CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11129	**Date: November 22, 2021**
	Change Request 12397

Transmittal 10934, dated August 13, 2021, is being rescinded and replaced by Transmittal 11129, dated, November 22, 2021 to update the background/policy section. Also, this Transmittal is no longer sensitive and may now be posted to the internet. All other information remains the same.

SUBJECT: 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)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to fully implement Section 53107 of the Bipartisan Budget Act of 2018 that requires CMS to make a reduced payment at 85 percent of the otherwise applicable payment amount based on the physician fee schedule (PFS) for physical therapy and occupational therapy services when they are furnished in whole or in part by a PTA or OTA for dates of service on and after January 1, 2022 when claims contain either the CQ or CO modifier.

EFFECTIVE DATE: January 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2022

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

Pub. 100-04	Transmittal: 11129	Date: November 22, 2021	Change Request: 12397

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I. GENERAL INFORMATION

A. Background: Section 53107 of the Bipartisan Budget Act (BBA of 2018) added a new section 1834(v) of the Social Security Act (the Act) which requires CMS, through the use of new modifiers, to make a reduced payment for occupational therapy and physical therapy services furnished in whole or in part by physical therapist assistants (PTAs) or occupational therapy assistants (OTAs) at 85 percent of the otherwise applicable Part B payment for dates of service on and after January 1, 2022. Section 1834(v)(2) of the Act requires that: (a) by January 1, 2019, CMS must establish a modifier to indicate that a therapy service was furnished in whole or in part by an OTA or PTA; and, (b) beginning January 1, 2020, each claim for an outpatient therapy service furnished in whole or in part by an OTA or PTA must include the modifier. Section 1834(v)(3) requires CMS to implement these amendments through notice and comment rulemaking.

The reduced PFS payment applies to physical therapists (PTs) in private practice (PTPPs) and occupational therapists (OTs) in private practice (OTPPs) and institutional therapy providers, including comprehensive outpatient rehabilitation facilities, with the exception of critical access hospitals (CAHs) and other providers that are not paid at or under the PFS rates.

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. We finalized a *de minimis* standard under which a service is considered to be furnished in whole or in part by a PTA or OTA when more than 10 percent of a service – whether timed or untimed ─ is furnished by the PTA or OTA.

In the CY 2020 final rule (84 FR 62702 through 62708), CMS finalized a *de minimis* policy that requires the CQ/CO modifier to be on claims when the PTA/OTA provided (a) more than 10 percent of an untimed service or (b) more than 10 percent of a 15-minute timed unit of service. The CQ/CO modifiers were required on claims for dates of service on and after January 1, 2020. Through CY 2022 rulemaking, CMS finalized a *de minimis* policy that requires the CQ/CO modifier to be on claims when the PTA/OTA provides more than 10 percent of a unit of service for other time intervals than the 15-minute one; this

includes the 20-minute time increment of the codes for remote therapeutic monitoring services.

During rulemaking for CY 2022, in response to concerns raised by stakeholders and to promote appropriate care, CMS finalized a policy for which the *de minimis* standard is not applicable. Specifically, we finalized rules for applying the CQ/CO modifiers by introducing the midpoint rule, also known as the "8-minute rule," in which the PT/OT provides at least 8 minutes (more than half, or 7.5 minutes, of the 15-minute unit) to bill the final unit of a multi-unit scenario on their own without the PTA/OTA minutes. In these cases, that final unit of service provided by the PT/OT is billed without the CQ/CO modifier.

In addition to the billing scenarios in which one final unit remains to be billed, CMS defined cases in which there are "two remaining units" left to bill in which one 15-minute unit is billed with the CQ/CO modifier and the other 15-minute unit is billed without it. These cases include scenarios in which the PT/OT and the PTA/OTA each furnish between 9 and 14 minutes of a 15-minute timed service when 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, and there are two remaining units left to be billed.

CMS finalized the following policies where the CQ/CO modifiers do apply:

- Services wholly furnished by PTAs and OTAs.
- In cases where one final 15-minute unit (of a multi-unit scenario) remains to be billed, the *de minimis* standard is applied to:
    - Services where the PTA/OTA furnishes 8 or more minutes of a 15-minute unit of service and the PT/OT furnishes less than 8 minutes – bill with the CQ/CO modifier as the *de minimis* standard is exceeded.
    - Services where both the PTA/OTA and the PT/OT each provide less than 8 minutes of a service – bill with the CQ/CO modifier if the minutes furnished by the PTA/OTA exceed the *de minimis* standard.

The below policies were finalized where the CQ/CO modifiers do not apply:

- When services are wholly furnished by PTs and OTs.
- When a PTA/OTA and a PT/OT furnish care to a patient at the same time where the patient requires both professionals – these scenarios reflect cases in which the assistant is helping the therapist to provide a highly skilled procedure or one in which both professionals are needed for safety reasons.
- To outpatient physical and occupational therapy services that are furnished by, or incident to, the services of physicians or certain nonphysician practitioners (NPPs). This is because therapy regulations require that the individual who performs the therapy service incident to the service of a physician or NPP must meet the qualifications and standards for a therapist (other than state licensure).
- In cases where there is one final 15-minute unit left to bill on a treatment day, the "8-minute rule" rule is applied when the PT/OT furnishes 8 or more minutes (the Medicare billing requirement for that final 15-minute service unit) – 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. Any minutes provided by the PTA/OTA are immaterial for purposes of billing.

