

Medicare Part B Functional Reporting Requirements Take Effect July 1

Beginning July 1, 2013, occupational therapy service providers billing outpatient therapy services under Medicare Part B will be required to report functional data for patients on the claim form.

Reporting will take the form of new G-codes, which identify the primary issue being addressed by therapy, and modifiers that reflect the patient's impairment/limitation/restriction. The data will be used to track functional change over time.

The G-code categories are: mobility (walking & moving around); changing and maintaining body position; carrying, moving, and handling objects; self-care; swallowing; motor speech; spoken language comprehension; spoken language expression; attention; memory; voice; other physical therapy/occupational therapy functional limitation; and other speech-language pathology functional limitation. A more detailed explanation of G-codes is available [here](#).

The G-code functional categories are not discipline-specific, and occupational therapists can use any and all of them. Occupational therapists should use their professional clinical judgment to select the G-code that reflects the primary reason for treatment and the appropriate modifier. "Practitioners can defend the practice of occupational therapy by using the full range of codes," says AOTA Chief Public Affairs Officer Christina Metzler. "CMS has clarified that there are no restrictions on which disciplines may use which codes." [See a brief slide presentation on CMS's position.](#)

This requirement was mandated by statute and implemented via regulation. The Centers for Medicare & Medicaid Services (CMS) first proposed this requirement in July 2012 (AOTA published an [Analysis of the Proposed Rule](#) at the time, and submitted a [Comment Letter to CMS](#)) and finalized it in the November 2012 [Physician Fee Schedule Final Rule for CY 2013](#), which creates and amends regulations governing payment practices for Medicare Part B outpatient therapy services in CY 2013. Initial reporting began January 1, with the first 6 months of the year constituting a voluntary testing period. Starting July 1, CMS contractors will reject claims without the required functional data and return them for re-submission with the required codes. Therapy providers who have been submitting Functional Reporting data during the testing period will not need to restart Functional Reporting on the first date of service (DOS) on or after July 1, 2013, for episodes of care for which Functional Reporting began during the testing period. In other words, for those episodes of care for which the therapist included Functional Reporting on the claims for DOS prior to July 1, 2013, reporting after July 1, 2013, is required at the next regularly scheduled reporting. For beneficiaries whose treatment began prior to July 1, 2013 but for whom Functional Reporting information has not been submitted, the first claim submitted with a DOS on or after July 1, 2013 should be treated as the initial claim and include the required Functional Reporting.

Note: During a CMS Open Door Forum on June 4, 2013, CMS officials indicated that therapists that submitted Functional Reporting during the testing period would have to start over on July 1. They stated that the CMS claims processing system is unable to track and reconcile G-codes and modifiers that have been reported for a patient pre-July 1 with those reported post-July 1. On June 17, CMS informed therapy associations and other stakeholders that after hearing from therapists and others, they reassessed the requirements and clarified that therapists who have been submitting Functional Reporting data will not have to restart on July 1.

Jennifer Hitchon, Counsel & Director of Regulatory Affairs for AOTA, discusses these Medicare reporting requirements in a [podcast](#) (recorded June 14, 2013) with accompanying slides available [here](#).