CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2622	**Date: December 21, 2012**
	Change Request 8005

Transmittal 2603, dated November 30, 2012, is being rescinded and replaced by Transmittal 2622, dated December 21, 2012, to update the Internet Only Manual (IOM) manuals to include functional reporting information and to revise the policy section to include CPT code 96125 in the list of evaluation codes and to provide direction for one-time therapy visits. All other information remains the same.

SUBJECT: 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

I. SUMMARY OF CHANGES: This Change Request implements the MCTRJCA claims-based data collection requirement for outpatient therapy services by requiring the reporting of 42 new nonpayable functional G-codes and 7 new modifiers on claims for physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: January 7, 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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/Table of Contents
R	5/10.5/Notification for Beneficiaries Exceeding Financial Limitations
R	5/10.6/Functional Reporting
N	5/10.7/Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

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:

Business Requirements

Manual Instructions

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2622	Date: December 21, 2012	Change Request: 8005

Transmittal 2603, dated November 30, 2012, is being rescinded and replaced by Transmittal 2622, dated December 21, 2012, to update the Internet Only Manual (IOM) manuals to include functional reporting information and to revise the policy section to include CPT code 96125 in the list of evaluation codes and to provide direction for one-time therapy visits. All other information remains the same.

SUBJECT: 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.

Effective Date: January 1, 2013
Implementation Date: January 7, 2013

I. GENERAL INFORMATION

A. Background: This Change Request implements a new claims-based data collection requirement for outpatient therapy services by requiring reporting with 42 new nonpayable functional G-codes and 7 new modifiers on selected claims for physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services.

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."

This claims-based data collection system is being implemented to include both the reporting of data by therapy providers and practitioners furnishing therapy services and the collection of data by the contractors. This reporting and collection system requires selected claims for therapy services to include nonpayable G-codes and related modifiers. These nonpayable G-codes and severity/complexity modifiers provide information about the beneficiary's functional status at the outset of the therapy episode of care, at specified points during treatment, and at the time of discharge. These G-codes and related modifiers are required on selected claims for all outpatient therapy services – not just those over the therapy caps.

Application of New Coding Requirements.

This claims-based data collection system is effective for therapy services with dates of service, on and after January 1, 2013. However, a testing period will be 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. A separate instruction will be issued regarding the editing required for claims with therapy services furnished on and after July 1, 2013. This instruction will enforce the functional reporting requirements and begin when returning and rejecting claims, as applicable, that do not contain the required functional G-code/modifier information.

To implement use of these G-codes for reporting function data on January 1, 2013, a new status indicator of "Q" has been created for the Medicare Physician Fee Schedule Database (MPFSDB). This new status indicator will identify codes being used exclusively for functional reporting of therapy services. These functional G-codes will be added to the MPFSDB with the new "Q" status indicator. Because these are nonpayable G-codes,

there will be no Relative Value Units or payment amounts for these codes. The new "Q" status code indicator reads, as follows: Status Code Indicator "Q" – "Therapy functional information code, used for required reporting purposes only."

A separate instruction was issued to alert contractors that these nonpayable functional G-codes will be added as "always therapy" codes to the new 2013 therapy code list.

Services Affected.

The reporting and collection requirements of beneficiary functional data apply to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the PT, OT, and SLP services furnished under the Comprehensive Outpatient Rehabilitation Facility (CORF) benefit. They also apply to the therapy services furnished personally by and incident to the service of a physician and certain nonphysician practitioners (NPPs), including, as applicable, nurse practitioners (NPs), certified nurse specialists (CNSs), and physician assistants (PAs).

Providers and Practitioners Affected.

These reporting requirements apply to the therapy services furnished by the following providers: hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and home health agencies (when the beneficiary is not under a home health plan of care). It also applies to the following practitioners: therapists in private practice (TPPs), physicians, and NPPs as noted above.

Function-related G-codes**.**

The following HCPCS G-codes are used to report the status of a beneficiary's functional limitations:

Mobility G-code set:

- G8978, *Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals.*
    - Short descriptor: Mobility current status

- G8979, *Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting.*
    - Short descriptor: Mobility goal status

- G8980, *Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting.*
    - Short descriptor: Mobility D/C status

***Changing & Maintaining Body Position* G-code set:**

- G8981, *Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals.*
    - Short descriptor: Body pos current status

- G8982, *Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
    - Short descriptor: Body pos goal status

- G8983, *Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting.*
    - Short descriptor: Body pos D/C status

Carrying, Moving & Handling Objects G-code set:

- G8984, *Carrying, moving & handling objects functional limitation, current status, at therapy episode outset and at reporting intervals*
    - Short descriptor: Carry current status

