

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4440	Date: November 1, 2019
	Change Request 11362

Transmittal 4346, dated August 1, 2019, is being rescinded and replaced by Transmittal 4440, dated, November 1, 2019 to update the background and policy sections, and add a business requirement (11362.5) clarifying payment instructions for PT and OT services. In addition, this correction also adds a new attachment (A). All other information remains the same.

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 7, 2019. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: New Modifiers to Identify Occupational Therapy (OT) and Physical Therapy (PT) Services Provided by a Therapy Assistant

I. SUMMARY OF CHANGES: The purpose of this Change Request is to implement the Bipartisan Budget Act of 2018 (BBA of 2018), section 53107 which requires reporting of new modifiers to identify therapy assistant services.

EFFECTIVE DATE: January 1, 2020

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 6, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/20.1-Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

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SUBJECT: New Modifiers to Identify Occupational Therapy (OT) and Physical Therapy (PT) Services Provided by a Therapy Assistant

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I. GENERAL INFORMATION

A. Background: The BBA of 2018 P. L. 115-123, section 53107 amended the Social Security Act (the Act) to add section 1834(v) that addresses a reduced payment for outpatient PT and OT services furnished in whole or in part by a therapy assistant, effective for claims with dates of service on and after January 1, 2022. Section 53107 of the BBA of 2018 (through section 1834(v) of the Act and hereafter referenced as section 53107), mandates the use of a new modifier to identify the PT and OT services provided in whole or in part by a therapy assistant and established the following timeline that requires the new therapy modifier:

- Be created by January 1, 2019
- Be on claims for dates of service on and after January 1, 2020
- Be tied to reduced payment rates at 85 percent of the physician fee schedule (PFS) amount effective in calendar year (CY) 2022.

Section 53107 also requires that these steps be achieved through rulemaking.

Since a beneficiary's incurred expenses for PT and OT services are tracked and accrued to different KX modifier and medical review threshold amounts (established via section 50202 of the BBA of 2018), CMS established two modifiers, CQ and CO, for services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs), respectively, through CY 2019 PFS rulemaking. The modifiers are defined 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

In the CY 2019 PFS final rule and in CY 2020 PFS rulemaking, CMS clarified that the CQ and CO modifiers are required to be used, when applicable, for services furnished in whole or in part by PTAs and OTAs on and after January 1, 2020, on the claim line of the service alongside the respective GP or GO therapy modifier, to identify those PTA and OTA services furnished under a PT or OT plan of care.

In CY 2020 PFS rulemaking, CMS established regulations to require that applicable claims for outpatient PT and OT services and claims for PT and OT services in comprehensive outpatient rehabilitation facilities (CORFs) furnished in whole or in part by PTAs and OTAs contain the prescribed modifier – the regulations are at §§ 410.60(d) and 410.59(d) and §410.105(d), respectively.

The percent payment reduction required per section 53107 of the BBA of 2018 is applicable only when payment for PT and OT services is made directly under the PFS (per section 1848 of the Act) or when payment is made based on the PFS (as specified in section 1834(k) of the Act). CMS clarified the suppliers and providers to which the CQ and CO modifiers apply through CY 2020 rulemaking.

For those practitioners submitting professional claims who are paid under the PFS, CMS explained that the CQ/CO modifiers apply only to services of physical and occupational therapists in private practice; and not to the therapy services furnished by or incident to the services of physicians or nonphysician practitioners (NPPs) – including nurse practitioners, physician assistants, and clinical nurse specialists – because PTAs and OTAs do not meet the qualifications and standards of physical or occupational therapists, as required by §§ 410.60 and 410.59, respectively.

For providers submitting institutional claims and paid at PFS rates for their outpatient PT and OT services, the CQ and CO modifiers apply to the following providers: outpatient hospitals, rehabilitation agencies, skilled nursing facilities, home health agencies and CORFs. However, the CQ and CO modifiers are not applicable to claims from critical access hospitals because they are paid on a reasonable cost basis (per section 1834(g)) of the Act), or from other providers for which payment for OT services is not made under section 1834(k) of the Act based on the PFS rates.

Among the policies finalized in CY 2020 PFS rulemaking is a policy that permits, for billing purposes, a PT or OT service when defined in 15-minute increments, for the same patient on the same date of service, to appear on two different claim lines – one with the CQ or CO modifier, and one without. A table is provided to illustrate processable claims using units of the same service defined in 15-minute increments – such PT and OT services are not considered duplicates (see Attachment A).

B. Policy: This notification implements the following payment policies related to the use of CQ and CO modifier on applicable claims for PT and OT services when those services are furnished in whole or in part by PTAs and OTAs: The CQ modifier is paired to the GP therapy modifier and the CO modifier is paired with the GO therapy modifier, and claims not so paired are rejected/returned as unprocessable. It also adds policy to instruct contractors not to consider physical therapy (identified by modifier GP) or occupational therapy (identified by modifier GO) services billed on the same day, to the same patient to be duplicates of the same service when one claim line is submitted with modifier CQ or CO and another is not.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility							
		A/B MAC			D M E	Shared- System Maintainers			Other
		A	B	H H H		F I S S	M C S	V M S	
11362.1	The contractors shall accept the new modifiers CQ and CO in their systems.		X	X		X			

