mln MATTERS®
KNOWLEDGE • RESOURCES • TRAINING

Reduced Payment for Physical Therapy and Occupational Therapy Services Furnished in Whole or In Part by a Physical Therapist Assistant or an Occupational Therapy Assistant

MLN Matters Number: MM12397 | Related Change Request (CR) Number: 12397
Related CR Release Date: November 22, 2021 | Effective Date: January 1, 2022
Related CR Transmittal Number: R11129CP | Implementation Date: January 3, 2022

Provider Types Affected

This MLN Matters Article is for physical and occupational therapists and therapy providers billing Medicare administrative Contractors (MACs) for services of physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) provided to Medicare patients.

Provider Action Needed

In this Article, you'll learn about:

- Changes in payments due to Section 53107 of the Bipartisan Budget Act of 2018 (BBA of 2018)
- A payment reduction for services provided by PTAs and OTAs
- Modifiers CQ and CO needed on claims for PTA and OTA services

Make sure your billing staff knows of these updates.

Background

Section 53107 of the BBA of 2018 added section 1834(v) to the Social Security Act that requires CMS, through the use of new modifiers, to reduce the payment for physical and occupational therapy services provided in whole or in part by PTAs or OTAs. We'll make the reduced payment at 85% of the otherwise applicable Part B payment amount. This reduced payment applies to dates of service on and after January 1, 2022.

The reduced PFS payment affects physical therapists (PTs) in private practice (PTPPs) and occupational therapists (OTs) in private practice (OTPPs), including PTPPs and OTPPs who have reassigned their benefits to physician groups or to groups of certain nonphysician practitioners (NPPs), including physician assistants, nurse practitioners and clinical nurse specialists when the PTPP/OTPP National Provider Identifier (NPI) appears as the rendering provider on the claim.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

The reduced PFS payment for PTA/OTA services also applies to institutional therapy providers, including comprehensive outpatient rehabilitation facilities, with the exception of critical access hospitals and other providers that aren't paid using Medicare Physician Fee Schedule (MPFS). This payment policy is applicable to the following bill types: 12X, 13X, 22X, 23X, 34X, 74X, and 75X.

In the CY 2019 final rule (83 FR 59654 through 59660), we created 2 new modifiers for the services that PTAs/OTAs provide. We have required the CQ/CO modifiers on claims, alongside the GP/GO therapy modifiers ─ which are used to indicate the services are furnished under a physical therapy or occupational therapy plan of care, respectively ─ from PTPPs, OTPPs, and therapy providers for services furnished in whole or in part by PTAs/OTAs for dates of service on or after January 1, 2020. They are:

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

In that CY 2019 PFS final rule, we also 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), we finalized applications of the *de minimis* standard that requires the CQ/CO modifier to be on claims when the PTA/OTA, independent of the PT/OT, provides:

- More than 10% of an untimed service or
- More than 10% of a 15-minute timed unit of service

We required the CQ/CO modifiers beginning with claims for dates of service on and after January 1, 2020.

In the CY 2022 final rule (86 FR 65169 through 65177), we finalized a *de minimis* policy that requires the CQ/CO modifier to be on claims when the PTA/OTA provides more than 10% of a unit of service for other time intervals than the 15-minute one. This includes the 20-minute time increment of the new codes for remote therapeutic monitoring (RTM) services.

Also, during PFS rulemaking for CY 2022, in response to concerns raised by stakeholders and to promote appropriate care, we 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). In these cases, the PT/OT bills the final unit of a multi-unit scenario without the CQ/CO modifier.

We also defined a limited number of cases in which there are 2 units left to bill in which you bill one 15-minute unit with the CQ/CO modifier and the other 15-minute unit without it. These cases include scenarios in which the PT/OT and the PTA/OTA each provide between 9 and 14 minutes of a 15-minute timed service when the total time of therapy services provided in combination by the PT/OT and PTA/OTA is at least 23 minutes, but no more than 28 minutes.

We also finalized the following policies, where the CQ/CO modifiers do apply:

- Services wholly provided 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 provides 8 or more minutes of a 15-minute unit of service and the PT/OT provides 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 provided by the PTA/OTA exceed the *de minimis* standard.

We finalized the below policies where the CQ/CO modifiers don't apply:

- When PTs and OTs wholly provide the services.
- When a PT/OT and a PTA/OTA provide care to a patient at the same time the patient requires both providers – these scenarios show cases in which the assistant is helping the therapist to provide a highly skilled procedure or one in which both providers are needed for safety reasons.
- When outpatient physical and occupational therapy services are provided by, or incident to, the services of physicians or certain nonphysician practitioners (NPPs). This is because therapy regulations require that the individual who does 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 1 final 15-minute unit left to bill on a treatment day, the "8-minute rule" rule is applied when the PT/OT provides 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 2 units left to be billed, and the PT/OT and the PTA/OTA each provide between 9 and 14 minutes of a 15-minute timed service when the total time of therapy services provided by the PT/OT and PTA/OTA is at least 23 minutes, but no more than, 28 minutes:

- Bill 1 unit without the CQ/CO modifier (for the unit the PT/OT provides), and
- Bill 1 unit of the service with the CQ/CO modifier (for the unit provided by the PTA/OTA)

Instructions for applying the CQ and CO modifiers for services provided in whole or in part by PTAs and OTAs and other applicable rules for services involving therapy assistants are posted on the Therapy Services CMS website along with billing scenario examples.

More Information

We issued CR 12397 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
November 30, 2021	Initial article released.