- G8985, *Carrying, moving & handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
    - Short descriptor: Carry goal status

- G8986, *Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting*
    - Short descriptor: Carry D/C status

Self Care G-code Set:

- G8987, *Self care functional limitation, current status, at therapy episode outset and at reporting intervals*
    - Short descriptor: Self care current status

- G8988, *Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
    - Short descriptor: Self care goal status

- G8989, *Self care functional limitation, discharge status, at discharge from therapy or to end reporting*
    - Short descriptor: Self care D/C status

Other PT/OT Primary G-code Set:

- G8990, *Other physical or occupational primary functional limitation, current status, at therapy episode outset and at reporting intervals*
    - Short descriptor: Other PT/OT current status

- G8991, *Other physical or occupational primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
    - Short descriptor: Other PT/OT goal status

- G8992, *Other physical or occupational primary functional limitation, discharge status, at discharge from therapy or to end reporting*
    - Short descriptor: Other PT/OT D/C status

Other PT/OT Subsequent G-code Set:

- G8993, *Other physical or occupational subsequent functional limitation, current status, at therapy episode outset and at reporting intervals*
    - Short descriptor: Sub PT/OT current status

- G8994, *Other physical or occupational subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*
    - Short descriptor: Sub PT/OT goal status

- G8995, *Other physical or occupational subsequent functional limitation, discharge status, at discharge from therapy or to end reporting*
    - Short descriptor: Sub PT/OT D/C status

Swallowing G-code Set:

- G8996, *Swallowing functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor: Swallow current status

- G8997, *Swallowing functional limitation, projected goal status, at initial therapy treatment/outset and at discharge from therapy*
    - Short descriptor: Swallow goal status

- G8998, *Swallowing functional limitation, discharge status, at discharge from therapy/end of reporting on limitation*
    - Short descriptor: Swallow D/C status

Motor Speech G-code Set: (Note: These codes are not sequentially numbered)

- G8999, *Motor speech functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor Motor speech current status

- G9186, *Motor speech functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
    - Short descriptor Motor speech goal status

- G9158, *Motor speech functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
    - Short descriptor: Motor speech D/C status

Spoken Language Comprehension G-code Set:

- G9159, *Spoken language comprehension functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor: Lang comp current status

- G9160, *Spoken language comprehension functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
    - Short descriptor: Lang comp goal status

- G9161, *Spoken language comprehension functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
    - Short descriptor: Lang comp D/C status

Spoken Language Expressive G-code Set:

- G9162, *Spoken language expression functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor: Lang express current status

- G9163, *Spoken language expression functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
    - Short descriptor: Lang express goal status

- G9164, *Spoken language expression functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
    - Short descriptor: Lang express D/C status

Attention G-code Set:

- G9165, *Attention functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor: Atten current status

- G9166, *Attention functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
    - Short descriptor Atten goal status

- G9167, *Attention functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
    - Short descriptor: Atten D/C status

Memory G-code Set:

- G9168, *Memory functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor: Memory current status

- G9169, *Memory functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
    - Short descriptor: Memory goal status

- G9170, *Memory functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
    - Short descriptor: Memory D/C status

Voice G-code Set:

- G9171, *Voice functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor Voice current status

- G9172, *Voice functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*
    - Short descriptor Voice goal status

- G9173, *Voice functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
    - Short descriptor: Voice D/C status

Other Speech Language Pathology G-code Set:

- G9174, *Other speech language pathology functional limitation, current status at time of initial therapy treatment/episode outset and reporting intervals*
    - Short descriptor: Speech lang current status

- G9175, *Other speech language pathology functional limitation, projected goal status at initial therapy treatment/outset and at discharge from therapy*

- Short descriptor: speech lang goal status

- G9176, *Other speech language pathology functional limitation, discharge status at discharge from therapy/end of reporting on limitation*
  - Short descriptor: speech lang D/C status

Severity/Complexity Modifiers.

For each of the above-listed nonpayable G-codes, a modifier must be used to report the severity/complexity for that functional measure. The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the therapist, physician, or NPP furnishing the therapy services. The beneficiary's current status, the anticipated goal status, and the discharge status are reported via the appropriate severity modifiers.

The seven severity modifiers are defined below:

Modifier	**Impairment Limitation Restriction**
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted

Required Reporting of Functional G-codes and Severity Modifiers.

The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims for certain dates of service (DOS). Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC). However, functional reporting is required on claims throughout the entire episode of care; so, there will be instances where two or more functional limitations will be reported for one beneficiary's POC, just not during the same time frame. In these situations, where reporting on the first reported functional limitation is complete and the need for treatment continues, reporting is required for a second functional limitation using another set of G-codes. Thus, reporting on more than one functional limitation may be required for some beneficiaries, but not simultaneously.