Number	Requirement	Responsibility									
		A/B MAC		H H H	D M E M A C	Shared- System Maintainers				Other	
		A	B			F I S S	M C S	V M S	C W F		
	These modifiers were established in the CY 2019 PFS final rule (83 FR 59657 through 59660).										
11362.2	The contractor shall reject/return as unprocessable claims reporting modifier CQ on detail lines that do not also contain modifier GP. Note, this applies on types of bill 12X, 13X, 22X, 23X, 34X, 74X, and 75X for claims processed by FISS.	X	X	X			X	X			
11362.3	The contractor shall reject/return as unprocessable claims reporting modifier CO on detail lines that do not also contain modifier GO. Note, this applies on types of bill 12X, 13X, 22X, 23X, 34X, 74X, and 75X for claims processed by FISS.	X	X	X			X	X			
11362.4	The contractor shall reject incoming (Part B) claims with the following messages: CARC 16 - Claim/service lacks information or has submission/billing error(s).Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC N822- Missing HCPCS modifier(s) Group Code: CO- Contractual Obligation		X								
11362.5	The contractors shall modify their logic to allow payment for PT and OT services billed on the same day for the same patient, when one line is billed with the respective CQ or CO modifier and another line is not.		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E D I	C M E D I
		A	B	H H H		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Carla Douglas, 410-786-4799 or carla.douglas@cms.hhs.gov , Wilfried Gehne, 410-786-6148 or wilfried.gehne@cms.hhs.gov , Pamela West, 410-786-2302 or pamela.west@cms.hhs.gov , Brian Reitz, 410-786-5001 or brian.reitz@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Medicare Claims Processing Manual

Chapter 5 – Part B Outpatient Rehabilitation and CORF/OPT Services

20.1 – Discipline Specific Outpatient Rehabilitation Modifiers- All Claims

(Rev. 4440, Issued: 11-01-19 Effective: 01-01-20, Implementation: 01-06-20)

Modifiers are used to identify therapy services whether or not financial limitations are in effect. When limitations are in effect, the CWF tracks the financial limitation based on the presence of therapy modifiers. Providers/suppliers must continue to report one of these modifiers for any therapy code on the list of applicable therapy codes except as noted in §20 of this chapter. Consult §20 for the list of codes to which modifiers must be applied. These modifiers do not allow a provider to deliver services that they are not qualified and recognized by Medicare to perform.

The claim must include one of the following modifiers to distinguish the discipline of the plan of care under which the service is delivered:

- GN Services delivered under an outpatient speech-language pathology plan of care;
- GO Services delivered under an outpatient occupational therapy plan of care; or,
- GP Services delivered under an outpatient physical therapy plan of care.

This is applicable to all claims from physicians, nonphysician practitioners (NPPs), PTPPs, OTPPs, SLPPs, CORFs, OPTs, hospitals, SNFs, and any others billing for physical therapy, speech-language pathology or occupational therapy services as noted on the applicable code list in §20 of this chapter.

Modifiers GN, GO, and GP refer only to services provided under plans of care for physical therapy, occupational therapy and speech-language pathology services. They should never be used with codes that are not on the list of applicable therapy services. For example, respiratory therapy services, or nutrition therapy services shall not be represented by therapy codes which require GN, GO, and GP modifiers.

Contractors edit institutional claims to ensure the following:

- that a GN, GO or GP modifier is present for all lines reporting revenue codes 042X, 043X, or 044X.
- that no more than one GN, GO or GP modifier is reported on the same service line.
- that revenue codes and modifiers are reported only in the following combinations:
 - Revenue code 42x (physical therapy) lines may only contain modifier GP
 - Revenue code 43x (occupational therapy) lines may only contain modifier GO
 - Revenue code 44x (speech-language pathology) lines may only contain modifier GN.
- that discipline-specific evaluation and re-evaluation HCPCS codes are always reported with the modifier for the associated discipline (e.g. modifier GP with a HCPCS code for a physical therapy evaluation).

Contractors return to the provider institutional claims that do not meet one or more of these conditions.

CMS has established two modifiers, CQ and CO, for services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs). The modifiers are defined 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*

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 PTAs and OTAs on the claim line of the service alongside the respective GP or GO therapy modifier, to identify those PTA and OTA services furnished under a PT or OT plan of care.

For those practitioners submitting professional claims who are paid under the PFS, the CQ/CO modifiers apply only to services of physical and occupational therapists in private practice (PTPPs and OTPPs); and not to the therapy services furnished by or incident to the services of physicians or nonphysician practitioners (NPPs) – including nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists (CNSs) – because PTAs and OTAs do not meet the qualifications and standards of physical or occupational therapists, as required by §§ 410.60 and 410.59, respectively.

For providers submitting institutional claims and paid at PFS rates for their outpatient PT and OT services, the CQ and CO modifiers apply to the following providers: outpatient hospitals, rehabilitation agencies, skilled nursing facilities, home health agencies and CORFs. However, the CQ and CO modifiers are not applicable to claims from critical access hospitals because they are paid on a reasonable cost basis, or from other providers for which payment for OT services is not made under the PFS rates. The CQ modifier must be paired to the GP therapy modifier and the CO modifier with the GO therapy modifier. Claims not so paired will be rejected/returned as unprocessable.

Attachment A:

The below table illustrates acceptable use of CQ and CO modifier on claims for PT and OT services as noted in the Background Section of this CR – such PT and OT services shall not be considered duplicates by the contractors.

Code	Therapy Modifier	Service Unit	Assistant Modifier
97110	GP	1	
97110	GP	1	CQ
97535	GP	1	
97535	GP	2	CQ
97530	GO	2	
97530	GO	1	CO