

Section on Geriatrics Recommended Outcome Measures for Medicare Functional Limitation/Severity Reporting

A Joint Report by the Section on Geriatrics Practice Committee (Greg Hartley, Chair), the Reimbursement/Legislative Affairs Committee (Ellen Strunk, Chair), and the GeriEDGE Task Force (Michelle Lusardi, Chair)

Part 1: Background and Reporting Process

The Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA; Section 3005(g); see <http://www.gpo.gov/fdsys/pkg/CRPT-112hrpt399/pdf/CRPT-112hrpt399.pdf>) states that “*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 reporting and collection system requires claims for therapy services to include nonpayable G-codes and related modifiers (e.g. severity/complexity modifiers). These non-payable G-codes provide information about the beneficiary’s functional status at:

- The outset of the therapy episode of care (the evaluation),
- Specified points during treatment (every 10th visit and at re-evaluation), and
- The time of discharge.

These G-codes and related modifiers are required on all claims for Medicare Part B therapy services regardless of who provides them: hospitals, critical access hospitals, skilled nursing facilities, home health agencies (when the patient is not under a home health plan of care), physical therapy private practices, physician-owned physical therapy practices, rehab agencies, or certified outpatient rehabilitation facilities. The G-codes and modifiers are also required on all Medicare Part B therapy claims, regardless of whether it is above or below the therapy cap amount.

Application of New Coding Requirements

While this functional data reporting and collection system is effective for therapy services with dates of service on and after January 1, 2013, providers are **required** to begin reporting G-codes and their modifiers on claims with dates of service **no later than July 1, 2013**. A testing period is in effect from January 1, 2013, through June 30, 2013, to allow providers to begin using the new codes and “test” their system’s claims processing with the codes. During this time period claims without G-codes and modifiers will be processed. Because the G codes are non-payable, there will be no payment for these codes.

A separate instruction/article (see MLN Matters® Article MM8126 at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8126.pdf>) contains more information about the claims processing instructions.

Function-related G-codes

Table 1 lists the Healthcare Common Procedure Coding System (HCPCS) G-codes used to report the status of a beneficiary’s functional limitations for PT/OT. (Speech Therapy has eight different codes which will not be listed here. See <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf> for this information):

Table 1: Functional Limitation G-Codes and Descriptors

Category	G-code	Long Descriptor	Short Descriptor
Mobility	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	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	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	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 discharge or to end reporting	Self care goal status
	G8989	Self care functional limitation, discharge status, at discharge from therapy or to end reporting	Self care D/C status
Other PT/OT Primary	G8990	Other physical or occupational primary functional limitation, current status, at therapy episode outset and at reporting intervals	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	Other PT/OT goal status
	G8992	Other physical or occupational primary functional limitation, discharge status, at discharge from therapy or to end reporting	Other PT/OT D/C status
Other PT/OT Subsequent	G8993	Other physical or occupational subsequent functional limitation, current status, at therapy episode outset and at reporting intervals	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	Sub PT/OT goal status
	G8995	Other physical or occupational subsequent functional limitation, discharge status, at discharge from therapy or to end reporting	Sub PT/OT D/C status

Severity/Complexity Modifiers

For each non-payable G-code shown above, 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 furnishing the therapy services. The evaluating therapist must determine the

1. The beneficiary's current impairment/restriction/limitation level – determined at evaluation or re-evaluation
2. The anticipated goal level of impairment/restriction/limitation level – e.g. what is the discharge goal level of impairment anticipated determined at evaluation or re-evaluation; and
3. The actual discharge status is reported

The seven modifiers are defined in Table 2.

Table 2: Severity Modifiers for Functional Limitation G-Codes

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

Required Reporting of Functional G-codes and Severity Modifiers

Only one functional limitation per discipline 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. 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 visits-- 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-evaluation, 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.

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.

Source: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf>

Part 2: Functional Limitation Reporting Categories and the International Classification of Functioning, Disability and Health (ICF)

The functional limitations categories selected by CMS are from the International Classification of Functioning, Disability and Health (ICF). The ICF is a classification of health and health-related domains. The ICF model acknowledges that every human being can experience some level of "disability" and views functioning and disability as an interaction between health, the environment, personal and social factors. For more information on the ICF, please see the APTA ICF web site (<http://www.apta.org/ICF/>). The way that CMS is using the term "functional limitation" is within the context of the areas of the ICF relating to "activity limitations" and "participation restrictions". It is worth reading and understanding these definitions in order to determine which functional limitation category your patient might best fit.