Specifically, functional reporting, using the G-codes and modifiers, is required on therapy claims for certain DOS as described below:

- At the outset of a therapy episode of care, i.e., on the DOS for the initial therapy service;

- At least once every 10 treatment days -- which is the same as the newly-revised progress reporting period -- the functional reporting is required on the claim for services on same DOS that the services related to the progress report are furnished;

- The same DOS that an evaluative procedure, including a re-evaluative one, is submitted on the claim (see below for applicable HCPCS/CPT codes);

- At the time of discharge from the therapy episode of care, if data is available; and,

- On the same DOS the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary.

As noted above, this functional reporting coincides with the progress reporting frequency, which is being changed through this instruction. Previously, the progress reporting was due every 10th treatment day or 30 calendar days, whichever was less. The new requirement is for the services related to the progress reports to be furnished on or before every 10th treatment day. In the example below, the G-codes for the mobility functional limitation (G8978 - 8980) are used to illustrate the timing of the functional reporting.

- At the outset of therapy -- the DOS the evaluative procedure is billed or the initial therapy services are furnished:
    - G8978 and G8979, along with the related severity modifiers, are used to report the current status and projected goal status of the mobility functional limitation.

- At the end of each progress reporting period -- the DOS when the progress report services are furnished:
    - G8978 and G8979, along with the related severity modifiers, are used to report the current status and projected goal status of the mobility functional limitation.

    - This step is repeated as clinically appropriate

- At the time the beneficiary is discharged from the therapy episode -- the DOS the discharge progress report services are furnished:
    - G8979 and G8980, along with the related severity modifiers, are used to report the projected goal and discharge status of the mobility functional limitation.

In the above example, if further therapy is medically necessary once reporting for the mobility functional limitation has ended, the therapist begins reporting on another functional limitation using a different set of G-codes. Reporting of the next functional limitation is required on the DOS of the first treatment day after the reporting was ended for the mobility functional limitation.

Evaluative Procedures. The presence of an HCPCS/CPT code on a claim for an evaluation or re-evaluation service listed below requires reporting of functional G-code(s) and corresponding modifier(s) for the same date of service:

92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004.

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

1. Therapy services under more than one therapy POC. Claims may contain more than two nonpayable functional G-codes when in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.
2. One-Time Therapy Visit. When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, the clinician reports 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.

Each reported functional G-code must also contain the following essential line of service information:

- Functional severity modifier in the range CH – CN

- Therapy modifier indicating the discipline of the POC – GP, GO or GN – for PT, OT, and SLP services, respectively

- Date of the corresponding billable service

- Nominal charge, e.g., a penny, for institutional claims submitted to the FIs and A/MACs. For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.

In addition, claims containing any of these functional G-codes must also contain another billable and separately payable (non-bundled) service.

Required Tracking and Documentation of Functional G-codes and Severity Modifiers.

The reported functional information is derived from the beneficiary's functional limitations set forth in the therapy goals, a requirement of the POC, that are established by a therapist, including – an occupational therapist, a speech-language pathologist or a physical therapist – or a physician/NPP, as applicable. The therapist or physician/NPP furnishing the therapy services must not only report the functional information on the therapy claim, but, he/she must track and document the G-codes and modifiers used for this reporting in the beneficiary's medical record of therapy services.

Provider Education.

Information for therapy providers and practitioners is provided in greater detail in the related educational MLN article issued with this instruction – related to the reporting and documentation requirements for therapy services furnished to beneficiaries.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
8005-04.1	Effective January 1, 2013, contractors shall accept the nonpayable HCPCS codes in the following ranges -- G8978 to G8999, G9158 to G9176, and G9186 -- for claims with dates of service on or after January 1, 2013. **NOTE:** The codes will have a MPFS status indicator of "Q." TOS is 1. **NOTE:** These new codes will be added to the Medicare Physician Fee Schedule Database (MPFSDB) with the new "Q" status code indicator. They will not have RVUs or payment amounts. This will be added to the 2013 MPFSDB.	X		X	X	X	X	X			I/OCE
800-04.2	Contractors shall accept the modifiers in the range CH - CN effective for claims with dates of service on or after January 1, 2013.	X		X	X	X					I/OCE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
8005-04.3	Contractors shall process claims with the following nonpayable HCPCS codes -- G8978 to G8999, G9158 to G9176, and G9186 -- regardless if a charge is submitted or not.	X			X			X			
8005-04.3.1	Contractors shall process claims with the following nonpayable HCPCS codes -- G8978 to G8999, G9158 to G9176, and G9186 -- when submitted with a nominal charge (e.g., $0.01) on the nonpayable line. **NOTE:** Institutional providers must submit a charge on the nonpayable line item.	X		X		X					
8005-04.3.2	Contractors shall deny claim lines for codes with status indicator "Q."	X			X						
8005-04.3.3	Contractors shall reject claim lines for codes with status indicator "Q."	X		X		X	X				
8005-04.3.4	Contractors shall use the following messages when denying the nonpayable G-codes: Medicare Summary Notice 36.7 - This code is for informational/reporting purposes only. You should not be charged for this code. If there is a charge, you do not have to pay the amount. Claim Adjustment Reason Code 246 - This non-payable code is for required reporting only. Group Code CO (Contractual Obligation) assigning financial liability to the provider.	X		X	X	X					
8005-04.4	The standard system maintainer shall bypass MSP-PAY for the nonpayable G codes, with "Q" status indicator, regardless if a charge is submitted or not.						X	X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
8005-04.5	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 site 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 your 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	X	X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s):

