Original Question:
We are a regional medical center that treats both pediatric patients and adults. We have been applying G codes (functional limitation codes) to our Medicare patients but have recently received denials from other payers due to missing "modifiers". When our denials team contact the commercial insurance, they state we are missing the severity modifiers, which sounds an awful lot like G codes. One such patient was a 9-year-old patient for an orthopedic diagnosis.

- Is anyone aware of changes with commercial insurances requiring G codes/functional limitation codes for patients, particularly in the pediatric population?
- Are you receiving any denials for your pediatric patients that appear related to functional codes?
- Are any of your therapists using G codes for pediatric patients? If so, do your therapists complete a progress note every 10 visits (as Medicare specifies) and would you be willing to share any education you may have developed related to that practice?

-ORG A

ORG B
Much of our population has Medicaid plans, but we have been required to include functional codes for pediatric patients with BCBS. I've copied our Senior SLP because I think we've been using WeeFIM scoring for such. We have not had denials from other carriers, as yet.

ORG C
As a children's hospital, we are not hearing of anything like this, at least not yet.

ORG D

To my knowledge they are only required now for Medicare, but I assume any insurance company could decide they want them added.

ORG E
We had seen a lot of denials from our Managed Medicaid partners for missing modifiers. They wanted a UB if a PTA or COTA saw the patient, and a U5 if a therapist saw them. There was some controversy that payers would pay less if an assistant provided the treatment. We have not required G-codes.

ORG F
We also see pediatric and adult patients. The information that I have from our operations manager on current insurance companies that require G codes in our area are attached.

ORG G
You are correct, the severity modifiers that your billing department is referring to are related to G-codes—this is exactly what they are looking for. We are being required to apply g-codes and modifiers to our Medicare patients, which, although few, we do see. In our practice, we see about 4500 outpatient pediatric therapy patients per month, and we have requests to apply g-codes probably less than 20 times per year. Because the volume is so low, we deal with this on a case by case basis and have chosen not to complete extensive training with our staff. When we receive a denial from the billing department, I walk the therapist through assigning the appropriate g-code and modifier and we

amend the medical record and update the billing. Most of our patients that are Medicare eligible come for an evaluation and a few follow-ups, so very few of them make it to the 10 visit mark. For this reason, the therapists have are only prompted to complete a progress note every 10 visits if it appears to be a recurring patient and we discuss this with the treating therapist individually. We do find that once the g-code is requested, our system is not set up to recognize that the same code needs to be applied to each of the next ten visits, so we often have to submit the same coding more than once. In this case, we just prompt the billing department to add the code but don't have the therapist complete any additional paperwork/testing. We have a "form email" that we use to initiate the g-code process with our therapists that I have attached, and most of the time I assist them with adding the modifier since I came here from a predominantly adult clinic and trained the staff at that facility. I would happy to speak with you in more detail if you have additional questions. Thanks!

Addition responses from ASHA Community Post by Laurie Havens, Director of Private Health Plans and Medicaid Advocacy with ASHA.

Special thank you to Terry Weigel and Laurie Havens for this additional resource

- I haven't heard of this, but quite honestly, requirements like this don't surprise me.
- In NYS, we have seen only 1 commercial insurance deny for no G codes for a patient with a Medicare replacement plan. Never have used for Pediatrics. This may be a very silly question, but could they be referring to the GN modifier showing it is a speech pathology service rendered? I know sometimes our claims say they are denied for one reason, but then digging further it's really something else entirely!
- I may have a silly question. Colorado Medicaid has chosen to use a G-code for Cognitive in place of the new 97127. This is a HCPCS code: G0515. My understanding is that this is different than the functional limitation codes reported with Medicare. I just want to confirm. Correct?
- I also wonder if the modifier they are referring to is GN - however, again, this wouldn't be a "severity modifier". I've not heard of this being used in pediatrics.

[We are utilizing the discipline modifiers – GP, GO and GN – so this is not the missing modifier.]

I did conduct additional research (searching various commercial payers, utilizing different wording, etc.) but still found very little information on G code requirements for non-Medicare payers. Below is what I did locate.

1. WEBPT had the following blog post from 2014 and identifies other payers requiring G codes. I researched the other sites they linked at the bottom of the post and didn't find any updated information similar to this (it is all outdated - 2014/2015.)
   http://www.functionallimitation.org/medicare-isnt-the-only-payer-requiring-flr/

2. I found an odd document from Anthem (it has redline edits in it, so looked like a draft instead of a final document but was accessible online). It contained this:

   In most cases, services rendered without direct (face-to-face) patient contact are considered to be an integral component of the overall medical management service and are not eligible for separate reimbursement. In addition, modifier 59 will not override the denial for the bundled services and or supplies listed below.

   These bundled services and supplies may include, but are not limited to:

   36. "Reporting only codes" including *Current Procedural Terminology* (CPT®)' Category II supplemental tracking codes for performance measurement, HCPCS" Quality Measure codes, and HCPCS" Functional Limitation codes (new)