Part B Insider (Multispecialty) Coding Alert

MODIFIERS: Warning--Don't Use 22 Modifier Unless You Can Show Extra Work

It's not enough to document previous procedure

Heads up: A clarification of the 22 and 51 modifiers could be coming within the next year--and it's not too soon to prepare.

The **American Medical Association's CPT Editorial Panel** discussed these modifiers at the panel's June meeting in Las Vegas, and they-re on the agenda again for October's Washington, D.C. meeting. According to observers, the panel wants to clarify the instructions for when you should use both modifiers.

The problem: The 22 modifier (Unusual procedural services), in particular, is a challenge for many practices, says **Maxine Lewis** with **Medical Coding Reimbursement Management** in Cincinnati. Many doctors think they should be able to use the 22 modifier whenever they have to do any extra work--but they don't explain why they deserve more reimbursement, says Lewis.

-As it is now, we think we deserve extra payment, so we send the payor the info for why we think we do, and wait to see if they pay extra,- says **Dianne Wilkinson**, compliance officer and quality manager with **MedSouth Healthcare** in Dyersburg, TN.

For example: A patient comes in for abdominal surgery. Because the patient has had previous bariatric surgery and a hysterectomy, she's bound to have adhesions. The physician has to spend time lysing those adhesions before completing the abdominal surgery. The physician may try to use the 22 modifier, but the carrier may argue that adhesions are -usual- in 90 percent of patients who have had previous abdominal surgery.

In other words, the fact that the patient has had abdominal surgery in the past doesn't automatically guarantee any extra reimbursement, Lewis warns.

The solution: The physician has to explain exactly what extra work he or she had to do, says Lewis. Instead of simply writing, -after lysing adhesions,- and then describing the main procedure, the surgeon should describe how much time the lysis took, or what it involved.

Tell your physicians that -their reimbursement will be affected if they don't document exactly what was going on in the surgery that made it -unusual,-- urges **Lisa Center**, a coder with **Mount Carmel Regional Medical Center** in Pittsburg, KS.

Another problem: It's never clear how much you should increase your fee with the 22 modifier. And there's no guarantee you-ll receive as much as you expect, Lewis cautions. Some physicians overuse the 22 modifier, while others become discouraged and never use it at all.

Many coders aren't sure when to use the 51 modifier (Multiple procedures)--especially since the AMA introduced the 59 modifier, says Wilkinson. She believes the 51 modifier is for -multiple procedures that are related to one another.-

For example: A patient has a cystoscopy, along with a urethral dilation and ureteral stent placement. You could use the 51 modifier for the secondary procedures, as long as those codes aren't exempt from the 51, says Wilkinson. But if a doctor performs an E/M service (with the 25 modifier), lesions removed from three locations, a trigger point injection and

a proctoscopy, then you would use the 59 modifier, she says.

In some circumstances, you could find yourself using both the 22 and 51 modifiers together, Lewis notes. For example, a patient may have a major surgery that goes well, but then the surgeon accidentally nicks a blood vessel and has to spend more time repairing the wound than he or she spent on the original surgery. In that circumstance, you might append both modifiers.

Note: For more detailed background information on appending the 22 modifier, see -Call On 22 If Your Surgeon Goes The Extra Mile- later in this issue.