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# PTA/OTA Modifiers

The CY 2020 Medicare Physician Fee Schedule Proposed Rule released on Monday, July 29, 2019, offers further clarification and instruction about the new therapy assistant modifiers to be implemented January 1, 2020. The comment period for this rule closes September 27, 2019.

The Bipartisan Budget Act (BBA) of 2018 directed the Secretary of Health and Human Services (HHS) to create modifiers indicating services that were provided by a physical therapist assistant (PTA) or an occupational therapy assistant (OTA), and mandated that services provided "in whole or in part" by an assistant will be reimbursed at 85% of the Fee Schedule rate beginning in 2022.

To comply with the BBA, CMS established two new modifiers to identify services provided by a PTA or OTA in the 2019 Medicare Physician Fee schedule final rule. These modifiers will be required on claims beginning January 1, 2020.

- **CQ: services provided in whole or in part by a PTA**
- **CO: services provided in whole or in part by an OTA**

The CQ and CO modifiers are described as "payment modifiers" and are to be applied "alongside" the GP and GO modifiers indicating services provided as part of a physical or occupational therapy plan of care (e.g., 97110GPCQ; 97535GOCO).

CMS also finalized a *de minimis* standard for defining services provided "in whole or in part" by an assistant (meaning a minimal standard or the minimum amount of service that constitutes "in part") in last year's final rule. Under this standard, a service is considered furnished in whole or in part by a PTA/OTA when more than 10% of the service is furnished by the assistant.

In the CY 2020 proposed rule, **CMS defines "service" to mean a specific procedure code** (CPT or HCPCS code) used to describe and bill for a PT or OT service (e.g., 97110, 97535, G0283, 97166). To apply the de minimis standard under which a service (or procedure) is considered to be furnished in whole or in part by the PTA or OTA and, therefore, would require the addition of the CQ/CO modifier, **CMS proposes to make the 10% calculation based on the respective "therapeutic minutes" of time spent by the therapist and the PTA/OTA, rounded to the nearest whole minute.** Time spent on "administrative" or "non-therapeutic" tasks (i.e., non-skilled services) is not considered in this calculation as it is not billable, skilled time.

**CMS offers 2 ways to compute this**:

1. Divide PTA/OTA minutes by the total minutes for the service, where total minutes are defined as:
    - The therapist's total time when the PTA/OTA minutes are furnished concurrently with the therapist, or
    - The sum of the PTA/OTA and therapist minutes when the assistant's services are furnished separately from the therapist.

Then multiply this number by 100 to calculate the percentage of the service that involves the PTA/OTA.

2. Divide the total time (total minutes) for the service as described in method #1 by 10 to identify the 10% de minimis standard, and then add one minute to identify the number of minutes of service by the PTA/OTA that would be needed to exceed the 10% standard. (CMS calls this the "simple method" as outlined in the following table.)

**TABLE 19: Simple Method for Determining when CQ/CO Modifiers Apply**

| METHOD TWO: Simple Method to apply 10% de minimis standard | | | |
|---|---|---|---|
| Total Time* examples using typical Service Total Times | Determine 10% standard by dividing service Total Time by 10 | Round 10% standard to next whole integer | PTA/OTA minutes needed to exceed – Apply CQ/CO |
| 10 | 1.0 | 1.0 | 2.0 |
| 15 | 1.5 | 2.0 | 3.0 |
| 20 | 2.0 | 2.0 | 3.0 |
| 30 | 3.0 | 3.0 | 4.0 |
| 45 | 4.5 | 5.0 | 6.0 |
| 60 | 6.0 | 6.0 | 7.0 |
| 75 | 7.5 | 8.0 | 9.0 |

*Total Time equals total therapy minutes plus any PTA/OTA independent minutes: Concurrent minutes: When PTA/OTA's minutes are furnished concurrently with the therapist, total time equals the total minutes of the therapist's service. Separate minutes: When the PTA/OTA's minutes are furnished separately from the minutes furnished by the therapist, total time equals the sum of the minutes of the service furnished by the PT/OT plus the minutes of the service furnished separately by the PTA/OTA.

CMS provides several examples and clinical scenarios to demonstrate application of the de minimis standard using both timed and untimed codes in the proposed rule.

Evaluations and re-evaluations (CPT codes 97161 – 97168). Eval/re-eval codes are untimed and therefore, only one unit can be billed on the claim regardless of time spent. As discussed in the CY 2019 Final Rule, PTAs and OTAs are not recognized to furnish evaluative or assessment services, but "to the extent that they furnish a portion of an evaluation or re-evaluation (such as completing clinical labor tasks for each code) that exceeds the 10 percent de minimis standard, the appropriate therapy assistant modifier (CQ or CO) must be used on the claim."

