2013 Physical Therapy G Codes

■ DAVID STERN, MD, CPC

Q. We offer Physical Therapy services to patients in our urgent care center and some patients have Medicare insurance. I understand there are new codes that we must use for Medicare. What are they and how do we use them?

A. The Centers for Medicare and Medicaid Services (CMS) was mandated by the Middle Class Tax Relief Act of 2012 to collect information regarding beneficiaries' function and condition, therapy services furnished, and outcomes achieved on patient function on claim forms by using non-payable HCPCS G-codes with additional severity modifiers, along with the normal charges and therapy modifiers.

All practices that provide outpatient therapy services must include this information on the claim form. The policy applies to physical therapy, occupational therapy, and speech-language-pathology services. When Medicare is the primary or secondary payor, Functional reporting using G-codes and modifiers is required on therapy claims for certain dates of service (DOS), as described below:

- At the outset of a therapy episode of care, that is, on the DOS of the initial therapy service;
- At least once every 10 treatment days;
- For the same DOS that any subsequent evaluation or re-evaluation is submitted on the claim;
- At the time of discharge from the therapy episode of care; and
- On the same DOS the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary.

HCPCS codes G8978-G8998 are used to describe functional limitation such as mobility, changing and maintaining body position, carrying, moving, and handling objects, and swallowing.

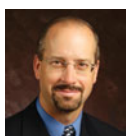
HCPCS codes G8998 and G9158-G9186 are used to describe functional limitation for motor speech, attention, memory, voice, and other motor speech functional limitations. When functional reporting is required on a claim for therapy services, two G codes will generally be required. Two exceptions are:

- Therapy services under more than one therapy plan of care. Claims may contain more than two G codes in cases where a beneficiary receives therapy services under multiple plans of care from the same therapy provider.
- A 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 all three G codes in the appropriate code set (current status, goal status, and discharge status), along with corresponding severity modifiers.

The severity modifiers required with the G codes are:

- 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

Beginning July 1, 2013, Medicare started denying claims that were missing these codes. ■



David E. Stern, MD is a certified professional coder and board certified in Internal Medicine. He was a Director on the founding Board of UCAOA and has received the organization's Lifetime Membership Award. He is CEO of Practice Velocity, LLC (www.practicevelocity.com), PV Billing and NMN Consulting, providers of software, billing and urgent care consulting services. Dr. Stern welcomes your questions about urgent care in general and about coding issues in particular.

Note: CPT codes, descriptions, and other data only are copyright 2011, American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).

Disclaimer: JUCM and the author provide this information for educational purposes only. The reader should not make any application of this information without consulting with the particular payors in question and/or obtaining appropriate legal advice.