Policy Contact: Pamela West, pamela.west@cms.hhs.gov, (410) 786-2302

Institutional Claims: Yvonne Young, yvonne.young@cms.hhs.gov (410) 786-1886.

Professional Claims: Leslie Trazzi, leslie.trazzi@cms.hhs.gov, (410) 786-7544, April Billingsley, april.billingsley@cms.hhs.gov, 410-786-0140

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*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: 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 obligated 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.

Medicare Claims Processing Manual
Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

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(Rev. 2622, 12-21-12)

10.5 - Notification for Beneficiaries Exceeding Financial Limitations

(Rev. 2622, Issued: 12-21-12, Effective: 01-01-13, Implementation: 01-07-13)

A. Notice to Beneficiaries

Contractors will advise providers/suppliers to notify beneficiaries of the therapy financial limitations at their first therapy encounter with the beneficiary. Providers/suppliers should inform beneficiaries that beneficiaries are responsible for 100 percent of the costs of therapy services above each respective therapy limit, unless this outpatient care is furnished directly or under arrangements by a hospital when outpatient hospital therapy services are excluded from the limitation. Patients who are residents in a Medicare-certified part of a SNF may not utilize outpatient hospital services for therapy services over the financial limits, because consolidated billing rules require all services to be billed by the SNF. However, when therapy cap exceptions apply, SNF residents may qualify for exceptions that allow billing within the consolidated billing rules.

It is the provider's responsibility to present each beneficiary with accurate information about the therapy limits, and indicate that, where necessary, appropriate care above the limits can be obtained at a hospital outpatient therapy department when outpatient hospital therapy services are excluded from the limitation.

Prior to March 1, 2009, providers could use the Notice of Exclusion from Medicare Benefits (NEMB Form No. CMS 20007) to inform a beneficiary of financial liability for therapy above the cap, where no exception applied; however, the NEMB form has been discontinued. In its place, providers *are* now *encouraged to* use *either* a form of their own design, or the Advanced Beneficiary Notice of Noncoverage (ABN, Form CMS-R-131) as a voluntary notice. When using the ABN form as a voluntary notice, the form requirements specified for its mandatory use do not apply. The beneficiary should not be asked to choose an option or sign the form. The provider should include the beneficiary's name on the form and the reason that Medicare may not pay in the space provided within the form's table. Insertion of the following reason is suggested: "Services do not qualify for exception to therapy caps. Medicare will not pay for physical therapy and speech-language pathology services over (add the dollar amount of the cap) in (add the year or the dates of service to which it applies) unless the beneficiary qualifies for a cap exception." Providers are to supply this same information for occupational therapy services over the limit for the same time period, if appropriate. A cost estimate for the services may be included but is not required. *It should be noted that the provider or practitioner who furnishes therapy services for which an exception to the caps is requested has a responsibility to inform the beneficiary of potential liability for the cost of therapy services received over the therapy caps should the therapy services be found not to be medically necessary.*

After the cap is exceeded, voluntary notice via a provider's own form or the ABN is appropriate, even when services are excepted from the cap. The ABN is also used **BEFORE** the cap is exceeded when notice about noncovered services is mandatory. For example, whenever the treating clinician determines that the services being provided are no longer expected to be covered because they do not satisfy Medicare's medical necessity requirements, an ABN must be issued before the beneficiary receives that service. At the time the clinician determines that skilled services are not *medically* necessary, the clinical goals have been met, or there is no longer potential for the rehabilitation of health and/or function in a reasonable time, the beneficiary should be informed. If the beneficiary requests further services, beneficiaries should be informed that Medicare most likely will not provide additional coverage, and the ABN should be issued prior to delivering any services. The ABN informs the beneficiary of his/her potential financial obligation to the provider and provides guidance regarding appeal rights. When the ABN is used as a mandatory notice, providers must adhere to the form requirements set forth in this manual in chapter 30, section 50.6.3.