The definitions of the terms described below come from the *International Classification of Functioning, Disability and Health, World Health Organization, 2001, Geneva*. You may also find all of the descriptions of the components classified in the ICF using the ICF Browser (<http://apps.who.int/classifications/icfbrowser/>).

1. **Mobility:** Moving by changing body position or location or by transferring from one place to another, by carrying, moving or manipulating objects, by walking, running or climbing, and by using various forms of transportation.

a. **Walking:** Moving along a surface on foot, step by step, so that one foot is always on the ground, such as when strolling, sauntering, walking forwards, backwards, or sideways. Inclusions: walking short or long distances; walking on different surfaces; walking around obstacles

b. **Moving Around:** Moving the whole body from one place to another by means other than walking, such as climbing over a rock or running down a street, skipping, scampering, jumping, somersaulting or running around obstacles. Inclusions: crawling, climbing, running, jogging, jumping, and swimming

c. **Moving around in different locations:** Walking and moving around in various places and situations, such as walking between rooms in a house, within a building, or down the street of a town. Inclusions: moving around within the home, crawling or climbing within the home; walking or moving within buildings other than the home, and outside the home and other buildings

d. **Moving around using equipment:** Moving the whole body from place to place, on any surface or space, by using specific devices designed to facilitate moving or create other ways of moving around, such as with skates, skis, or scuba equipment, or moving down the street in a wheelchair or a walker.

e. **Moving around using transportation:** Using transportation to move around as a passenger, such as being driven in a car or on a bus, rickshaw, jitney, animal-powered vehicle, or private or

public taxi, bus, train, tram, subway, boat or aircraft. Inclusions: using human-powered transportation; using private motorized or public transportation

2. Changing basic body position: Getting into and out of a body position and moving from one location to another, such as getting up out of a chair to lie down on a bed, and getting into and out of positions of kneeling or squatting. Inclusion: changing body position from lying down, from squatting or kneeling, from sitting or standing, bending and shifting the body's center of gravity

a. Maintaining a body position: Staying in the same body position as required, such as remaining seated or remaining standing for work or school. Inclusions: maintaining a lying, squatting, kneeling, sitting and standing position

b. Transferring oneself: Moving from one surface to another, such as sliding along a bench or moving from a bed to a chair, without changing body position. Inclusion: transferring oneself while sitting or lying

3. Lifting and carrying objects: Raising up an object or taking something from one place to another, such as when lifting a cup or carrying a child from one room to another. Inclusions: lifting, carrying in the hands or arms, or on shoulders, hip, back or head; putting down

a. Moving objects with lower extremities: Performing coordinated actions aimed at moving an object by using the legs and feet, such as kicking a ball or pushing pedals on a bicycle. Inclusions: pushing with lower extremities; kicking

b. Fine hand use: Performing the coordinated actions of handling objects, picking up, manipulating and releasing them using one's hand, fingers and thumb, such as required to lift coins off a table or turn a dial or knob. Inclusions: picking up, grasping, manipulating and releasing.

c. Hand and arm use: Performing the coordinated actions required to move objects or to manipulate them by using hands and arms, such as when turning door handles or throwing or catching an object. Inclusions: pulling or pushing objects; reaching; turning or twisting the hands or arms; throwing; catching.

4. Self Care: caring for oneself, washing and drying oneself, caring for one's body and body parts, dressing, eating and drinking, and looking after one's health.

a. Washing oneself: Washing and drying one's whole body, or body parts, using water and appropriate cleaning and drying materials or methods, such as bathing, showering, washing hands and feet, face and hair, and drying with a towel. Inclusions: washing body parts, the whole body; and drying oneself.

b. Caring for body parts: Looking after those parts of the body, such as skin, face, teeth, scalp, nails and genitals, that require more than washing and drying. Inclusions: caring for skin, teeth, hair, finger and toe nails.

c. Toileting: Planning and carrying out the elimination of human waste (menstruation, urination and defecation), and cleaning oneself afterwards. Inclusions: regulating urination, defecation and menstrual care.

d. Dressing: Carrying out the coordinated actions and tasks of putting on and taking off clothes and footwear in sequence and in keeping with climatic and social conditions, such as by putting on, adjusting and removing shirts, skirts, blouses, pants, undergarments, saris, kimono, tights, hats, gloves, coats, shoes, boots, sandals and slippers. Inclusions: putting on or taking off clothes and footwear and choosing appropriate clothing

e. Looking after one's health: Ensuring physical comfort, health and physical and mental well-being, such as by maintaining a balanced diet, and an appropriate level of physical activity, keeping warm or cool, avoiding harms to health, following safe sex practices, including using condoms, getting immunizations and regular physical examinations. Inclusions: ensuring one's physical comfort; managing diet and fitness; maintaining one's health

