Part B Insider (Multispecialty) Coding Alert

Slash Denials On Modifier -22 And Unlisted Procedure Claims With These 4 Tips

Documentation is key to reimbursement, but first you need to know when - and when not - to append modifier -22

Most coders are no stranger to denied claims with unlisted procedures or modifier -22, but you can secure payment on the first try by simply knowing what documentation to attach.

When your physician's efforts during a procedure go beyond the usual description for the procedure code, you have two choices: use an unlisted procedure code or append modifier -22 (Unusual procedural services). Deciding which coding route to take is your first challenge when faced with this situation - and there are separate circumstances under which you should use each option.

Distinguish the Differences

Extra time and effort: You should append modifier -22 when your physician performs a procedure that has an assigned CPT Codes, "but unusual circumstances cause it to be more difficult or complicated," says **Lynn M. Anderanin, CPC**, director of coding and appeals at **Healthcare Information Services** in Des Plaines, IL. Examples of unusual circumstances include "excessive blood loss, altered anatomy, and previous surgery that has caused adhesions and/or scar tissue," she notes.

Some experts recommend this general rule of thumb: Append modifier -22 when the physician spent at least 25 percent more time/effort than usual to perform the procedure.

Entirely different procedure: You should report an unlisted procedure code when there is no specific CPT code to describe the procedure your physician performed, Anderanin says. In some cases the physician may plan on performing a listed procedure, but extra work and unusual circumstances are so extensive that the procedure turns into an entirely different service.

Using modifier -22 is not appropriate in these cases because the original CPT code does not provide an accurate description of the new service. Instead, you should select the best unlisted code to describe the procedure - for example, 43289 (Unlisted laparoscopy procedure, esophagus).

Expect Payment Delays

Many carriers can't automate the processing of claims with unlisted codes or modifier -22 because there are no consistent or standardized payment criteria they can apply. Carriers therefore suspend these claims for manual review and pricing - and the person reviewing will want to see an operative note or a procedure report before making a payment decision.

Payment difference: If your claim with modifier -22 gets denied, the carrier will still pay you the fee for the procedure code alone. Then you can appeal for the additional deserved reimbursement. However, if a payer denies your claim for an unlisted procedure code, you may not receive any reimbursement until you complete the appeal.

Always appeal: "We automatically appeal any claim with a modifier -22 and any unlisted procedure paid under 80 percent of [our] charge," Anderanin says. If you provide solid documentation, you should receive additional reimbursement for most appeals.

Get Paid on the First Try With Good Documentation

Preparing a claim for an unlisted procedure or modifier -22 takes a lot of work because of documentation requirements - which is why you should strive to code the claim right the first time and avoid toiling with denials. Use these expert documentation tips to help master unlisted procedure and modifier -22 claims:

1. Underline important op notes. You should send both a copy of the operative notes and a separate explanatory letter from the physician when trying to justify unusual procedural services or an unlisted procedure. Make sure your physician knows to clearly document the procedure he performs so you have supporting evidence for your claim. Then, before sending your claim, underline the information in the op note that explains the unusual procedural services.

Bad idea: Billers sometimes highlight the important sections of the op note, but these marks usually don't show up well when the payer scans the document into its system. To make sure the carrier can easily locate the most important parts of the op note, experts recommend you underline. Or make things easy on yourself by including a separate section on your operative notes for special circumstances - this way your physician can include all the pertinent information here.

2. Include physician explanation. In addition to the operative notes, you should "request a letter from the physician further explaining the procedure," Anderanin says. The physician's letter should explain the unusual amount of work that merits modifier -22 or the unlisted procedure that he performed.

For modifier -22 claims, you may also want to ask your physician to explain the usual procedure and usual time for completion so the claim reviewer has a way to quantify the additional work/time you're trying to get paid for.

Special forms: Some carriers have a specific form for the physician to fill out and send with claims using modifier -22, so check with your carriers to see if such a form is available. The form will ask for all the necessary information for the carrier's claim review.

3. Avoid medical jargon and complex terminology. Remember that a nurse or other claims reviewer with little medical knowledge will be reviewing your claim and making the payment decision. The operative note you send doesn't need to use simplified language, but the physician's explanatory letter should describe the procedure and special circumstances in layman's terms with only simple medical terminology. You may even want to include pictures or charts to help explain the procedure.

Bottom line: If the person making the payment decision can't readily understand what the physician did, there's little chance you'll receive the reimbursement you deserve.

4. Determine price before submitting your claim. If you don't assign and explain a fee for your physician's services, chances are the carrier will arrive at a figure lower than what you deserve.

Compare Complexity for Unlisted Procedures

"The best way to price an unlisted procedure is to sit down with the physician and decide how much time it took him and if there is a CPT code that describes a very similar procedure," says **Catherine Brink, CMM, CPC**, president of **HealthCare Resource Management Inc.** in Spring Lake, NJ. If an established CPT code describes a similar procedure of comparable complexity, then go ahead and compare it to your unlisted procedure.

For example, your physician might write in his explanatory letter "'the unlisted procedure is XX percent more complicated than procedure XXXXX' - and assign the fee accordingly," Anderanin says.

New technology catch: If the unlisted procedure your physician performed uses emerging technology and a whole new technique, you shouldn't try to compare it to a listed CPT code - that just doesn't make sense, Brink says. Instead, simply have the physician explain the procedure and base your pricing on the amount of time, work and other costs that went into performing the service, she says.

Add Additional Percentage for Modifier -22

For modifier -22 claims, you should increase your fee commensurate with the extra work your physician performed by asking for an additional percentage. For example, if the usual practice fee is $1,000 and you decide your physician's service deserves 30 percent more, ask for $1,300.

Little-known fact: Some practices have negotiated into their insurer contracts a fixed percentage for additional reimbursement on modifier -22. A fixed percentage guarantee can ensure you adequate payment so long as you provide adequate documentation.

Or, you may decide to simply establish a fixed percentage increase for all modifier -22 claims your office reports. For example, Anderanin says "we add an additional 25 percent to our normal charge."