Internal Medicine Coding Alert

Think Youve Made Your Case for Modifier -22? Not if You Havent Done These 5 Things

If youre submitting claims for unusual procedural services without first determining how youre going to defend them, chances are your case wont hold up with payers unless you use this defense crafted by coding experts.

The careful and proper usage of modifier -22 (Unusual procedural services) can be an invaluable tool in obtaining additional reimbursement for surgical services, says **Arlene Morrow, CPC, CMM, CMSCS**, a coding specialist and consultant with AM Associates in Tampa, Fla. But, coders, beware: Overuse of this modifier may be a red flag to carriers monitoring claims coded for the purpose of obtaining improper payment, she says.

CPT guidelines indicate that when the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier -22 to the usual procedure code. And convincing the carrier that a procedure was greater than that usually required is crucial for claims with modifier -22, because when approved, these claims will yield additional reimbursement in many cases an additional 20 to 25 percent more than their standard payment.

Morrow recommends developing written policies and procedures for consistent coding and documentation application as your standard plan of attack when submitting claims with modifier -22. Be sure your plan contains these five elements:

1. Develop an Unusual Argument

CPT designed modifiers to represent the extra physician work involved in performing a procedure because of extenuating circumstances present in a patient encounter. Modifier -22 represents those extenuating circumstances that dont merit the use of an additional or alternative CPT code, but instead raise the reimbursement for a given procedure, says **Cheryl A. Schad, BA, CPCM, CPC**, owner of Schad Medical Management in Mullica, N.J.

For example, suppose a patient presents for an electrocardiogram (ECG) service. Although the relevant codes describe 24-hour monitoring, sometimes services may be provided for shorter or longer periods. Most payers indicate that monitoring of fewer than 12 hours is a standard ECG service, but policies vary when monitoring is performed over two or more consecutive days, such as a 48-hour evaluation. Many practices bill the global code (e.g., 93224, Electrocardiographic monitoring for 24 hours by continuous original ECG waveform recording and storage, with visual superimposition scanning; includes recording, scanning analysis with report, physician review and interpretation) with modifier -22 and two units of service to describe 48-hour monitoring.

Most carriers including Medicare subscribe to the policy that unusual operative cases can result from the following circumstances outlined by The Regence Group, a Blue Cross Blue Shield association:

excessive blood loss for the particular procedure
presence of an excessively large surgical specimen (especially in abdominal surgery)
trauma extensive enough to complicate the particular procedure and not billed as additional procedure codes
other pathologies, tumors, malformation (genetic, traumatic, surgical) that directly interfere with the procedure but are not billed separately
services rendered that are significantly more complex than described for the CPT code in question.

Other circumstances that may merit the use of modifier -22 include morbid obesity, low birth rate, conversion of a procedure from laparoscopic to open, and significant scarring or adhesions, experts say.

2. Document the Evidence

The key to collecting additional reimbursement for unusual services is all in the documentation, Schad says.

Sometimes a physician will tell you to append modifier -22 to a procedure because they did x, y and z, she says, but when you look at the documentation, the support isnt there.

The documentation is your chance to demonstrate the special circumstances, such as extra time or highly complex trauma, that warrant modifier -22, Morrow says.
For example, if an internist spends an inordinate amount of time excising a lesion located in the crease of the neck of a very obese person and he documents how much additional time he spent performing the reduction, you can append modifier -22 to the lesion excision code to indicate the complexity of the removal of the lesion, according to the Principles of CPT Coding manual published by the American Medical Association.

For every claim with modifier -22, you should submit both a paper claim and the operative report, Schad instructs coders. The operative report should clearly identify additional diagnoses, pre-existing conditions or any unexpected findings or complicating factors that contributed to the extra time and effort spent performing the procedure, Morrow says.

Morrow recommends that every operative note have a separate section such as a Special Circumstances section in which the physician must indicate when a procedure is significantly more difficult than anticipated.

The hitch: Theres a good chance that the person employed by the insurance carrier to review your claim is not a medical professional. So you have to translate what went on in the operating room into quantifiable terms, Schad says. Getting paid for modifier -22 is very subjective, and it depends on the utilization reviewer or the claims reviewer, Schad says.