(Source: <http://www.apta.org/Payment/Medicare/CodingBilling/FunctionalLimitation/>)

Part 3: Section on Geriatrics Recommended Outcome Measures for Medicare Functional Limitation and Severity Reporting

Upon request of its members and the APTA, the Section on Geriatrics set out to develop a list of tests and measures that clinicians working with older adults could use to assist them in meeting the functional claims reporting requirement as well as to provide supportive documentation for both the severity modifiers and intensity of therapy services. The Section on Geriatrics assembled a group of clinicians who are either currently serving on the SOG Practice Committee, the GeriEDGE Task Force, the Reimbursement Committee, or are considered experts in functional outcomes or measurement (see acknowledgements at the end of this report for a complete list). What follows is a list of **recommended** measures with best evidence, practicality of use, responsiveness, and psychometrics.

First and foremost, however, it should be said that a therapist can and should use as many tools as needed to adequately and comprehensively determine the appropriate G-code category and the level of severity of the reportable functional impairment. The selection of both is based on the therapist's clinical reasoning in interpreting the results of tests and measures and the overall presentation of the patient. The tests and measures are used to support the therapist's selection of the severity modifier. The severity ratings need to be selected based on the individual presentation of the patient/client, looking at the aggregate of data gathered with the use of standardized tests and measures as well as medical status, complexities and co-morbidities, environmental demands, etc. The measures are expected to be universal, not setting specific.

The **recommended** measures are:

- **Walking Speed [self-selected/fast-paced]**. There is strong evidence for its use, self-selected speeds may be preferred over fast paced, but both can be useful.
 - <http://www.rehabmeasures.org/PDF%20Library/10%20Meter%20Walk%20Test%20Instructions.pdf>
- **Six Minute Walk Test**. There is strong evidence for this capacity test. It can be modified to the 2 or 3 minute versions in more impaired patients.
 - Six Minute Version:
<http://www.csc.unc.edu/spir/public/UNLICOMMSMWSixMinuteWalkTestFormQxQ08252011.pdf>
 - 2 Minute Version:
<http://www.rehabmeasures.org/PDF%20Library/2%20Minute%20Walk%20Test%20Instructions.pdf>
- **Timed Up and Go (TUG) and/or TUG Manual [dual task]**. There is strong evidence for the use of this test which also captures information on gait speed.
 - <http://www.rehabmeasures.org/PDF%20Library/Timed%20Up%20and%20Go%20Test%20Instructions.pdf>
 - <http://www.rehabmeasures.org/Lists/RehabMeasures/PrintView.aspx?ID=1057>

- **Five Times Sit to Stand Test and/or 30 Second Sit to Stand.** There appears to be stronger evidence for Five Times Sit to Stand than the 30 Second Sit to Stand, though either would be suitable for the purposes intended here.
 - <http://web.missouri.edu/~proste/tool/>
- **Sitting Balance Scale.** There is limited evidence supporting its use, but it is a good tool for very low level patients.
 - <http://www.ncbi.nlm.nih.gov/pubmed/21574772>
- **Berg Balance Scale.** Excellent evidence to support its use and it is suitable for multiple levels of patient severity.
 - <http://www.fallpreventiontaskforce.org/pdf/BergBalanceScale.pdf>
- **Patient Specific Functional Scale.** This test may be a good measure of self-care and UE function.
 - <http://www.tac.vic.gov.au/media/upload/patient-specific.pdf>
- **Disabilities of the Arm, Shoulder, and Hand Scale (DASH or QuickDash).** Strong evidence to support its use. It captures moving, carrying, handling objects well.
 - <http://www.dash.iwh.on.ca/>
- **Fullerton Advanced Balance Scale.** Good evidence to support its use. It captures balance deficits on high level patients who may not show deficits on less advanced tests.
 - <http://hhd.fullerton.edu/csa/documents/FABScaleScoringFormwithCut-OffValues.pdf>
- **Elderly Mobility Scale.** This test captures low level activities and may be appropriate for institutionalized, homebound, or frail patients.
 - www.csp.org.uk/sites/files/csp/.../agile_outcome_measures_ems_v2_0.pdf
- **Falls Efficacy Scale – International.** Strong evidence to support its use as a self-reported measure of balance confidence.
 - <http://www.health.qld.gov.au/stayonyourfeet/documents/33346.pdf>

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