The ABN can be found at: http://www.cms.hhs.gov/BNI/Downloads/ABNFormInstructions.zip

B. Access to Accrued Amount

All providers and contractors may access the accrued amount of therapy services from the ELGA screen inquiries into CWF. Provider/suppliers may access remaining therapy services limitation dollar amount through the 270/271 eligibility inquiry and response transaction. Providers who bill to FIs or A/B MACs will also find the amount a beneficiary has accrued toward the financial limitations on the HIQA. Some suppliers and providers billing to carriers or A/B MACs may, in addition, have access to the accrued amount of therapy services from the ELGB screen inquiries into CWF. Suppliers who do not have access to these inquiries may call the contractor to obtain the amount accrued.

Beneficiaries are provided with the most current amount accrued toward their caps on each MSN.

10.6 - *Functional Reporting*

(Rev. 2622, Issued: 12-21-12, Effective: 01-01-13, Implementation: 01-07-13)

A. General

Section 3005(g) of the Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) amended Section 1833(g) of the Act to require a claims-based data collection system for outpatient therapy services, including physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) services. 42 CFR 410.59, 410.60, 410.61, 410.62 and 410.105 implement this requirement. The system will collect data on beneficiary function during the course of therapy services in order to better understand beneficiary conditions, outcomes, and expenditures.

Beneficiary unction information is reported using 42 nonpayable functional G-codes and seven severity/complexity modifiers on claims for PT, OT, and SLP services. Functional reporting on one functional limitation at a time is required periodically throughout an entire PT, OT, or SLP therapy episode of care.

The nonpayable G-codes and severity modifiers provide information about the beneficiary's functional status at the outset of the therapy episode of care, including projected goal status, at specified points during treatment, and at the time of discharge. These G-codes, along with the associated modifiers, are required at specified intervals on all claims for outpatient therapy services – not just those over the cap.

B. Application of New Coding Requirements

This functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013. A testing period will be in effect from January 1, 2013, until July 1, 2013, to allow providers and practitioners to use the new coding requirements to assure that systems work. Claims for therapy services furnished on and after July 1, 2013, that do not contain the required functional G-code/modifier information will be returned or rejected, as applicable.

C. Services Affected

These requirements apply to all claims for services furnished under the Medicare Part B outpatient therapy benefit and the PT, OT, and SLP services furnished under the CORF benefit. They also apply to the therapy services furnished personally by and incident to the service of a physician or a nonphysician practitioner (NPP), including a nurse practitioner (NP), a certified nurse specialist (CNS), or a physician assistant (PA), as applicable.

D. Providers and Practitioners Affected.

The functional reporting requirements apply to the therapy services furnished by the following providers: hospitals, CAHs, SNFs, CORFs, rehabilitation agencies, and HHAs (when the beneficiary is not under a home health plan of care). It applies to the following practitioners: physical therapists, occupational therapists, and

speech-language pathologists in private practice (TPPs), physicians, and NPPs as noted above. The term "clinician" is applied to these practitioners throughout this manual section. (See definition section of Pub. 100-02, chapter 15, section 220.)

E. Function-related G-codes

There are 42 functional G-codes, 14 sets of three codes each. Six of the G-code sets are generally for PT and OT functional limitations and eight sets of G-codes are for SLP functional limitations.

The following G-codes are for functional limitations typically seen in beneficiaries 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 to be used for functional limitations not described by one of the four categories.

NONPAYABLE G-CODES FOR FUNCTIONAL LIMITATIONS

	Long Descriptor	**Short Descriptor**
Mobility G-code Set		
G8978	*Mobility: walking & moving around functional limitation, current status, at therapy episode outset and at reporting intervals*	Mobility current status
G8979	*Mobility: walking & moving around functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Mobility goal status
G8980	*Mobility: walking & moving around functional limitation, discharge status, at discharge from therapy or to end reporting*	Mobility D/C status
***Changing & Maintaining Body Position* G-code Set**		
G8981	*Changing & maintaining body position functional limitation, current status, at therapy episode outset and at reporting intervals*	Body pos current status
G8982	*Changing & maintaining body position functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Body pos goal status
G8983	*Changing & maintaining body position functional limitation, discharge status, at discharge from therapy or to end reporting*	Body pos D/C status
Carrying, Moving & Handling Objects G-code Set		
G8984	*Carrying, moving & handling objects functional limitation, current status, at therapy episode outset and at reporting intervals*	Carry current status
G8985	*Carrying, moving & handling objects functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Carry goal status
G8986	*Carrying, moving & handling objects functional limitation, discharge status, at discharge from therapy or to end reporting*	Carry D/C status
Self Care G-code Set		
G8987	*Self care functional limitation, current status, at therapy episode outset and at reporting intervals*	Self care current status
G8988	*Self care functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at*	Self care goal status

	discharge or to end reporting	
G8989	*Self care functional limitation, discharge status, at discharge from therapy or to end reporting*	Self care D/C status

