OHSUHealthServices

Manual:	Reimbursement Policy		
Policy Title:	**Therapy Assistant Modifiers CO & CQ**		
Section:	Modifiers		
Subsection:	None		
Date of Origin:	9/8/2021	**Policy Number:**	RPM077
Last Updated:	11/29/2021	**Last Reviewed:**	11/29/2021

Reimbursement Guidelines

A. General

OHSU Health Services follows CMS policy for physical therapy assistant (PTA) or occupational therapy assistant (OTA) services. All services furnished in whole or in part by a PTA or OTA are required to be billed with modifier CQ and CO, respectively.

B. Reimbursement Adjustments

1. Effective for dates of service 1/1/2022 and following, payment for PTA/OTA services is at 85 percent of the otherwise applicable payment amount/rate for the service.

2. Additional adjustments for multiple therapy reduction rules (procedure codes with a multiple procedure indicator of "5") may also apply on the line item. (Moda [A])

C. Requirements & Guidelines for Modifiers CO & CQ

1. Concurrent Services.

   Portions of services provided by the PTA/OTA together with the physical therapist (PT) or occupational therapist (OT) are counted as services provided by the PT or OT. (CMS[1])

2. Modifier requirements apply to each unit.

   a. Modifiers CO and CQ apply at the level of each unit of each therapy service procedure code billed.

   b. For timed therapy services, if the therapy time supports multiple units of the same code, modifiers CO/CQ may be required on some units and not on others, depending upon how

much of a timed therapy service was provided by the PTA/OTA independently of the PT/OT and how much was provided either concurrently with both providers or by the PT/OT alone.

3. Services are furnished in whole or in part by a PTA or OTA when:
    a. The PTA/OTA furnishes all of the minutes of a service independent of the respective physical therapist (PT) or occupational therapist (OT).
    b. The PTA/OTA furnishes more than 10% of the minutes of a service independent of the respective physical therapist (PT) or occupational therapist (OT).

        This 10 percent standard is also known as the de minimis standard – it was finalized during CY 2020 PFS rulemaking, and its non-application to certain billing scenarios was revised in the CY 2022 final rule.
    c. Exceptions.

        Two exceptions were established with CY 2022 rulemaking for modifiers CO and CQ.

        i. When only one final 15-minute procedure code unit left to bill and the PT/OT furnishes 8 or more minutes – that final unit is billed without the CQ/CO modifier because the PT/OT provided enough minutes on their own (more than half) to report the service.

        ii. When there are two units of the same service remaining to be billed, and the PT/OT and the PTA/OTA each furnish between 9 and 14 minutes of a 15-minute timed service where the total time of therapy services furnished in combination by the PTA/OTA and PT/OT is at least 23 but no more than 28 minutes, one unit of the service is billed with the CQ/CO modifier (for the unit furnished by the PTA/OTA) and one unit is billed without it (for the unit furnished by the PT/OT).

        For more details about these exceptions and for specific billing scenario examples, see the CMS website "Billing Examples Using CQ/CO Modifiers for Services Furnished In Whole or In Part by PTAs and OTAs." (CMS[2])

4. Combine properly with therapy plan of care modifiers. (CMS[2])
    a. The CQ modifier must be reported with the GP therapy modifier.
    b. The CO modifier with the GO therapy modifier.
    c. Violations of these requirements may result in denials that require corrected claims.

5. Provider types. (CMS[2])
    b. Modifiers CO and CQ apply to:

        i. All professional providers (for which CMS payment is made under section 1848, aka PFS).

        ii. Institutional providers (for which CMS payment is made under section 1834(k) of the Social Security Act). This includes:

            1) Outpatient hospitals.

            2) Rehabilitation agencies.

3) Skilled nursing facilities.

4) Home health agencies.

5) Comprehensive outpatient rehabilitation facilities (CORFs).

c. Modifiers CO and CQ do not apply to Critical Access Hospitals (CAH).

d. If other providers believe they are not subject to the modifier CO & CQ requirements, they will need to file a written appeal and provide CMS documentation to support that CMS does not pay their provider type for outpatient therapy services under the PFS or section 1834(k) of the Act.

D. Example Scenarios

For example scenarios for use of modifiers CO & CQ, please see "Billing Examples Using CQ/CO Modifiers for Services Furnished In Whole or In Part by PTAs and OTAs." (CMS[2])

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
BBA	=	Balanced Budget Act, Bipartisan Budget Act
CAH	=	Critical Access Hospital
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CORF	=	Comprehensive Outpatient Rehabilitation Facility
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MPFS MPFSD MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")

Acronym or Abbreviation		Definition
OT	=	Occupational Therapy, Occupational Therapist
OTA	=	Occupational Therapy Assistant
PT	=	Physical Therapy, Physical Therapist
PTA	=	Physical Therapy Assistant
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill

Definition of Terms

Term	Definition
De Minimis Standard	Portions of a service furnished by the PTA/OTA independent of the physical therapist/ occupational therapist (PT/OT), as applicable, that do not exceed 10 percent of the total service are not subject to the payment reduction; while portions of a service furnished by the PTA/OTA independent of the therapist that exceed 10 percent of the total service, or unit of service, must be reported with the CQ/CO modifier, alongside of the corresponding GP/GO therapy modifier. (CMS[1])

Modifier Definitions:

