Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Follow These 5 Routes to Modifier 22 Claim Success

You decide which services warrant the effort associated with modifier 22

Catch 22: If you-re using modifier 22 on almost all of your surgical claims, you-re headed for an audit. But if you-re not using modifier 22 at all, you could be passing up ethical reimbursement increases.

Did you know? In the past, some Medicare carriers have suggested that physicians should use modifier 22 (Increased procedural services) with fewer than 5 percent of all cases. In other words, you should always apply modifier 22 sparingly--but that doesn't mean you should never use this modifier at all.

Key: When a procedure may require significant additional time or effort that falls outside the range of services described by a particular CPT code--and no other CPT code better describes the work involved in the procedure--modifier 22 is your best option, says **Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO**, owner of **MJH Consulting** in Denver.

Follow these expert tips, and you-ll be stepping toward modifier 22 success.

1. Know When to Use Modifier 22

You should use modifier 22 -when the service(s) provided is greater than that usually required for the listed procedure,- according to CPT. However, neither CPT nor Medicare provides guidelines about what type of service merits its use--that's up to you.

Example: If your physician uses a telemetry-at-home device, which is not an event monitor but a live, real-time patient monitoring at home, some carriers do require 93799 (Unlisted cardiovascular service or procedure). Other payers will require the Holter monitor codes (93224-93233) appended with modifier 22 because the technology is new.

2. Support the -Increased- 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 don't merit using an additional or alternative CPT code, but instead raise the reimbursement for a given procedure.

Catch this: The key to collecting reimbursement for increased procedures is all in the documentation. Sometimes a physician will tell you he did -x, y and z,- but when you look in the documentation, the support isn't there. Documentation is your chance to demonstrate the special circumstance that warrants modifier 22.

Also, don't forget to add on the additional dollar amount that you are asking for, says **Karen Green, CPC-H**, coding specialist in a physician's practice in Eau Clair, Wis. -Payers just don't pay you extra with this modifier; you need to say I am asking for ____ extra and this is why.-

Some situations in which you might use modifier 22 include:

- morbid obesity
- significant scarring or adhesions in the operative field- extremely prolonged cases

3. Count Time as a Vital Factor

Some experts suggest that you shouldn't use modifier 22 unless the procedure takes at least twice as long as usual. Several memorandums from Medicare carriers indicate that time is an important factor when deciding to use this modifier.

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.

What to do: If your physician performed a series of increased procedural services, you would append the modifier on the code with the highest relative value unit (RVU), says **Sandy Fuller, CPC, MCS-P, HIS** supervisor and compliance officer for **Cardiovascular Associates** of East Texas. You must also have a letter in layman's terms that tells why this was a difficult procedure, and -it's always good to have the time in the letter, along with the time of the normal case for this physician.-

4. Use Unlisted-Procedure Code as a Last Resort

Avoid making the mistake of using an unlisted-procedure code when you could use modifier 22. Some coders go this route because they realize the payer must manually review such claims and the carrier's computer cannot automatically deny them. But you could be setting your practice up for missed reimbursement.

Rationale: Unlisted-procedure codes require the same amount of documentation as modifier 22. If you do not include an -accompanying narrative- with an unlisted- procedure code, the Medicare Carriers Manual, section 3005.4 (C.1.k), instructs carriers to return the claim as unprocessable.

Because filing a claim with an unlisted-procedure code takes just as much time and effort and because the reimbursement rates don't appear to be higher, many coding experts recommend that you stick with modifier 22. If the modifier 22 claim gets denied, the physician still gets paid for the base code. But if the carrier rejects the unlisted-procedure code, the physician may get nothing and may have to fight for reimbursement for the entire procedure.

5. If Possible, Use CPT Codes Instead of a Modifier

Instead of attaching modifier 22 when a procedure is above and beyond its normal scope, you should consider reporting a CPT code that more specifically explains why the procedure was prolonged or increased.

Example: A physician attempts to catheterize the aorta from a left femoral artery vascular access site but has difficulty advancing the catheter. He performs a sheath injection to visualize the artery but then abandons the initial access site before obtaining a separate access from the right femoral artery.

In this case, you should report 36140 (Introduction of needle or intracatheter; extremity artery) and 75710 (Angiography, extremity, unilateral, radiological supervision and interpretation) in addition to the procedure codes that reflect the work performed from the second access site. Reporting these two codes, rather than applying modifier 22 to others, is more accurate and less of a hassle.