The following "other PT/OT" functional G-codes are used to report:

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

	Long Descriptor	**Short Descriptor**
Other PT/OT Primary G-code Set		
G8990	*Other physical or occupational therapy primary functional limitation, current status, at therapy episode outset and at reporting intervals*	Other PT/OT current status
G8991	*Other physical or occupational therapy primary functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Other PT/OT goal status
G8992	*Other physical or occupational therapy primary functional limitation, discharge status, at discharge from therapy or to end reporting*	Other PT/OT D/C status
Other PT/OT Subsequent G-code Set		
G8993	*Other physical or occupational therapy subsequent functional limitation, current status, at therapy episode outset and at reporting intervals*	Sub PT/OT current status
G8994	*Other physical or occupational therapy subsequent functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Sub PT/OT goal status

The following G-codes are for functional limitations typically seen in beneficiaries receiving SLP services. Seven are for specific functional communication measures, which are modeled after the National Outcomes Measurement System (NOMS), and one is for any "other" measure not described by one of the other seven.

	Long Descriptor	**Short Descriptor**
Swallowing G-code Set		
G8996	*Swallowing functional limitation, current status, at therapy episode outset and at reporting intervals*	Swallow current status
G8997	*Swallowing functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Swallow goal status
G8998	*Swallowing functional limitation, discharge status, at discharge from therapy or to end reporting*	Swallow D/C status
Motor Speech G-code Set (Note: These codes are not sequentially numbered)		
G8999	*Motor speech functional limitation, current status, at therapy episode outset and at reporting intervals*	Motor speech current status
G9186	*Motor speech functional limitation, projected goal status at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Motor speech goal status
G9158	*Motor speech functional limitation, discharge status, at discharge from therapy or to end reporting*	Motor speech D/C status

Spoken Language Comprehension G-code Set		
G9159	*Spoken language comprehension functional limitation, current status, at therapy episode outset and at reporting intervals*	Lang comp current status
G9160	*Spoken language comprehension functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Lang comp goal status
G9161	*Spoken language comprehension functional limitation, discharge status, at discharge from therapy or to end reporting*	Lang comp D/C status
Spoken Language Expressive G-code Set		
G9162	*Spoken language expression functional limitation, current status, at therapy episode outset and at reporting intervals*	Lang express current status
G9163	*Spoken language expression functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Lang press goal status
G9164	*Spoken language expression functional limitation, discharge status, at discharge from therapy or to end reporting*	Lang express D/C status
Attention G-code Set		
G9165	*Attention functional limitation, current status, at therapy episode outset and at reporting intervals*	Atten current status
G9166	*Attention functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Atten goal status
G9167	*Attention functional limitation, discharge status, at discharge from therapy or to end reporting*	Atten D/C status
Memory G-code Set		
G9168	*Memory functional limitation, current status, at therapy episode outset and at reporting intervals*	Memory current status
G9169	*Memory functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Memory goal status
G9170	*Memory functional limitation, discharge status, at discharge from therapy or to end reporting*	Memory D/C status
Voice G-code Set		
G9171	*Voice functional limitation, current status, at therapy episode outset and at reporting intervals*	Voice current status
G9172	*Voice functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Voice goal status
G9173	*Voice functional limitation, discharge status, at discharge from therapy or to end reporting*	Voice D/C status

The following "other SLP" G-code set is used to report:

- *on one of the other eight NOMS-defined functional measures not described by the above code sets; or*
- *to report an overall, composite or other score from assessment tool that does not clearly represent one of the above seven categorical SLP functional measures.*

	Long Descriptor	**Short Descriptor**
Other Speech Language Pathology G-code Set		
G9174	*Other speech language pathology functional limitation, current status, at therapy episode outset and at reporting*	Speech lang current status

	intervals	
G9175	*Other speech language pathology functional limitation, projected goal status, at therapy episode outset, at reporting intervals, and at discharge or to end reporting*	Speech lang goal status
G9176	*Other speech language pathology functional limitation, discharge status, at discharge from therapy or to end reporting*	Speech lang D/C status

F. Severity/Complexity Modifiers

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

Modifier	***Impairment Limitation Restriction***
CH	*0 percent impaired, limited or restricted*
CI	*At least 1 percent but less than 20 percent impaired, limited or restricted*
CJ	*At least 20 percent but less than 40 percent impaired, limited or restricted*
CK	*At least 40 percent but less than 60 percent impaired, limited or restricted*
CL	*At least 60 percent but less than 80 percent impaired, limited or restricted*
CM	*At least 80 percent but less than 100 percent impaired, limited or restricted*
CN	*100 percent impaired, limited or restricted*

The severity modifiers reflect the beneficiary's percentage of functional impairment as determined by the clinician furnishing the therapy services.