Modifier	Modifier Description & Definition
GO	Services delivered under an outpatient occupational therapy plan of care
GP	Services delivered under an outpatient physical therapy plan of care
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"In the calendar year (CY) 2019 PFS final rule (83 FR 59654 through 59660), CMS created 2 new modifiers for services furnished by therapy assistants, as follows:

- CQ Modifier: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
- CO Modifier: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

CMS requires these payment modifiers to be appended on claims for therapy services, alongside the GP and GO therapy modifiers which are used to indicate the services are furnished under a physical therapy or occupational therapy plan of care, respectively." (CMS[4])

"The CQ modifier must be reported with the GP therapy modifier and the CO modifier with the GO therapy modifier. Claims with modifiers not so paired will be rejected/returned as unprocessable." (CMS[2])

"We require that claims for services furnished in whole or in part by a PTA or an OTA must include the CQ or CO modifier, respectively, when:

- the PTA/OTA furnishes all of the minutes of a service independent of the respective physical therapist (PT) or occupational therapist (OT); or
- the PTA/OTA furnishes a portion of a service (or unit of service) separately from the part that is furnished by the PT/OT, such that the minutes for that portion of a service (or unit of a service) furnished by the PTA/OTA exceed 10 percent of the total minutes for that service (or unit of a service) – except in the specific cases that are outlined below." (CMS[2])

"For those practitioners submitting professional claims who are paid under the physician fee schedule (PFS), the CQ/CO modifiers apply to services of physical and occupational therapists in private practice (PTPPs and OTPPs).

The CQ and CO modifiers must be used when applicable for all outpatient therapy services for which payment is made under section 1848 (the PFS) or section 1834(k) of the Social Security Act (the Act)." (CMS[2])

Cross References

A. "Modifier 51 - Multiple Procedure Fee Reductions." OHSU Health Services Reimbursement Policy Manual, RPM022.

References & Resources

1. CMS. "Therapy Services." Centers for Medicare and Medicaid Services (CMS). Last modified November 11, 2021. Last accessed November 29, 2021. https://www.cms.gov/Medicare/Billing/TherapyServices .

2. CMS. "Billing Examples Using CQ/CO Modifiers for Services Furnished In Whole or In Part by PTAs and OTAs." Centers for Medicare and Medicaid Services (CMS). Last modified November 11, 2021. Last accessed November 29, 2021. https://www.cms.gov/medicare/therapy-services/billing-examples-using-cqco-modifiers-services-furnished-whole-or-part-ptas-and-otas .

3. AOTA. "Occupational Therapy Assistant Modifier Required in 2020." American Occupational Therapy Association. Last accessed November 29, 2021. https://www.aota.org/Advocacy-Policy/Federal-Reg-Affairs/Coding/2020-OTA-Payment-Modifier-Requirement.aspx .

4. CMS. “Reduced Payment for Physical Therapy and Occupational Therapy Services Furnished In Whole or In Part by a Physical Therapist Assistant (PTA) or Occupational Therapy Assistant (OTA).” CMS Transmittal 11129/CR12397. November 22, 2021. Last accessed November 30, 2021. https://www.cms.gov/files/document/r11129cp.pdf .

Background Information

The Balanced Budget Act of 2018 (BBA of 2018) called for a payment adjustment when a patient is seen by a therapy assistant rather than a therapist. Section 53107 of the BBA of 2018 added a new section 1834(v) of the Social Security Act which contains the details of these rules.

Effective for claims with dates of service on and after January 1, 2020, the CQ and CO modifiers are required to be used, when applicable, for services furnished in whole or in part by a PTA or OTA on the claim line of the service, along with the respective GP or GO therapy modifier, to identify those services furnished in whole or in part by a PTA or OTA under a physical therapy or occupational therapy plan of care.

The requirement of “in whole or in part” applies when the therapy assistant has provided greater than 10% of an untimed therapeutic service code and/or a timed therapeutic service code at the 15-minute unit level. The requirement does not apply when a PT or OT therapist and a therapy assistant are working concurrently on the same patient. The PTA/OTA modifier will only apply to time where the PTA/OTA is performing the service independently.

The CQ and CO modifiers must be used when applicable for all outpatient therapy services for which payment is made under section 1848 (the PFS) or section 1834(k) of the Social Security Act (the Act). This requirement also applies to institutional claims, including: outpatient hospitals, rehabilitation agencies, skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities (CORFs). However, the CQ and CO modifier requirements do not apply to claims from critical access hospitals (CAHs) or other providers that are not paid for outpatient therapy services under the PFS or section 1834(k) of the Act.

The CQ modifier must be reported with the GP therapy modifier and the CO modifier with the GO therapy modifier. Claims submitted to CMS with modifiers not paired according to these requirements will be rejected/returned as unprocessable.

Effective for claims with dates of service on and after January 1, 2022, a 15% payment reduction will be applied to claims with modifiers CO and/or CQ. This complies with the BBA of 2018’s requirements to reduce the payment for occupational therapy and physical therapy services furnished in whole or in part

by occupational therapy assistants (OTAs) and physical therapist assistants (PTAs) to 85 percent of the usual non- therapy assistant Part B payment for the service.

Although the 15% payment reduction does not go into effect until 2022, the modifier requirement went into effect for CMS for claims for services provided on or after January 1, 2020.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document OHSU Health Services' payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. OHSU Health Services Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the OHSU Health Services Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and OHSU Health Services Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; OHSU Health Services strives to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****