3. in Payer Lingo

Your operative report does not have to cater to the carrier receiving the claim, but an additional note from the physician to the insurance carrier should.

Some carriers have specific forms for the physician to fill out and send with claims using modifier -22. Georgia Medicare provides practices with a Modifier -22 Explanation Form to help in reviewing your claim.

The form asks for the patients name, HIC number, date of surgery, length of surgery (operative time), unusual circumstances during the surgery that may warrant additional reimbursement, a copy of the operative report, and the physicians signature, dated, with the printed name below.

If your carrier does not have a form specifically for modifier -22 claims, you may want to follow the recommendation published in the June 2000 Bulletin of the American College of Surgeons (ACOS): Include a statement separate from the operative report that is written by the physician and explains the unusual amount of work in laymans terms.

According to the bulletin, the separate report should state the patients name, health insurance identification number, the procedure date, the requested percent increase for the procedure fee, and the circumstances behind the request to justify the percentage increase above the customary fee. You should also use two or three paragraphs to justify why the procedure was unusual using simple medical explanations and terminology, realizing that the letter will (hopefully) be read by a nurse or other reviewer.

Also include the typical average circumstances or time for completion and compare it to the actual circumstances. Schad recommends that you send two operative reports: one for the unusual procedure, and another for the same procedure that would not be considered unusual. The reviewer can then compare a typical cholecystectomy, for example, to the one you are trying to have paid.

The ACOS recommends closing the note by referring the reviewer to the operative report and including the physicians contact information.

You should refer to these factors when conveying unusual procedural services to a non-medical professional:
Time: Time is quantifiable, making it easy for a carrier to convert into additional reimbursement. For example, statements such as 50 percent more time than usual was required to excise the lesion because of the patients obesity, making the total procedure 90 minutes instead of 30 minutes can be very effective.
Blood loss: Document the quantity of blood lost during the procedure and compare it to what is typically lost during the same type of procedure. For example, include statements such as 1,000 ccs of blood, rather than the standard 100 ccs of blood, were lost during the procedure.
Special instruments: Compare the instruments/
equipment used to perform the procedure to those typically used.
Technique: Clearly indicate when there has been a change in technique during the procedure and, more important, why there was a change in technique for example, Adhesions prohibited a successful open procedure, hence its conversion to a laparoscopic one.

4. Request Additional Reimbursement and Wait

Even though you may not receive what you request, It is very important to increase your fee commensurate with the extra work value when submitting claims for modifier -22, Morrow says.

Ask for an additional percentage; for example, if the usual practice fee is $1,000 and you decide the fee should be increased by 30 percent, ask for $1,300, Morrow says. Some practices prefer to request an additional fixed dollar amount, for example $300 in the prior example. She lets coders in on the secret that many practices have negotiated into their managed-care contracts a fixed percentage for additional reimbursement. For example, modifier -22 might be pegged a 40 percent fee increase when submitted and approved for complicated trauma cases.

Insurance companies inevitably take longer to process paper claims than electronic ones. And getting claims for modifier -22 approved can make for an especially laborious process, Schad says.

The bottom line: Dont bother to submit a claim for modifier -22 if you dont have the documentation youre wasting your time and spinning your wheels, because youre not going to get paid, Schad says.

5. Check Your List of Dos and Donts

Run through your quick list of dos and donts before submitting your claim:
w Do include a copy of the operative report with your claim
w Do check your carriers local medical review policies before submitting a claim for modifier -22 not all private payers honor this modifier
w Do use critical care codes instead of modifier -22 when appropriate
w Do be sure at least 25 percent more time/effort than usual was required to perform the procedure
w Do append modifier -22 to assistant-at-surgery procedures
w **Dont** append modifier -22 to secondary procedure codes
w **Dont** use modifier -22 for re-operations or E/M visits
w **Dont** assume lysis of average adhesions merits the use of modifier -22
w **Dont** report modifier -22 simply because the physician performs a procedure via a lesser-preferred approach
w **Dont** substitute an unlisted-procedure code instead of modifier -22 to avoid carrier denials.