Modifiers GN, GO,GP, CQ, and CO Reimbursement Policy					
Policy Number	0061	**Annual Approval Date**	04/2024	**Approved By**	Optum Reimbursement and Technology Committee Optum Quality and Improvement Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. Optum reimbursement policies may use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement. Coding methodology, clinical rationale, industry-standard reimbursement logic, regulatory issues, business issues and other input is considered in developing reimbursement policy.*

This information is intended to serve only as a general reference resource regarding Optum's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, Optum may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to Client enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by Optum due to programming or other constraints; however, Optum strives to minimize these variations.

Optum may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This policy applies to all UnitedHealthcare products, all network and non-network providers.
Fee schedule/provider contract/client contract may supersede

Policy

Overview

This policy describes Optum requirements for billing a UnitedHealthcare health plan for Always Therapy services for a physical therapy, occupational therapy and/or speech therapy plan of care regardless of provider type delivering the service

Reimbursement Guidelines

Specialty Specific Modifiers
To ensure accurate adjudication of claims physical therapy, occupational therapy, and speech therapy service providers are required to append the claim with HCPCS specialty specific modifiers.

When physical therapy, occupational therapy or speech therapy services are provided, the claim must include the following modifiers to identify the therapy benefit to which the services will be applied:

- Modifier GN – Services delivered under an outpatient speech therapy plan of care.
- Modifier GO – Services delivered under an outpatient occupational therapy plan of care.
- Modifier GP – Services delivered under an outpatient physical therapy plan of care.

The HCPCS modifiers CQ and CO modifiers are required to be used for services furnished “in whole or in part” by a physical therapy assistant (PTA) or occupational therapy assistant (OTA). These modifiers should be used on the claim line of the service, alongside the respective GP or GO therapy modifier. Modifier CQ must be paired with the GP therapy modifier and modifier CO must be paired with the GO therapy modifier.

HCPCS modifiers CQ and CO do not apply to services furnished by PTAs and OTAs that are “incident to” the services of physicians or nonphysician practitioners.

Other reimbursement policies that address reimbursement for the codes reported, may also apply.

The following “Always Therapy” codes will require the appropriate provider specialty modifier on all claims:

Code	Modifier
92507	GN, GO or GP
92508	GN, GO or GP
92521	GN
92522	GN
92523	GN
92524	GN
92526	GN, GO or GP
92597	GN
92607	GN
92608	GN, GO or GP
92609	GN, GO or GP
96125	GN, GO or GP
97012	GN, GO or GP
97016	GN, GO or GP
97018	GN, GO or GP
97022	GN, GO or GP
97024	GN, GO or GP
97026	GN, GO or GP
97028	GN, GO or GP
97032	GN, GO or GP
97033	GN, GO or GP
97034	GN, GO or GP
97035	GN, GO or GP
97036	GN, GO or GP
97039	GN, GO or GP
97110	GN, GO or GP
97112	GN, GO or GP
97113	GN, GO or GP
97116	GN, GO or GP
97124	GN, GO or GP
97139	GN, GO or GP

Code	Modifier
97140	GN, GO or GP
97150	GN, GO or GP
97161	GP
97162	GP
97163	GP
97164	GP
97165	GO
97166	GO
97167	GO
97168	GO
97530	GN, GO or GP
97533	GN, GO or GP
97535	GN, GO or GP
97537	GN, GO or GP
97542	GN, GO or GP
97750	GN, GO or GP
97755	GN, GO or GP
97760	GN, GO or GP
97761	GN, GO or GP
97763	GN, GO or GP
97799	GN, GO or GP
98975	GN, GO or GP
98976	GN, GO or GP
98977	GN, GO or GP
98980	GN, GO or GP
98981	GN, GO or GP
G0281	GN, GO or GP
G0283	GN, GO or GP
G0329	GN, GO or GP
G0515	GN, GO or GP

Same specialty modifiers should be documented in box 24d on the CMS-1500.

Use of the modifiers may change the payment of the service and is not intended to set any preset limitations to the services billed.

Note: Member's benefits may vary according to benefit design. Member benefit language should be reviewed before applying the terms of this policy.

Background

In 2019, CMS established modifiers to delineate which therapy services were rendered "in whole or in part" by a PTA or OTA. Beginning January 1, 2022, providers using the Medicare physician fee schedule will be paid at 85% of the fee schedule rate for services provided by PTAs or OTAs. This impacts private practice, outpatient hospitals, rehab agencies, skilled nursing facilities (SNFs), home health agencies, and Comprehensive Outpatient Rehabilitation Facility (CORFs).

Application of the De Minimis Standard

To identify when the CQ/CO modifiers do and do not apply:

- Portions of a service furnished by the PTA/OTA – independent of the physical therapist/ occupational therapist – that do not exceed 10% of the total service or 15-minute unit of a timed service **are not** considered to be furnished "in whole or in part" by a PTA/OTA, so are not subject to a payment reduction.
- Portions of a service that exceed 10% of the total service or 15-minute unit of a service, when furnished by the PTA/OTA independent of the therapist, must be reported with the CQ/CO modifier, alongside the corresponding GP/GO therapy modifier. These services **are** considered to be furnished "in whole or in part" by a PTA/OTA and are subject to the payment reduction.
- Portions of a service provided by the PTA/OTA together with the physical therapist/occupational therapist are considered for this purpose to be services provided by the therapist.

Calculating De Minimis

- Numerical method: Divide the total of the PTA/OTA + PT/OT minutes by 10, round to the nearest integer then add one minute to get the number of minutes needed to exceed the de minimis standard above which the CQ/CO modifier applies.

$$\frac{\text{Total of PTA/OTA+PT/OT minutes}}{10}\ (\text{round off}) + 1\ \text{minute}$$

- Percentage method: Divide the PTA/OTA minutes by the sum of the PTA/ OTA and therapist minutes and then multiply this number by 100 to calculate the percentage of the service that involves the PTA/OTA, if this number is greater than 10% the CQ/CO modifier applies.

$$\frac{\text{PTA/OTA minutes}}{\text{PTA/OTA+PT/OT minutes}}\ \text{x}\ 100$$

Resources

- American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services
- Healthcare Common Procedure Coding System, HCPCS Release and Code Sets
- Centers for Medicare and Medicaid Services

History / Updates	
04/25/2008	New
02/2009	Annual review and update
04/2010	Annual review and update
04/2011	Annual review and update
04/2012	Annual review and update
04/2013	Annual review and update
04/2014	Annual review and update
04/2015	Annual review and update
04/2016	Annual review and update
04/2017	Annual review and update
04/2018	Annual review and update
4/2019	Policy language modified for consistency with UHC policy directing that billings of all physical therapy, occupational therapy and speech therapy service require discipline specific modifiers. Additionally, annual updates to the policy were completed
04/2020	Annual review and update
04/2021	Annual review and update
05/2022	Annual review and update; Added requirements for the application of coding modifiers CQ and CO. Updated the “Always Therapy” code list to include Remote Therapeutic Monitoring (RTM) services
04/2023	Annual review and update
04/2024	Annual review and update