Eli's Rehab Report

Outpatient Outlook: 3 Keys to Troubleshooting Your Functional Limitation Reporting Woes

CMS makes ex post facto clarifications.

Functional limitation reporting is in full swing. This requirement for Medicare patients has been in effect since Jan. 1, 2013, but many rehab providers are still ironing out operational snafus.

The **Centers for Medicare & Medicaid Services** (CMS) released an MLN Matters article in late July to clarify details (http://tinyurl.com/murwq2t). We've also provided expert tips on tackling the biggest challenges you've voiced regarding functional limitation reporting.

1. Nail Down the Most Accurate Severity Level

Therapists are finding that selecting a severity level isn't that cut-and-dried.

Take note: Choosing the severity level is even more difficult when therapists use "self-report" standardized tests, says **Mary Daulong, PT, CHC, CHP,** president/CEO of **Business & Clinical Management Services** in Spring, TX.

"Many factors can skew the level of limitation with these types of tools," Daulong says, listing some examples below:

- The patient's psychological status, as it relates to his/her disability and overall health;
- The patient's perception of the limitation and what the limitation implies, as well as consequences implied by the patient's scoring; and,
- The tool itself (e.g. it may not be age, gender, or otherwise appropriate).

In the end, you must balance the science of the given facts and the art of your clinical judgment.

"While clinical judgment 'rules,' one cannot totally disregard the patient's responses even when the clinician believes that the patient's scoring was inaccurate either intentionally or unintentionally," Daulong says.

To arrive at the most accurate severity modifier, Daulong suggests the following:

- Ensure that an accurate and detailed pre-morbid functional history and current functional status is obtained during the initial evaluation;
- Carefully review co-morbidities and complexities so you can determine if these will impact the severity score;
- Study and choose standardized tests that accurately measure the functional status of your diagnostic groups. Lean more heavily on 'performance' standardized tests than 'self report' tests; and
- Develop a 'practice'-specific worksheet for the functional limitation and the severity level modifiers for easy access and reference.

2. Know How to Juggle Multiple Functional Limitations

Generally, CMS only wants you to report one functional limitation at a time.

"However, if during the entire episode of care, the patient meets the goal for a functional G code area and still requires skilled care, another G-code [area] should be reported and tracked," says **Kate Brewer, PT, MBA, GCS, RAC-CT,**

president of **Greenfield Rehabilitation Agency** in Greenfield, WI and president of **Progressive Rehab Solutions**. "[You] just should not be tracking more than one [functional limitation] at a time."

Exception: If a patient is receiving therapy from more than one discipline, the patient may have multiple functional limitations reported on the same date of service. That's because each discipline with a related POC is required to report their own G-codes.

Another unique scenario is if you're reporting evaluative procedures for multiple POCs for the same therapy discipline. You may only report on one functional limitation for the reporting episode, but functional limitation reporting is required any time you're reporting an evaluative or re-evaluative procedure on a claim.

How to proceed: Suppose a patient needs therapy following surgery for a rotator cuff repair and also for a total hip replacement. "The therapists (same discipline i.e. PT) must choose which of the two will be considered the primary limitation," Daulong says. "Let's say they choose the shoulder limitation: they would, then, most likely proceed to report the functional limitation 'Carrying, Handling and Moving Objects' with the applicable severity modifier at all required reporting periods."

"The total hip replacement condition would be reported only once as if it were a single visit episode (for reporting purposes)," Daulong explains. "They would, most likely, document and code the "Mobility: Walking & Moving Around" functional limitation's current status at the initial evaluation, the projected goal status for discharge and the discharge status (which would be the same as the current status because they are being performed on the same date)."

3. Take Unneeded Stress Out of G-Coding Details

"Therapists sometimes get befuddled by the timing of the G-codes (when to actually add them) and exactly which ones to use," notes **Meryl Freeman, MS, PT,** manager of outpatient rehab at **Rex Healthcare** in Raleigh, NC. "For example, using G-codes on the eval only, which ones to use for the 10th visit, what happens when the patient hasn't fully met their primary goal, which ones to use after the primary goal is met, etc."

"From an operational aspect, the most tedious part is to ensure that the G codes are done at the right visit and tracked appropriately so not to trigger denial for non-compliance," Brewer says.

Solution: "A good billing/documentation software program can take some of the hassle out for therapists by helping them track when these codes are due and to help show them patient progress through tracking G-codes to justify medical necessity," Brewer says. "Right now, the best thing a clinic/business can do is to track and monitor to ensure nothing is being missed."

"Our HIM department actually has some G-code edits that crop up, similar to the CCI edit process," Freeman says. "We get dinged if the therapist neglects to put the G-codes on an evaluation, for example."

Freeman's department has also tied in the G-code process to the charge entry. "Each G-code/severity modifier combo is tied into a single charge that helps with ease of entry."