PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

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Title	**Modifier CQ-Physical Therapy Assistant and Modifier CO-Occupational Therapy Assistant**		
Number	**CP.PP.417.v1.4**		
Last Approval Date	03/07/25	**Original Effective Date**	08/10/21
Cross Reference	*Physical Medicine and Rehabilitation Services*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose/ Application	This policy describes how the Plan recognizes the application of the physical therapy assistant and occupational therapy assistant modifiers appended to physical medicine procedure codes submitted on a CMS-1500 paper claim for or an 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Definitions	**Occupational Therapy Assistant**: An individual who is licensed as an Occupational Therapy Assistant (OTA), unless licensure does not apply, is registered or certified, if applicable, as an OTA by the State in which he or she is practicing. **Physical Therapy Assistant**: An individual who is licensed as a Physical Therapy Assistant (PTA), unless licensure does not apply, is registered or certified, if applicable, as a PTA by the State in which he or she is practicing.
Policy	Following criteria contained in the Bipartisan Budget Act (BBA) of 2018, submissions for payment of physical medicine and rehabilitation services furnished in whole or part by a therapy assistant, either a Physical Therapy Assistant (PTA) or an Occupational Therapy Assistant (OTA) **must be submitted** with the appropriate therapy assistant modifiers as follows: • **CQ** – Outpatient **physical therapy services** furnished in whole or part by a physical therapist assistant. • **CO** – Outpatient **occupational therapy services** furnished in whole or part by an occupational therapist assistant. **<u>Plan of Care Modifiers</u>** In addition, both the physical medicine and rehabilitation services rendered by therapists as well as therapy assistants must **ALL** be appended with a **plan of care modifier** to indicate such therapy services are part of a defined plan of care.

	These services which need a plan of care modifier are defined by the Centers for Medicare and Medicaid Services (CMS) and is based on the current CMS "Annual Therapy Update" listing of codes (LINK) under classification "5" which reads: "5 = These codes are "always therapy" services, regardless of who performs them. These codes always require a therapy modifier − GP, GO, or GN − to indicate that they are furnished under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively." The plan of care modifiers to also append to a physical therapy or occupational therapy code include: • **GP** – Service delivered under an outpatient physical therapy plan of care • **GO** – Service delivered under an outpatient occupational therapy plan of care The services of the PTA or OTA must be supervised by a licensed physical therapist or a licensed occupational therapist. PTAs and OTAs may not provide evaluative or assessment services, make any clinical judgements or decisions, develop, manage, or take responsibility for the service. PTAs and OTAs act at the direction of and under the supervision of the treating physical therapist or the treating occupational therapist in accordance with state laws where they are practicing. Claims for which the services are furnished in whole or part by a PTA or an OTA must include the CQ or CO modifier when: • The PTA/OTA furnished 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 exceeds the mid-point of the service (e.g., at least 8 minutes of a 15 minute service) of the total minutes for that service (or unit of a service) Refer to CMS Publication 100-04, Chapter 5-Part B Outpatient Rehabilitation and CORF/OPT Services, Section 20.2.C to determine how to count minutes for timed codes in 15-minute units (LINK). Services rendered by the PTA or OTA are billed **ONLY** by the supervising physical therapist or supervising occupational therapist on two lines on a claim form and **NOT** by the individual PTA or OTA as follows: • Line one: Represents the services rendered by the supervising physical therapist or supervising occupational therapist appended with the appropriate plan of care modifier (GP or GO). • Line two: Represents the services rendered by the PTA or OTA appended with the appropriate therapy assistant modifier (CQ or CO) and the appropriate plan of care modifier (GP or GO).

	When the PTA or OTA renders the entire service and the supervising physical therapist or supervising occupational therapist did not render **any part of the service**, the supervising physical therapist or supervising occupational therapist will bill just one line for the service rendered by the PTA or OTA appended with the appropriate therapy assistant modifier (CQ or CO) and the appropriate plan of care modifier (GP or GO). The costs of supplies used in furnishing covered therapy care is included in the payment for the services billed by the physical therapist or occupational therapist and not separately billable. Documentation in the patient's record must identify and describe the services performed and time spent for each service rendered by the PTA or OTA as well as the services and time spent for any service rendered by the supervising physical therapist or supervising occupational therapist, when applicable. In addition, the ordering physician and a treatment plan must also be documented in the patient's record, periodically updated as needed, and be available for audit review upon request. Reimbursement for services appended with modifiers CQ and CO will be adjusted to 85% of the provider's applicable contracted Fee Schedule allowed amount.
Codes and Coding Guidelines	
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined at the Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	
Laws, Regulations & Standards	Balanced Budget Act of 2018
References and Resources	• American Medical Association (AMA) Current Procedural Terminology (CPT) Codebook • Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedural Coding System (HCPCS) Codes • CMS Publication 100-02-Medicare Benefits Policy Manual, Ch 15, Sect 220-230 • CMS Publication 100-04-Medicare Claims Processing Manual, Ch 5, Section 20.2.C • Transmittal R4440CP-New Modifiers to Identify Occupational Therapy (OT) and Physical Therapy (PT) Services Provided by a Therapy Assistant, Issued 11/01/2019 • Bipartisan Budget Act (BBA) 2018, Sect 53107 • CY2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Federal Register, 12/28/2020 • CY2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Feceral Register, 11/19/2021

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department	
Annual Review Dates	03/07/25; 04/11/24; 05/19/23; 06/06/22; 08/10/21	
Version History	08/10/21	• Creation of Policy; • Modifier reimbursement reduction is effective with claim dates of service on and after January 1, 2022.
	06/06/22	Created a separate section in the Policy for "Plan of Care Modifiers" which are required
	05/19/23	• Revised the Policy title. • Reference in the Policy to "outpatient physical therapy and occupational therapy services" was changed to "physical medicine and rehabilitation services" to reflect their classification more accurately as listed in the CPT Codebook. • In the Plan of Care modifier section of the policy, inserted the paragraph which identifies the source of the list of "always therapy codes" that require a plan of care modifier • At the end of the Policy section, removed the effective date of the reimbursement percentage due to the date being over a year.
	04/11/24	Added the seventh and eighth paragraphs which discusses the "de minimis" or 10% requirement of time for services rendered by the Physical Therapy Assistant (PTA) or the Occupational Therapy Assistant (OTA) and provides a link to the CMS criteria on how to count minutes for timed codes
	03/07/25	Annual review; from the policy section removed "This 10 percent standard is also known as the "de minimis" standard as established by the Center for Medicare and Medicaid Services (CMS) CY 2022 final rule." As the 10% rule was replaced by the standard "mid-point" rule for timed codes and added "the mid-point of the service (e.g., at least 8 minutes of a 15 minute service)"

This policy was published on March 14, 2025