In cases where there are two remaining units left to be billed, and the PT/OT and the PTA/OTA each furnish between 9 and 14 minutes of a 15-minute timed service when 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).

Instructions for applying the CQ and CO modifiers for services furnished in whole or in part by PTAs and OTAs and other applicable rules for services involving therapy assistants will be posted on the Therapy

Services CMS website after the CY 2022 PFS final rule is issued along with billing scenario examples at: https://www.cms.gov/Medicare/Billing/TherapyServices.

B. Policy: This notification implements the reduced payment of 85 percent of the otherwise applicable payment amount based on the PFS when a claim for a physical or occupational therapy service is billed with a CQ or CO modifier to indicate that the service was provided in whole or in part by a PTA/OTA. The reduced rate applies for dates of service on and after January 1, 2022. This policy applies to professional claims from PTPPs and OTPPs; and, applies to claims from physician or NPP groups when the PTPP or OTPP has reassigned their billing rights to the group and their National Provider Identifier (NPI) appears as the rendering provider. This policy also applies to institutional claims to the following bill types: 12X, 13X, 22X, 23X, 34X, 74X, and 75X.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12397.1	Contractors shall pay the reduced amount (85%) for physical therapy (PT) and occupational therapy (OT) services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) when the CQ or CO modifier, respectively, is included on claims from therapists in private practice or therapy providers, for dates of service on and after January 1, 2022. The reduced payment is triggered by the presence of the CQ or CO modifier and is taken from the paid amount, i.e., the actual amount paid not the MPFS allowed amount.					X	X			
12397.2	Contractors shall apply the 85% last, taken before sequestration. **Intended methodology example -**PTA/OTA Adjustment applied to provider paid amount Billed amount $120 Allowed amount $100					X	X			

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	Coinsurance - $20 $80 15% PT/OT reduction - $12 $68 2% sequestration red - $1.36 Total Medicare pmt. $66.64									
12397.3	Contractors shall create a new field at the line level to carry the reduction amount for the PTA/OTA services when modifiers CO or CQ are present. The reduction amount will be sent to the Common Working File (CWF), Integrated Data Repository, and Provider and Statistical Reimbursement System. CWF shall create a line level field to house the new 15% reduction for therapy. Required field size: 15% Reduction for Therapy-PIC 9(08)V99(02) $$$$$$$$cc This will require updates to add new field only to copybook for HUOP. Impacted institutional type of bills: 12x, 13x, 22x, 23x, 34x, 74x, and 75x.					X			X	
12397.3.1	Contractors shall ensure that the new field is passed to the downstream systems.						X		X	FPS, NCH
12397.3.2	Contractors shall make any necessary updates that are needed to the HIMR Screen for CLMH to add the new field for the 15% reduction amount for therapy to OUTH/HHAH.						X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12397.3.2.1	Contractor shall update the MCS Desktop Tool (MCSDT) application based on the revised OUTH HIMR Screens.						X			
12397.4	For claims subject to the PTA/OTA adjustment, contractors shall include on the CWF claim transmission record (HUBC) the adjustment amount attributable to each line in the "Other Amounts Applied" field, using a new Other Amount Indicator of 'B1'						X			
12397.4.1	Contractors shall accept the new Other Amount Indicator 'B1' for 15% reduction for Therapy at the detail line.								X	NCH
12397.4.2	Contractors shall modify edits that affect the new Other Amount Indicator.								X	NCH
12397.5	Contractors shall make the necessary system/table updates to use the following message to specify why payment was reduced: Claim Adjustment Reason Code (CARC) 45 - Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Remittance Advice Remark Code (RARC) N851 - Payment reduced because services were furnished by a therapy assistant. Group Code – CO (Contractual Obligation)		X	X		X				
12397.6	Contractors shall note that the beneficiary is not liable for the CQ and CO modifier payment reduction amount (i.e., the	X	X	X		X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	provider cannot bill the beneficiary for the 15% reduction amount).									
12397.7	Contractors shall be in compliance with the instructions found in the CMS Internet Only Manual Publication 100-04, Chapter 5, Section 20.1.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12397.8	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X	X		

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): Brian Reitz, 410-786-5001 or brian.reitz@cms.hhs.gov , Pamela West, 410-786-2302 or pamela.west@cms.hhs.gov , Carla Douglas, 410-786-4799 or carla.douglas@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: 0

Medicare Claims Processing Manual
Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

Table of Contents
(Rev. 11129; Issued: 11-22-21)

20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims

(Rev. 11129, Issued: 11-22-21, Effective: 01-01-22, Implementation: 01-03-22)

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. *However, the CQ and CO modifiers do apply to claims from physician or NPP groups when a PTPP or OTPP has reassigned their benefits to the group and their NPI appears as the rendering provider of the therapy service(s) on the claim.*

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 *PT and* 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.

For dates of service, on and after January 1, 2022, claims billed with a CQ or CO modifier to indicate the services were furnished in whole or in part by a PTA or OTA are paid at an amount equal to 85 percent of the otherwise applicable Part B payment that's based on the MPFS. The 15 percent reduction is taken last, e.g., after the MPPR (and other reductions where applicable) and right before sequestration. This reduction is taken from the paid amount, i.e., the actual amount paid not the MPFS allowed amount.

Regulations for the payment of therapy claims and the policy for assigning the therapy assistant modifiers (CO and CQ) for services provided in whole or in part by OTAs and PTAs are found at §§ 410.59(a)(4) and 410.60(a)(4) for outpatient occupational and physical therapy services, respectively and at § 410.105(d) for CORF OT and PT services.