Dynamic Chiropractic

BILLING / FEES / INSURANCE

Billing for Services: The Element of Time

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Q: Can I bill for a 15-minute timed physical medicine service if I only perform the service for five minutes?

A: Before the answer is given, let's be sure that the concepts of use of time and units of billing are understood. When billing for a time-dependent service, such as massage 97124 or exercise 97110, according to Current Procedural Terminology (CPT), these codes have a 15-minute time allotment. Under Centers for Medicare & Medicaid Services (CMS) guidelines, to bill for the service you essentially must spend more than 50 percent of the time to qualify for billing the service. Technically, under CMS rules, the specific time is a minimum of eight minutes. Therefore, to bill for the service, you must spend at least eight minutes performing the service. To take this a step further, to bill for two units of the service, one would need to do a minimum of 23 minutes of treatment: 15 minutes for the first unit and eight minutes of additional time. Following this pattern, one unit = 8-22 minutes, two units = 23-37 minutes, three units = 38-52 minutes, and four units = 53-67 minutes.

From this explanation, it may be ascertained that the answer to the above question is no. And in many circumstances, that would be correct, when the appropriate time is not utilized. But, in some circumstances, the service can and should be billed. Bear in mind that it is not unusual to have a patient who cannot tolerate more than five minutes of a procedure initially, though with progress and adaptation, he or she can tolerate the full 15 minutes of the treatment. In other cases, five minutes may be all that is necessary to accomplish the treatment goal. In these circumstances, the service should be billed, but it is necessary to add modifier -52 to the treatment code. This modifier is used to indicate when a service or procedure is partially reduced or eliminated at the physician's election.

In this specific case, the modifier is used to demonstrate that the time utilized was at a reduced level. An example would be 97124-52, demonstrating that less than eight minutes of time was used but that the service was performed. This provides a means of reporting reduced services without disturbing the identification of the basic service. The fee for the service may remain the same, although in some instances, a provider may wish to report a lesser fee. In either instance, the treatment notes should reflect the rationale for use of the service, time performing the service and any other reasoning factors behind the service.

Editor's note: This issue's We Get Letters & E-Mail section includes a reader comment regarding Mr. Collins' column, along with his response to that reader. See www.chiroweb.com/archives/24/07/16.html.

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