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Less Time Than Required

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Q: When is it appropriate to use a 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 Code Sheet, the appropriate usage of -52 modifier includes:

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

Inappropriate usage of -52 includes:

1. Do not use on a time-based codes.
2. Do not use for terminated procedures.
3. Do not use for situations when the patient has the inability to pay the full charge.
4. Do not report on Evaluation & Management and Consultations codes.

According to the CPT Assistant codebook's instruction, a unit of time is attained when the mid-point is passed. For physical medicine codes, including constant attendance modalities 97032-97036, therapeutic procedures 97110-97542 and acupuncture 97810-97814 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 8 minutes, which is the minimum beyond the mid-point. When a 15-minute service is performed for 7 minutes or less it not reportable. As a consequence the -52 modifier is not appropriate to use when a timed service is done for 7 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.

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15-minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 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, then 2 units should be billed. Time intervals for 1 through 4 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 mulitple timed services are performed. For example, if 10 minutes were spent face-to-face with an initial insertion 97810 (assuming a manual

set) could be billed. The patient is then left to rest on this set for 15-minutes and upon returning an additional 10-minutes of face-to-face time with a second insertion was performed an additional or second set could not be billed. The reason a second set would not be billable is that total face-to-face time is only 20 minutes. Twenty minutes of face-to-face time qualifies for only one unit or set as acupuncture requires not only an additional insertion but additional time that meets the 8 minute rule requirements. Only if the combined face-to-face time equaled 23 minutes or greater could there be 2 units billed.

In another example using physical medicine services, a provider does 10-minutes of massage, 97124 and 10-minutes of therapeutic exercise, 97110 on the same date of service the total time would equal 20 minutes. Twenty minutes 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 there be 2 units billed.

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

Modifier -52 should not be used if there is another specific procedure code that appropriately describes the lesser or reduced service that was 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% to 50% from the usual allowed charge by most payers. Most payers require when submitting a claim with modifier -52, attach a brief explanation stating the nature of the reduced services and 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.

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