Dynamic Chiropractic

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Code Connection: Guidelines for the Use of Modifier -52

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QUESTION: *When is it appropriate to use modifier -52? Can I use it for a timed service when I do less than the time required by the code?*

Modifier -52 identifies that a service or procedure has been partially reduced or eliminated at the physician's discretion. This is to indicate the basic service described by the procedure code has been performed, but not all aspects of the service have been performed.

Per the timed guidelines of the CPT code set and *CMS Modifier 52 Fact Sheet*, appropriate vs. inappropriate use of -52 modifier includes:

Appropriate Use

- Procedures for which services performed are significantly less than usually required.
- Services modified at the physician's discretion to be less than the usual procedure.
- When the documentation describing the service fully supports that the service furnished was less than usually required.

Inappropriate Use

- Do not use on time-based codes.
- Do not use for terminated procedures.
- Do not use for situations in which the patient is unable to pay the full charge.
- Do not report on Evaluation & Management (E&M) and Consultations codes.

When modifier -52 is used to indicate reduced services, the treatment record should indicate what was different about the procedure (how the service was reduced), and approximately what percentage of the usual work was completed and/or not done.

For example, when less than the specified number of X-ray views is performed for a radiology procedure code, ensure no other code exists for the number of views done and indicate on the claim and the treatment notes the number of views performed (e.g., 73600-52, "one view").

Modifier -52 should not be used if there is another specific procedure code that appropriately describes the lesser or reduced service actually performed; the other procedure code is the most appropriate code and should be reported.

Finally, modifier -52 should not be used when the full service is performed, but the total fee for the service is reduced or discounted. No CPT modifier exists for a reduced fee.

Payment for services submitted with modifier -52 will generally be reduced by 25-50 percent from the usual allowed charge by most payers. Most payers require, when submitting a claim with modifier -52, that you attach a brief explanation stating the nature of the reduced services, the reason why and any or all medical documentation supporting the claim. This will help the payer in assessing the fee value to the service performed. If an electronic claim, this can be done in block 19.

Reporting Time-Based Codes: A Quick Review

According to the *CPT Assistant*, a unit of time is attained when the midpoint is passed. For physical medicine codes, including constant attendance modalities 97032-97036 and therapeutic procedures 97110-97542, there is a 15-minute requirement. These timed services do not require a full 15 minutes of service to be coded for one unit, but eight minutes, which is the minimum beyond the midpoint. When a 15-minute service is performed for seven minutes or less, it not reportable. As a consequence, the -52 modifier is not appropriate to use when a timed service is done for seven minutes or less.
Documentation requirements with the American Physical Therapy Association's *Defensible Documentation for Patient/Client Management* document and Centers for Medicare and Medicaid Services (CMS) National Policy indicate the following:

As discussed in several of my most recent articles, when only one service is provided in a day, providers should not bill for services performed for less than eight minutes. For any single timed CPT code in the same day measured in 15-minute units, providers should bill a single 15-minute

unit for treatment greater than or equal to eight minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes, two units should be billed. Time intervals for one to four units are as follows:

- 1 unit: ≥ 8 minutes through 22 minutes
- 2 units: ≥ 23 minutes through 37 minutes
- 3 units: ≥ 38 minutes through 52 minutes
- 4 units: ≥ 53 minutes through 67 minutes

These time limits are considered cumulative when multiple timed services are performed. For instance, if 10 minutes of massage 97124 and 10 minutes of therapeutic exercise 97110 were performed on the same date of service, the total time would equal 20 minutes, which qualifies for only one unit. Consequently, only one unit may be billed for timed services for this date of service.

The higher valued of the two services or the one performed for the greater time would be the appropriate code to bill for one unit. Only if the combined time equaled 23 minutes or greater could you bill for two units.

Editor's Note: Feel free to submit billing questions to Mr. Collins at sam@hjrossnetwork.com. Your question may be the subject of a future column.

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