IMPORTANT STATEMENT

The purpose of ODS Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise their medical judgment in providing the most appropriate care. Reimbursement policy is not intended to dictate care decisions or medical practice.

Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. Fee determinations will be based on the applicable provider contract language and ODS reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will control.

General Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance, but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
External Policies

- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

Definition

Modifier -52 identifies that the service or procedure has been partially reduced or eliminated at the physician’s discretion. The basic service described by the procedure code has been performed, but not all aspects of the service have been performed.

Coding Guidelines

When modifier -52 is used to indicate reduced services, the billing office 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.

- In some simple cases, this can be done with a brief statement of additional information on the claim itself. Most electronic clearinghouse services have fields to accommodate and transmit this additional information.
  - If the procedure code is time-based (e.g. “each 15 minutes” or “each additional hour”), indicate on the claim how much time was actually performed.
  - If less than the specified number of views were performed for a radiology procedure code, ensure that no other code exists for the number of views done, and indicate on the claim the number of views performed (e.g. 74010-52 “two views”).
  - When an inherently bilateral procedure is performed unilaterally, a claim notation can be made to indicate the procedure was only performed on one side (e.g. 93921 “left leg only”, 92556 “right ear only”).
- If the nature and extent of the reduction cannot clearly and completely be explained with a notation on the claim itself, then a letter or statement should be attached to the claim, and the medical records documenting the service should also accompany the claim (e.g. operative report, radiology report, visit notes, etc). Generally this means that the claim cannot be submitted electronically and must drop to manual submission.
**Inappropriate Use of Modifier -52**

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.

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. When fees for vaccines are reduced because the vaccine supply was obtained from a state agency, modifier SL *State supplied vaccine* should be used.

Modifier -52 is not considered valid when used with:
- All-or-nothing procedure codes
  (e.g. 72020 XR spine, single view; 97010 – 97028 PT modalities, one or more areas, non-timed codes)
- Unlisted procedure codes
  (Code definition is specific to each claim)
- Codes in a series where a lesser code is available
  (e.g. instead of 90806-52 use 90804)
- Evaluation and management (E/M) codes other than Preventive Medicine Service codes
  - Select the code that best describes the level of service performed. If services documented do not meet the criteria for the lowest level of E/M available, then service either is not reportable, or an unlisted code must be used.
  - For Preventive Medicine E/M codes modifier 52 will be considered valid to report an annual women’s exam when other systems usually included in an age-appropriate preventive exam are not addressed.

**Reimbursement Policy**

Claims for reduced services are manually priced. The allowance is adjusted based on the percentage of the full service that has been performed and documented.

**Reimbursement Guidelines**

When modifier 52 is submitted, the claim should be accompanied by both a statement explaining what percentage and portion of the service was not completed and the operative report or records documenting the service. If the statement explaining the nature and amount of the service reduction and the medical records for the reduced service did not accompany the claim, this information will need to be requested in most cases, resulting in further delay of the claim.

**Reduced Services of Time-Based Codes**

For any time-based procedure codes (codes with descriptions that specify an increment of time such as minutes or hours) the duration of the service must be clearly documented in the medical record. Documentation in terms of “units” does not constitute documentation of time or duration. The actual number of minutes or begin-to-end times must be used.
Only one time-based code may be performed at a time. If three units of “each 15 minutes” codes are billed, the total duration of the visit must be a minimum of 45 minutes, with additional time expected if evaluation and management, radiology, or supervised modalities are also billed. If more than one procedure code is billed for the same date of service, then in order to fully support all of the billed services the time must be separately documented for each specific procedure or time-based service. This will clearly document what portion of the total visit was spent performing each of the billed codes.

Methods and examples for time documentation:

Acceptable:
- Specific number of minutes. Example: “Manual therapy to lumbar spine x 15 minutes.”
- Listing begin-time and end-time for service. Example: “E-stim to cervical neck, 09:30 – 09:45.”

Unacceptable:
- Documenting time in terms of “units”. Examples: “One unit of pulsed ultrasound was administered.” or “Ther Ex 1 unit.”
- Documenting time using a range. Example: “Therapeutic activities x 6 – 12 minutes as appropriate per assessment and symptoms.”
- Documenting a quantity but not specifying the measurement or increment used. Example: “97110 Exercises x 2”
- No time mentioned at all. Example: Checking or circling “NMR” or “TE” with no additional information documented.

When a time-based procedure code is billed with modifier -52 attached, if the time/duration is not documented in the medical record, then the documentation is incomplete. The service is not fully supported in the record, and the reduced service is not eligible for separate reimbursement. The reduced service will be denied with an explanation code stipulating that the service was not documented (due to the incomplete documentation).

When the duration of a reduced time-based procedure is documented in the record:
- Time must be reported in full one-minute increments. Any fractions of less than one-minute will not be considered in the review.
- If the time is documented with a range of time, only the lowest amount of time is considered to be supported in the record. Example: “Total time for performing exercises is 5 – 8 minutes.” Only five (5) minutes is supported by this documentation.
- If the amount of time the service was performed is less than 50% of the time described for the procedure code, then the service will not be separately reimbursable, but will be considered incidental to the other services performed on that date.
- If the amount of time the service was performed is 50% or more of the time described in the procedure code definition, the service will be reimbursed at the full rate.

For 15-minute PT modalities, this policy effectively mirrors the CMS "8-minute rule." For services of eight to 14 minutes, round up to the next unit.
  a. 0 - 7 minutes (& 7.5 minutes) – not separately reimbursable
  b. 8 – 22 minutes – 1 unit
  c. 23 – 37 minutes – 2 units
For procedure codes stipulating “each 30 minutes,” at least 15 minutes of the service must be performed and clearly documented to be separately reimbursable.

For procedure codes stipulating “each hour” or “each additional hour,” at least 30 minutes of the service must be performed and clearly documented to be separately reimbursable.

References


Cross References

None.