Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Learn the Truth Behind These 4 Modifier 22 Myths--And Avoid More Denials

A longer-than-normal procedure does not automatically justify modifier 22

Did you know that performing lysis of adhesions during surgery is not always a reason to apply modifier 22? If not, you could be coding--and recouping reimbursement--non-compliantly.

Once you've learned the secrets to using this special tool, you'll find that "denials" and "modifier 22" don't have to go hand-in-hand. Make sure you're not falling victim to any of the following coding myths:

Myth 1: "The physician's surgery was longer than expected, and she wants me to find a way to code to compensate for the extra time. I should apply modifier 22."

Fact: More time does not automatically qualify your service for a modifier 22, and you can't just use this modifier if you don't think your procedure pays enough, says **Quin Buechner MS, MDiv, CPC, CHCO**, president & CEO of **ProActive Consulting**, LLC in Cumberland, WI. CPT Codes 2006 specifies modifier 22 for "unusual"--not "longer"--procedural services, he clarifies. "And you need to supply significant support as to why the procedure was 'unusual.'"

Rule of thumb: Only use modifier 22 when unusual circumstances during the procedure make the physician's work last at least 25 percent longer than normal, suggests **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS,** coordinator for HIM Certificate Programs at **Clarkson College** in Omaha, NE. One thing that could easily extend a procedure is when a surgeon begins with one approach and must unexpectedly convert to another.

Example: A patient is scheduled for laparoscopic appendectomy. At the beginning of the surgery, the physician discovers a ruptured appendix with abscess and must convert to an open procedure to clean out the purulent fluid, extending the surgery by one hour. You would apply a modifier 22 to 44970 (Laparoscopy, surgical, appendectomy).

Myth 2: "The physician found some adhesions and had to perform lyses to proceed with the surgery. Since this was unexpected and extended the surgery time, I should apply a modifier 22."

Fact: Adhesions are indeed a case where modifier 22 is acceptable, but most patients who've had previous surgery will have some scarring or adhesions--so stumbling across a few is not unusual and will not automatically merit the modifier, remarks Buechner. Only when the amount exceeds what you would normally find in a patient who underwent previous surgeries and significantly extends the current procedure would you use modifier 22.

Example: A surgeon begins an open appendectomy. The patient's abdomen has dense adhesions throughout the cavity that the surgeon must spend an additional two hours dissecting away in order to free up the bowel prior to starting the appendectomy. You're in the clear to add modifier 22 to 44960 (Appendectomy; for ruptured appendix with abscess or generalized peritonitis), Bucknam says.

Myth 3: "Modifier 22 is the automatic solution if I'm to accurately code for a surgery that included significantly more work or time because of an unusual procedure."

Fact: Believe it or not, other codes or modifiers could suffice to describe unusual circumstances--and you should use these before resorting to modifier 22, Bucknam recommends. "There are a number of codes that specifically describe the procedure as 'complex,' and this usually includes the extra work of previous surgeries and may include other specific alterations." CPT also lists add-on codes that describe work related to previous surgeries and include the extra work

related to scarring and/or altered anatomy, she adds.

Example: A patient undergoes an open aortic valve valvuloplasty with a cardiopulmonary bypass, as well as a second surgery to have the wires removed from his sternum. In addition to coding 33400 (Valvulo-plasty, aortic valve; open, with cardiopulmonary bypass), you would code 33530 (Reoperation, coronary artery bypass procedure or valve procedure, more than one month after original operation [List separately in addition to code for primary procedure]) instead of appending modifier 22 to the primary procedure code 33400.

"Code 33530 incorporates all the work that's related to the fact that the surgeon put wires in the sternum, such as any scar tissue, adhesions or altered anatomy. You would very often use a modifier 22 to describe those things, but they are already implied by that code," Bucknam points out.

Myth 4: "The physician encountered an unexpected anatomical abnormality that extended the original procedure by 90 minutes. Even though modifier 22 is clearly appropriate in this case, I shouldn't bother applying it because I know my payer won't accept it without an appeal."

Fact: You should code for what you did, regardless of whether you think you'll get properly reimbursed, Buechner says. Other than staying compliant by reporting the truth, if you choose to appeal, you can only gain at this point.

Tip: Always include an operative report with a cover letter and use tools such as V-codes that can support your usage of modifier 22, Bucknam suggests. "By highlighting the information you want [Medicare] to notice, you make it easy for them to decide if the additional reimbursement is appropriate," she says.

Example: A patient with a Body Mass Index (BMI) of 35 undergoes a liver transplant. The patient's obesity creates a complicated procedure that lasts an hour more than expected. Using V85.35 (Body Mass Index 35.0-35.9) on your claim and cover letter will help pinpoint why your modifier 22 was necessary.

Polish Your Documentation

Even if you are in the clear to use modifier 22, the physician's documentation may not be strong enough to merit the extra reimbursement. Take the example under Myth 2 of a laparoscopic appendectomy that converts to an open appendectomy. Suppose the op note for that procedure details the appendix removal itself, a sentence or two about the spreading of purulent fluid and the physician's attempt to remove it before finishing the surgery.

Experts warn: Based on this documentation, I would not add modifier 22, Bucknam says.

What's missing: "The op note does not address the work related to the purulent spillage in any particular way," Bucknam says. One way to better demonstrate the additional work would be to mention the amount of extra time required to perform the unusual services. The op note should emphasize "the additional work of multiple washouts with a detailed description of inspection of the abdominal cavity for sites of infection or that other steps were taken to minimize the chance of future infection," Bucknam recommends.

Bottom line: No matter how complicated a procedure the surgeon records, if the documentation doesn't explain why the procedure was at least 25 percent more extensive than a typical procedure, you may as well leave your money on the table.

Extra help: If the doctor tells you that a procedure took an unusual amount of time and wants you to append modifier 22, record how long the surgery actually took versus how long it should have taken. The best way to prove this in documentation is to find out how long the OR was booked and then compare it to the anesthesia record.

Smart idea: You're better off sending a modifier 22 claim by paper and with a cover letter because your carrier may automatically reject electronic submissions. But sending paper claims only could create timely filing issues.

Experts recommend submitting modifier 22 claims both by paper and electronically. Careful: You'l lose the

reimbursement if your carrier thinks you claimed something twice. Solution: Mark clearly on your paper claim: "documentation copy only, not a duplicate claim; already submitted electronically."