

# **The PTA Differential: Correct Ordering of Modifiers, More Clinical Scenarios and Documentation**

## **Correct Ordering of Modifiers**

In the 2020 PFS final rule, CMS stated that it does not have central standard systems edits to reject or return claims for physical therapy services if the CQ modifier is not in the first modifier position. However, because some CMS contractors processing professional claims may have such systems in place, CMS issued instructions to contractors to reorder modifiers so that claims with the CQ modifier are not returned. This reordering is effective for dates of service on and after January 1, 2020.

## **More Clinical Scenarios**

All units of procedure code are furnished entirely by the PT. A PT administers therapeutic exercises (97110) for 30 minutes. Billing: Report 2 units of 97110 GP.

All units of the procedure code are furnished entirely by the PTA. A PTA performs therapeutic exercises for 30 minutes. Billing: Report 2 units of 97110 GP CQ.

Different services are furnished separately. A PT performs therapeutic exercises (97110) for 30 minutes with patient Y. A PTA then performs therapeutic activities (97530), for 15 minutes with the same patient. Billing: Report 2 units of 97110 GP and 1 unit of 97530 GP CQ. The rationale is that a provider may separately report on two different claim lines when the codes are different.

The PT and the PTA furnish care jointly. A PT performs therapeutic activities (97530) for 45 minutes. During that time, the therapist requires the assistance of a PTA for 8 minutes to help position the patient for the activity. Because the PT furnished all three 15-minute units while assisted by the PTA, there is no need to affix the CQ modifier. Billing: Report 3 units of 97530 GP.

The same service (timed CPT code) is furnished separately by the PT and the PTA. A PT furnishes therapeutic exercises (97110) for 30 minutes. The PT leaves. The PTA takes over the exercises for another 15 minutes. Billing: Report 2 units of 97110 GP and 1 unit of 97110 GP CQ. The rationale is that a provider may separately report on two different claim lines, the number of 15-minute units of a code to which the CQ modifier applies and the number of 15-minute units of a code to which the CQ modifier does not apply. (The same rationale applies in the following examples.)

Example: The PTA furnishes 15 minutes of therapeutic exercises. The PT then furnishes 11 minutes of therapeutic exercises, for a total of 26 minutes of CPT code 97110, meaning 2 units can be billed. Billing: Report 1 unit of 97110 GP CQ and 1 unit of 97110 GP.

Example: The PTA furnishes 16 minutes of therapeutic exercises, and the PT furnishes 9 minutes of therapeutic exercises, for a total of 25 minutes. Billing: Report 1 unit of 97110 GP CQ and 1 unit of 97110 GP.

The same service (untimed CPT code) is furnished separately by the PT and the PTA. CPT code 97150 describes outpatient therapy services provided simultaneously by a provider to two or more individuals. It's untimed and cannot be billed in multiple units on the claim, so one unit of the service is billed for each patient in the group. For example: The PT furnishes 15 minutes of 97150 to patients A and B. The PTA then furnishes an additional 6 minutes of 97150 to both patients, for a total of 21 minutes of group therapy.

Billing: Report 1 unit of 97150 GP CQ for patient A. Report 1 unit of 97150 GP CQ for patient B. Rationale:  $10\% \text{ of } 21 = 2.1$ . Round down to 2.0 (nearest whole integer). Add 1 minute = 3. If the PTA furnishes 3 or more minutes of group therapy, the CQ modifier applies.

## Documentation

Responding to significant feedback on the 2020 Medicare PFS proposed rule from APTA and other stakeholders, CMS did not adopt proposed documentation requirements to accompany application of the CQ modifier policy. Although there are no new documentation requirements, PTs and PTAs should continue to comply with all current documentation requirements to support billing on the claim. These requirements can be found in MBPM Chapter 15 Section 220.3(E) and include the following:

“To support the number of 15-minute timed units billed on a claim for each treatment day, CMS requires that the total timed-code treatment time be documented in the medical record, and that the treatment note must document each timed service, whether or not it is billed, because the unbilled timed service(s) can impact billing. The minutes that each service is furnished can be, but are not required to be, documented. CMS also requires that each untimed service be documented in the treatment note in order to support these services billed on the claim; and, that the total treatment time for each treatment day be documented — including minutes spent providing services represented by the timed codes (the total timed-code treatment time) and the untimed codes.”