G. Required Reporting of Functional G-codes and Severity Modifiers

The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims at certain specified points during therapy episodes of care. Claims containing these functional G-codes must also contain another billable and separately payable (non-bundled) service. Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC).

Functional reporting using the G-codes and corresponding severity modifiers is required reporting on specified therapy claims. Specifically, they are required on claims:

- *At the outset of a therapy episode of care (i.e., on the claim for the date of service (DOS) 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-evaluative one, (HCPCS/CPT codes 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004) 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 [progress] report are furnished); and*
- *At the time reporting of a particular functional limitation is ended in cases where the need for further therapy is necessary.*
- *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 beneficiary 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 beneficiary during the therapy episode of care. Thus, reporting on more than one functional limitation may be required for some beneficiaries but not simultaneously.

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

When functional reporting is required on a claim for therapy services, two G-codes will generally be required.

Two exceptions exist:

1. *Therapy services under more than one therapy POC. Claims may contain more than two nonpayable functional G-codes when in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.*
2. *One-Time Therapy Visit. When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, the clinician reports 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.*

Each reported functional G-code must also contain the following line of service information:

- *Functional severity modifier*
- *Therapy modifier indicating the related discipline/POC -- GP, GO or GN -- for PT, OT, and SLP services, respectively*
- *Date of the related therapy service*
- *Nominal charge, e.g., a penny, for institutional claims submitted to the FIs and A/MACs. For professional claims, a zero charge is acceptable for the service line. If provider billing software requires an amount for professional claims, a nominal charge, e.g., a penny, may be included.*

Note: The KX modifier is not required on the claim line for nonpayable G-codes, but would be required with the procedure code for medically necessary therapy services furnished once the beneficiary's annual cap has been reached.

The following example demonstrates how the G-codes and modifiers are used. In this example, the clinician determines that the beneficiary's mobility restriction is the most clinically relevant functional limitation and selects the Mobility G-code set (G8978 – G8980) to represent the beneficiary's functional limitation. The clinician also determines the severity/complexity of the beneficiary's functional limitation and selects the appropriate modifier. In this example, the clinician determines that the beneficiary has a 75 percent mobility restriction for which the CL modifier is applicable. The clinician expects that at the end of therapy the beneficiaries will have only a 15 percent mobility restriction for which the CI modifier is applicable. When the beneficiary attains the mobility goal, therapy continues to be medically necessary to addresss a functional limitation for which there is no categorical G-code. The clinician reports this using (G8990 – G8992).

At the outset of therapy. On the DOS for which the initial evaluative procedure is furnished or the initial treatment day of a therapy POC, the claim for the service will also include two G-codes as shown below.

- *G8978-CL to report the functional limitation (Mobility with current mobility limitation of "at least 60 percent but less than 80 percent impaired, limited or restricted")*
- *G8979-CI to report the projected goal for a mobility restriction of "at least 1 percent but less than 20 percent impaired, limited or restricted."*

At the end of each progress reporting period. On the claim for the DOS when the services related to the progress report (which must be done at least once each 10 treatment days) are furnished, the clinician will report the same two G-codes but the modifier for the current status may be different.

- *G8978 with the appropriate modifier are reported to show the beneficiary's current status as of this DOS. So if thebeneficiary has made no progress, this claim will include G8978-CL. If the beneficiary made progress and now has a mobility restriction of 65 percent CL would still be the appropriate modifier for 65 percent, and G8978-CL would be reported in this case. If the beneficiary now has a mobility restriction of 45 percent, G8978-CK would be reported.*
- *G8979-CI would be reported to show the projected goal. This severity modifier would not change unless the clinician adjusts the beneficiary's goal.*

This step is repeated as necessary and clinically appropriate, adjusting the current status modifier used as the beneficiary progresses through therapy.

At the time the beneficiary is discharged from the therapy episode. The final claim for therapy episode will include two G-codes.