- "For example, when a PTA/OTA assists the PT/OT concurrently for a 5-minute portion of the 30 minutes that a PT or OT spend furnishing an evaluation…the respective CQ or CO modifier is applied to the service because the 5 minutes surpasses the 10 percent de minimis standard."
- "If the PTA/OTA separately furnishes a portion of the service that takes 5 minutes (for example, performing clinical labor tasks such as obtaining vital signs, providing self-assessment tool to the patient and verifying its completion), and then the PT/OT separately (without the PTA/OTA) furnishes a 30 minute face-to-face evaluative

procedure – bringing the total time of the service to 35 minutes…the CQ or CO modifier would be applied to the service." (10% of 35 minutes is 3.5 minutes, rounded to 4 minutes – and the assistant provided more than 4 minutes)

Group Therapy (CPT 97150). Like evaluative services, group is an untimed code and cannot be billed in multiple units on the claim. For group, the CQ/CO modifier would apply when the PTA/OTA wholly furnishes the service without the therapist and when the total minutes of the service furnished by the PTA/OTA (whether concurrently with or separately from the therapist) exceed 10% of the total time.

Supervised Modalities (CPT 97010-97028; HCPCS codes G0283, G0281, G0329). The CQ or CO modifiers would be applied to the supervised modality service when the PTA/OTA fully furnishes all of the minutes of the service or when the minutes provided by the assistant exceeds 10% of the total minutes of the service. For example, the CQ/CO modifiers would be applied if:

- The PTA/OTA concurrently furnishes 2 minutes of a total 8-minute paraffin bath (CPT 97018) treatment by the therapist, because 2 minutes is more than 10% of 8 minutes (i.e., 0.8 minutes or 1 minute after rounding).
- The PTA/OTA furnishes 3 minutes of the service separately from the therapist who furnishes 5 minutes, for a total of 8 minutes (because 3 minutes exceeds 10% of the 8-minute treatment).

Services defined by 15-minute increments/units (e.g., CPT 97110-97542, 97750-97755, 97760-97763). CMS states that based on CPT instructions for these codes as described in the American Medical Association (AMA) CPT manual, the therapist (or supervised therapy assistant, as appropriate) is required to furnish the service directly in a one-on-one encounter with the patient – meaning they are treating only one patient during that time. In this proposed rule, CMS refers to language in the Medicare Claims Processing Manual, Chapter 5, §20.2 describing the "8-minute rule" for appropriate billing of timed codes and then gives examples of applying the de minimis standard to timed codes as outlined below:

- *Scenario One: One service, described by a single timed HCPCS codes, is furnished in a treatment day.*
    1) The PT/OT and PTA/OTA each separately furnish minutes of the same therapeutic exercise service (CPT 97110) in different time frames: The PT/OT furnishes 7 minutes, and the PTA/OTA furnishes 7 minutes, for a total of 14 minutes. One unit of 97110 is reported on the claim with the CQ/CO modifier to indicate the service provided by the assistant exceeded the 10% standard.
    2) The PT/OT and PTA/OTA each separately furnish minutes of 97110 in different time frames: The PT/OT furnishes 20 minutes, and the PTA/OTA furnishes 25 minutes, for a total of 45 minutes. All 3 units of 97110 would be billed with the

   CQ/CO modifier because the 25 minutes furnished by the PTA/OTA exceeds the 10% standard.
3) The PTA/OTA works concurrently (i.e., along with or at the same time as) with the PT/OT to furnish neuromuscular reeducation (CPT 97112) for a 30-minute session. In this example, both units of 97112 would be billed with the CQ/CO modifier.

