims, with dates of service on and after January 1, 2013, processed on and after April 1, 2013 through June 30, 2013, contractors shall alert providers to include the applicable 42 new G-codes and seven modifiers on future therapy claims through a new Remittance Advice message. The scenarios below illustrate what will be effective April 1, 2013 and a separate instruction will be issued regarding the editing required for claims with therapy services furnished on and after July 1, 2013. Note this instruction and scenarios included are not applicable to institutional claims. There will be no alert messaging for institutional claims between April 1, 2013, and July 1, 2013. For professional and institutional claims, the instruction effective July 1, 2013 will enforce the functional reporting requirements by requiring claims that do not contain the required functional G-code and modifier information to be returned or rejected.

1. Effective for therapy claims with dates of service on or after January 1, 2013 and processed on and after April 1, 2013 through June 30, 2013, contractors shall alert providers, who submit claims containing functional G-codes (G8978-G8999, G9158-G9176, and G9186) without a severity/complexity modifier (CH-CN), that functional G-codes require a severity/complexity modifier, and effective July 1, 2013, claims that do not include required functional reporting information will be returned or rejected using a new Remittance Advice message.

2. Effective for therapy claims with dates of service on or after January 1, 2013 and processed on and after April 1, 2013 through June 30, 2013, contractors shall alert providers, who submit claims containing any of the following CPT evaluation/re-evaluation therapy codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004 without functional information, that these codes require functional G-code(s) and appropriate modifier(s), and effective July 1, 2013, claims that do not include required functional reporting information will be returned or rejected using a new Remittance Advice message.

Refer to CR 8005, Pub 100-04, Transmittal 2622, Dated December 21, 2012, for detailed instructions on the implementation of the 42 nonpayable G-codes and seven modifiers. Per this CR 8005, claims without the required G-codes and modifiers are to be processed during the testing period of January 1, 2013 through June 30, 2013. Note this CR makes no changes to that process.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8166.1	Effective for therapy claims processed on and after April 1, 2013 through June 30, 2013, with dates of service on and after January 1, 2013, contractors shall return the following Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) when any of the following non-payable HCPCS codes (G8978 to G8999, G9158 to G9176, and G9186) are submitted without the appropriate modifier (CH – CN).		X			X						
8166.1.1	Effective for dates of service on and after April 1, 2013, through June 30, 2013, contractors shall return: CARC 246 – "This non-payable code is for required reporting only" and RARC N565- "Alert: This non-payable reporting code requires a modifier. Future claims containing this non-payable reporting code must include an appropriate modifier for the claim to be processed."		X			X						
8166.2	Effective for therapy claims processed on and after April 1, 2013, through June 30, 2013, with dates of service on and after January 1, 2013, contractors shall return the following CARC and RARC when any of		X			X						

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	the following CPT codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004 are submitted without the appropriate, non-payable HCPCS codes (G8978 to G8999, G9158 to G9176, and G9186) and appropriate modifiers (CH – CN).											
8166.2.1	Contractors shall return: CARC 246- "This non-payable code is for required reporting only." and RARC N566- "Alert: This procedure code requires functional reporting. Future claims containing this procedure code must include an applicable non-payable code and appropriate modifiers for the claim to be processed."		X			X						
8166.3	Contractors shall continue to process and adjudicate therapy claims as described in CR 8005, Pub 100-04, Transmittal 2622, dated December 21, 2012.		X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8166.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X			X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information: N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kathy Bryant, 410-786-3448 or Kathy.Bryant@cms.hhs.gov (Policy Contact), Brian Reitz, 410-786-5001 or Brian.Reitz@cms.hhs.gov (Professional Contact), Simone Dennis, 410-786-8409 or Simone.Dennis@hhs.cms.gov (Policy Contact), April Billingsley, 410-786-0140 or April.Billingsley@hhs.cms.gov (Professional Contact)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
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