Empire BlueCross

Modifiers GN-GO-GP Required on Therapy Claims

In 2013 The Centers for Medicare and Medicaid Services (CMS) implemented a new claims-based data collection requirement for outpatient therapy services. CMS requires reporting with 42 new non payable functional G-codes and 7 new modifiers on claims for Physical Therapy (PT), Occupational Therapy (OT) and Speech Language Pathology (SLP) services. As part of the change, CMS is again requiring the GP, GO & GN modifiers be billed for informational purposes. To align with CMS’s change, we will implement this requirement to allow for consistency in claims processing.

Providers and Practitioners Affected are hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and home health agencies (when the beneficiary is not under a home health plan of care). It also applies to the following practitioners: therapists in private practice (TPPs), physicians, and non-physician practitioner’s (NPPs).

There are two exceptions that exist when functional reporting is required on a claim for therapy services.

1. Therapy services under more than one therapy Plan of Care (POC). Claims may contain more than two non-payable functional G-codes in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.
2. One-Time Therapy Visit. When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, the clinician reports on the claim for the DOS of the visit, all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.

Each reported functional G-code must also contain the functional therapy modifier indicating the discipline of the POC – GP, GO or GN for PT, OT & SLP. Therapy claims billed without the appropriate therapy modifier (GP, GO, GN) will be denied as a billing error.


Y0071_14_21916_1_10/13/14
Empire BlueCross BlueShield

Modifiers GN-GO-GP Required on Therapy Claims

In 2013 The Centers for Medicare and Medicaid Services (CMS) implemented a new claims-based data collection requirement for outpatient therapy services. CMS requires reporting with 42 new non payable functional G-codes and 7 new modifiers on claims for Physical Therapy (PT), Occupational Therapy (OT) and Speech Language Pathology (SLP) services. As part of the change, CMS is again requiring the GP, GO & GN modifiers be billed for informational purposes. To align with CMS’s change, we will implement this requirement to allow for consistency in claims processing.

Providers and Practitioners Affected are hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), rehabilitation agencies, and home health agencies (when the beneficiary is not under a home health plan of care). It also applies to the following practitioners: therapists in private practice (TPPs), physicians, and non-physician practitioner’s (NPPs).

There are two exceptions that exist when functional reporting is required on a claim for therapy services.

1. Therapy services under more than one therapy Plan of Care (POC). Claims may contain more than two non-payable functional G-codes in cases where a beneficiary receives therapy services under multiple POCs (PT, OT, and/or SLP) from the same therapy provider.
2. One-Time Therapy Visit. When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider, the clinician reports on the claim for the DOS of the visit, all three G-codes in the appropriate code set (current status, goal status and discharge status), along with corresponding severity modifiers.

Each reported functional G-code must also contain the functional therapy modifier indicating the discipline of the POC – GP, GO or GN for PT, OT & SLP. Therapy claims billed without the appropriate therapy modifier (GP, GO, GN) will be denied as a billing error.


Y0071_14_21916_I_10/13/14

Services provided by Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc., licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.