- *G8979-CI would be reported to show the projected goal. G8980-CI would be reported if the beneficiary attained the 15 percent mobility goal. Alternatively, if the beneficiary's mobility restriction only reached 25 percent; G8980-CJ would be reported.*

To end reporting of one functional limitation. As noted above, functional reporting is required to continue throughout the entire episode of care. Accordingly, when further therapy is medically necessary after the beneficiary attains the goal for the first reported functional limitation, the clinician would end reporting of the first functional limitation by using the same G-codes and modifiers that would be used at the time of discharge. Using the mobility example, to end reporting of the mobility functional limitation, G8979-CI and G8980-CI would be reported on the same DOS that coincides with end of that progress reporting period.

To begin reporting of a second functional limitation. At the time reporting is begun for a new and different functional limitation, within the same episode of care (i.e., after the reporting of the prior functional limitation is ended). Reporting on the second functional limitation, however, is not begun until the DOS of the next treatment day -- which is day one of the new progress reporting period. When the next functional limitation to be reported is NOT defined by one of the other three PT/OT categorical codes, the G-code set (G8990 - G8992) for the "other PT/OT primary" functional limitation is used, rather than the G-code set for the "other PT/OT subsequent" – because it is the first reported "other PT/OT" functional limitation. This reporting begins on the DOS of the first treatment day following the mobility "discharge" reporting, which is counted as the initial service for the "other PT/OT primary" functional limitation and the first treatment day of the new progress reporting period. In this case, G8990 and G8991, along with the corresponding modifiers, are reported on the claim for therapy services.

The table below illustrates when reporting is required using this example and what G-codes would be used.

Example of Required Reporting

Key: Reporting Period (RP)	*Begin RP #1 for Mobility at Episode Outset*	*End RP#1for Mobility at Progress Report*	*Mobility RP #2 Begins Next Treatment Day*	*End RP #2 for Mobility at Progress Report*	*Mobility RP #3 Begins Next Treatment Day*	*D/C or End Reporting for Mobility*	*Begin RP #1 for Other PT/OT Primary*
Mobility: Walking & Moving Around							
G8978 – Current Status	*X*	*X*		*X*			
G 8979– Goal Status	*X*	*X*		*X*		*X*	
G8980 – Discharge Status						*X*	
Other PT/OT Primary							
G8990 – Current Status							*X*
G8991 – Goal Status							*X*
G8992 – Discharge Status							
No Functional Reporting Required			*X*		*X*		

H. Required Tracking and Documentation of Functional G-codes and Severity Modifiers

The clinician who furnishes the services must not only report the functional information on the therapy claim, but, he/she must track and document the G-codes and severity modifiers used for this reporting in the beneficiary's medical record of therapy services.

For details related to the documentation requirements, refer to Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 220.3, subsection F - MCTRJCA-required Functional Reporting. For coverage rules related to MCTRJCA and therapy goals, refer to Pub. 100-02: a) for outpatient therapy services, see chapter 15, section 220.1.2 B and b) for instructions specific to PT, OT, and SLP services in the CORF, see chapter 12, section 10.

10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

(Rev. 2622, Issued: 12-21-12, Effective: 01-01-13, Implementation: 01-07-13)

Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding carrier-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and

80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the 837 Professional electronic format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims (any claim submitted using the 837 Institutional electronic format or the UB-04 paper claim form).

To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services. When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

The full fee schedule payments and the MPPR payments are summarized below in the following example for services on an institutional claim (Note: on professional claims, the reduction percentage is 20 percent).

	Procedure 1 Unit 1	Procedure 1 Unit 2	Procedure 2	Full MPFS Payment	MPPR Total Payment	Proposed Payment Calculation
Work	$7.00	$7.00	$11.00	$25.00	$25.00	no reduction
PE	$10.00	$10.00	$8.00	$28.00	$23.50	$10 + (.75 x $10) + (.5 x $8)
Malpractice	$1.00	$1.00	$1.00	$3.00	$3.00	no reduction
Total	$18.00	$18.00	$20.00	$56.00	$51.50	$18 + ($18-$10) + (.75 x $10) +($20-$8) + (.75 x $8)

The therapy payment amount that has been reduced by the MPPR is applied toward the therapy caps described in section 10.2. As a result, the MPPR may increase the amount of medically necessary therapy services a beneficiary may receive before exceeding the caps. The reduced amount is also used to calculate the beneficiary's coinsurance and deductible amounts.

Contractors indicate services have been subject to the MPPR using the following coding on the provider's remittance advice:

- Group code CO and
- Claim adjustment reason code 59 - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)

Contractors shall use the following message on Medicare Summary Notices for claims subject to the MPPR:

- 30.1 The approved amount is based on a special payment method, or
- 30.1 La cantidad aprobada está basada en un método especial de pago.