Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Call on 22 if Your Surgeon Goes the Extra Mile

22 means more work for coders, too--but the payoff can be worth it

With appropriate documentation and judicious application, modifier 22 (Unusual procedural services) can yield increased payment for especially difficult or time-consuming procedures.

To be sure you are appending modifier 22 appropriately, follow these six tips:

1. Know How to Define -Unusual-

No payor will allow additional payment for a procedure unless you can provide convincing evidence that the service/procedure the physician provided was truly -out of the ordinary- and significantly more difficult or time-consuming than usual.

The basics: The time to append modifier 22 is when the service(s) the physician provides are -greater than that usually required for the listed procedure,- according to Appendix A (-Modifiers-) of the CPT manual.

CPT codes describe a -range of services.- In other words, although one procedure may go smoothly, the next procedure of the same type may take longer or prove to be more difficult. The fee schedule amounts assigned to individual codes assume that the -easy- and -hard- procedures will average out over time.

In some cases, however, the surgery may require significant additional time or effort that falls outside the range of services described by a particular CPT code, says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO**, owner of MJH Consulting in Denver. When you encounter such circumstances--and no other CPT code better describes the work involved in the procedure--you should consider modifier 22 to be an option.

2. -Unusual- Means Just That

Key idea: Recognize that truly -unusual- circumstances will occur in only a minority of cases.

CMS guidelines stipulate that you should apply modifier 22 to indicate -an increment of work infrequently encountered with a particular procedure- and not described by another code.

Situations that might call for modifier 22 include (but are not limited to):

- excessive blood loss

- presence of 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 by the CPT code in question.

Additional circumstances that could merit using modifier 22 include morbid obesity, low birth rate, conversion of a

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procedure from laparoscopic to open, and significant scarring or adhesions.

Example: During a laparoscopic cholecystectomy (47562, Laparoscopy, surgical; cholecystectomy), the surgeon must spend almost 90 minutes lysing adhesions.

Although the primary surgical procedure generally includes lysing adhesions (making it not payable), in this case, circumstances call for--and the physician documentation can demonstrate--significant additional effort. Using modifier 22 appropriately can allow the physician to receive additional compensation for the additional work he performed.

3. Document the Evidence

Collecting additional reimbursement for unusual services with modifier 22 hinges primarily on your documentation's strength: Documentation is ultimately what demonstrates the special circumstances--such as extra time or highly complex trauma--that warrant modifier 22 and additional payment.

Best advice: -Many payors would prefer that you submit the claim [electronically] and send the report separately,- says **Marcella Bucknam, CPC, CCS, CPC-H, CCS-P.** -Also, some electronic software will allow you to append a copy of an electronic note as an attachment, and many payors like that. We are also finding that a number of payers would prefer just the part of the note that justifies modifier 22.-

The op 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.

The documentation you submit should list additional diagnoses or pre-existing conditions, as appropriate, to demonstrate any unexpected or complicating factors.

-It's important to include the diagnoses that support the additional work. Adhesions, scarring, infected mesh, etc., can all be coded and will support your request for additional reimbursement,- Bucknam says.

And the documentation should include a separate section--titled -special circumstances- or something similar--that precisely explains, in clear language, how much, and why, additional time and/or effort was necessary.

Hint: Avoid medical jargon and state in concise language the reason for the surgery's -unusual- nature. You should do your best to translate what went on in the operating room into easy-to-interpret information.

4. Compare and Contrast

One of the most effective ways to demonstrate the unusual nature of a procedure is to compare the actual time, effort or circumstances to those the physician typically needs or encounters, Hammer says.

You might cite the typical average time for completion and compare it to the actual circumstances (for instance, -the procedure required 90 minutes to complete, instead of the usual 35-45 minutes-).

Example: During a colonoscopy, the surgeon removes nearly two dozen polyps from various regions of the colon using snare technique (45385, Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor[s], polyp[s], or other lesion[s] by snare technique). In this case, although the descriptor for 45385 specifies -polyps- (plural), the amount of physician effort clearly exceeds that usually encountered for this type of procedure.

You should report this session using 45385-22 and include a cover letter explaining, for instance, -The physician removed 22 polyps via snare. Typically, the physician encounters no more than 8-10 removable polyps during procedures of this type. This procedure required in excess of two hours to complete, as compared to 40 minutes for a typical procedure of this type.-

You-ll have to exert considerable extra effort to file a manual claim and include all the necessary documentation for a

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modifier 22 claim. But without the effort, your physician probably won't get the reimbursement she deserves for a truly unusual procedure.

The bottom line: Don't bother to submit a claim for modifier 22 if you don't have the documentation--because you-re not going to recover any additional fee.

5. Give Concrete Reasons for 22

When explaining or defending the reasons for modifier 22, you might consider these factors:

- Time: Time is quantifiable, making it easier for a carrier to convert into additional reimbursement.

Example: Statements such as -200 percent more time than usual was required to excise the lesion because of the patient's 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 a patient typically loses during the same type of procedure.

Example: Include statements like -1,000 cc of blood, rather than the standard 100 cc of blood, were lost during the procedure.-

- Special instruments: Compare the instruments/equipment used to perform the procedure to those typically used (if different).

- Technique: Clearly indicate when there has been a change in technique during the procedure and, more important, why there was a change in technique.

Example: -Due to extensive adhesions, the physician had to convert the laparoscopic procedure to an open procedure.-

6. Ask for the Money

Payors won't automatically increase your payments for modifier 22 claims. You have to ask for the money, Hammer says. You can include this request as a portion of the cover letter that explains the unusual nature of the procedure.

Example: During recurrent inguinal repair (49520, Repair recurrent inguinal hernia, any age; reducible) on a 55-year-old patient, the surgeon must remove mesh placed during the previous repair. The area of the previous repair shows extensive scarring, and the mesh removal requires an hour longer than average to complete.

CPT does not contain a separate code for mesh removal, and usually the service is bundled to hernia repair. Because of the extra work in this case, however, you can append modifier 22 to 49520. You should include a statement in your cover letter saying, for instance, -Because this surgery took an hour longer than the typical procedure of this type, we are requesting 20 percent additional reimbursement in this case.-

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