CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2091	**Date: NOVEMBER 12, 2010**
	Change Request 7170

SUBJECT: Correct Reporting of Modifiers and Revenue Codes on Claims for Therapy Services

I. SUMMARY OF CHANGES: This Change Request creates new edits in Medicare claims processing systems to ensure correct billing of therapy-related codes on institutional claims.

EFFECTIVE DATE: April 1, 2011
IMPLEMENTATION DATE: April 4, 2011

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	5/20.1/Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

III. FUNDING:
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.

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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2091	Date: November 12, 2010	Change Request: 7170

SUBJECT: Correct Reporting of Modifiers and Revenue Codes on Claims for Therapy Services

Effective Date: April 1, 2011

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background: On Medicare institutional claims, outpatient rehabilitation services are identified by the provider reporting revenue code 042x (physical therapy), 043x (occupational therapy) or 044x (speech-language pathology). Individual procedures are also identified as being provided under an outpatient rehabilitation plan of care by the provider reporting modifier GN (speech-language pathology), GO (occupational therapy) or GP (physical therapy).

During analysis of Medicare claims data for outpatient rehabilitation services, CMS has found that these codes and modifiers are not always used in a correct and consistent manner. CMS has found outpatient rehabilitation claims that report both a GO and GP modifier for the same service.

These claims represent non-compliant billing by outpatient rehabilitation providers. They also complicate CMS' ability to analyze claims data for purposes of Medicare program improvements. The requirements below will create new edits in Medicare institutional claims processing systems to return claims with these errors to the provider for correction.

B. Policy: This Change Request contains no new policy. The requirements below improve enforcement of longstanding instructions.

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	
7170.1	Medicare contractors shall return institutional claims to the provider if any service line on the claim contains more than one occurrence of the modifiers GN, GO or GP.	X		X		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	
7170.2	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					

IV. SUPPORTING INFORMATION

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

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

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

V. CONTACTS

Pre-Implementation Contact(s): Wil Gehne, wilfried.gehne@cms.hhs.gov, 410-786-6148

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

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.

B. *For Medicare Administrative Contractors (MAC)*:

The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts specified 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.

20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

(Rev. 2091, Issued: 11-12-10; Effective Date: 04-01-11; Implementation Date: 04-04-11)

Modifiers are used to identify therapy services whether or not financial limitations are in effect. When limitations are in effect, the CWF tracks the financial limitation based on the presence of therapy modifiers. Providers/suppliers must continue to report one of these modifiers for any therapy code on the list of applicable therapy codes except as noted in §20 of this chapter. Consult §20 for the list of codes to which modifiers must be applied. These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform.

The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- GN Services delivered under an outpatient speech-language pathology plan of care;
- GO Services delivered under an outpatient occupational therapy plan of care; or,
- GP Services delivered under an outpatient physical therapy plan of care.

This is applicable to all claims from physicians, nonphysician practitioners (NPPs), PTPPs, OTPPs, SLPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, speech-language pathology or occupational therapy services as noted on the applicable code list in §20 of this chapter.

Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by therapy codes which require GN, GO, and GP modifiers.

Contractors edit to ensure that more than one GN, GO or GP are not reported on the same service line on all institutional claims. Contractors will return to the provider any claim that reports more than one of these modifiers on the same line.

Contractors also edit to ensure that the therapy modifiers are present based on revenue codes 042X, 043X, or 044X. Claims containing revenue codes 042X, 043X, or 044X without a therapy modifier GN, GP, or GO are returned to the provider. Additionally, contractors ensure that revenue codes and modifiers are reported in the following combinations:

- *Revenue code 42x (physical therapy) lines may only contain modifier GP*
- *Revenue code 43x (occupational therapy) lines may only contain modifier GO*
- *Revenue code 44x (speech-language pathology) lines may only contain modifier GN.*

Contractors return to the provider institutional claims that contain lines with any other combinations of these revenue codes and modifiers.