- *Scenario Two: Services represented by different timed HCPCS codes are furnished in a treatment day.* CMS states providers should follow current policy as outlined in the Medicare Claims Processing Manual to identify the correct codes to bill and the units to bill for the service(s) provided for the most time. CMS proposes that when the PT/OT and the PTA/OTA each independently furnish a service defined by a *different* procedure code for the same number of minutes, for example 10 minutes each for a total of 20 minutes qualifying for only 1 unit to be billed, the code for the service furnished by the PT/OT is selected to break the tie. That is, one unit of that service would be billed without the CQ/CO modifier. CMS then goes on to give additional examples of modifier application when timed codes are rendered:
  1) When only 1 unit of service can be billed (i.e., treatment time equals 8-22 minutes)
     - The PT/OT independently furnishes 15 minutes of manual therapy (CPT 97140), and the PTA/OTA independently furnishes 7 minutes of 97110, for a total of 22 minutes. One unit of 97140 should be billed without the assistant modifier.
     - The PT/OT independently furnishes 7 minutes of 97140, and the PTA/OTA independently furnishes 15 minutes of 97110, again for a total of 22 minutes. In this case, one unit of 97110 should be billed with the CQ/CO modifier.
     - If the PT/OT and the PTA/OTA each independently furnish an equal number of minutes of 97140 and 97110, respectively, and the total minutes qualify for only billing one unit of service, bill the code furnished by the PT/OT without the modifier (the tie breaker that was previously described).
  2) When two or more units can be billed (i.e., treatment time equals 23 or more minutes), follow current CMS instructions for billing procedure codes for each timed code
- The PT/OT furnishes 20 minutes of 97112 and the PTA/OTA furnishes 8 minutes of 97110 for a total of 28 minutes. One unit of 97112 should be billed without the modifier, and one unit of 97110 should be billed with the CQ/CO modifier.
- The PT/OT furnishes 32 minutes of 97112; the PT/OT and the PTA/OTA each separately furnish 12 and 14 minutes, respectively, of 97110 for a total of 26 minutes; and the PTA/OTA independently furnishes 12 minutes of self-care (CPT 97535), for a total

treatment time of 70 minutes allowing 5 units to be billed. Two units of 97112 should be billed without the modifier, two units of 97110 should be billed with the CQ/CO modifier because the PTA/OTA minutes exceeded the 10% standard for that service, and one unit of 97535 should be billed with the CQ/CO modifier.

- The PT/OT independently furnishes 12 minutes of 97112, and the PTA/OTA independently furnishes 8 minutes of 97535 and 7 minutes of 97110, for a total treatment time of 27 minutes, allowing 2 units to be billed. One unit of 97112 should be billed without the modifier, and one unit of 97535 should be billed with the CQ/CO modifier. CPT 97110 is not separately billable in this scenario, although the minutes for all 3 codes must be documented and counted toward the total time.
- The PT/OT furnishes 15 minutes of each of two services described by CPT codes 97112 and 97535, and is assisted by the PTA/OTA who furnishes 3 minutes of each service concurrently with the PT/OT. The total treatment time of 30 minutes allows for 2 units to be billed, and each code would be billed with the CQ/CO modifier because 3 minutes exceeds the 10% standard for the 15-minute total time for each code (i.e., 1.5 minutes, rounded to 2).

**CMS also proposes to require that, beginning January 1, 2020, the treatment notes explain, "via a short phrase or statement," the application or non-application of the CQ/CO modifier for each service furnished that day.** This documentation requirement would be included in subsection 220.3.E (Treatment Notes) in Chapter 15 of the Medicare Benefit Policy Manual. This treatment note requirement would apply to both timed and untimed services.

CMS goes on to give examples of the "short phrase or statement" that could be documented to support the application (or non-application) of the assistant modifiers:

- "Code 97110: CQ/CO modifier applied – PTA/OTA wholly furnished"
- "Code 97150: CQ/CO modifier applied – PTA/OTA minutes = 15%"
- "Code 97530: CQ/CO modifier not applied – PTA/OTA minutes less than 10% standard"
- For services furnished exclusively by therapists without the use of PTAs/OTAs, the note could say "CQ/CO modifier NA" or "CQ/CO modifier NA – PT/OT fully furnished all services."

*CMS is seeking comments on whether it would be appropriate to require documentation of the minutes as part of the CQ/CO modifier explanation* as a means to avoid possible "additional burden associated with a contractor's medical review process conducted for these services." And CMS states they are interested in "hearing from therapists and therapy providers about current burden" with the medical review process based on current policy that does not require times for individual services to be documented.

Based on comments received, CMS states if they were to adopt a policy to include documentation of assistant minutes and total time minutes, the modifier explanation could

read similar to the following "Code 97162 (TT = 30 minutes): CQ/CO modifier not applied – PTA/OTA minutes (3) did not exceed the 10 percent standard," where TT means total time.

CMS reiterates that, as discussed in the CY 2019 proposed and final rules, the reduced payment rate (i.e., services paid at 85% of the fee schedule) for outpatient services furnished in whole or in part by therapy assistants which becomes effective January 1, 2022, *does not apply* to OP services furnished in CAHs.

CMS encourages stakeholder feedback and comments on these proposed policies and the other items in the proposed rule.

Information on the assistant modifiers can be found in the **CY 2020 Proposed Rule**, beginning on page 252.