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Eli's Rehab Report

5 Tips to Speed Your Modifier -22 Payment

If you're submitting a claim for unusual procedural services without first determining how you are going to defend that claim, chances are your case won't hold up with the payer - unless you use this defense crafted by coding experts.

"The careful and proper usage of modifier -22 (Unusual procedural services) can be an invaluable tool in obtaining proper additional reimbursement for surgical services," says **Arlene Morrow, CPC, CMM, CMSCS**, a coding specialist and consultant with AM Associates in Tampa, Fla. But coders, beware: Overuse of this modifier
may be a red flag to carriers monitoring claims coded for the purpose of obtaining improper payment, she says.

CPT guidelines indicate that "when the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier '-22' to the usual procedure code." And conveying to the carrier that a procedure was truly "greater than that usually required" is crucial for claims with modifier -22 because, when approved, these claims will yield additional reimbursement. No payer wants to dish out extra dough - in many cases an additional 20 to 25 percent more than their standard payment - without being certain there is just cause for the additional pay.

Morrow recommends developing "written policies and procedures for consistent coding and documentation application" as your standard plan of attack when submitting claims with modifier -22. And you should be sure your plan of attack contains these five elements:

1. Develop an 'Unusual' Argument

CPT designed modifiers to represent the extra physician work that is involved in performing a procedure because of extenuating circumstances involved in a patient encounter. Modifier -22, in particular, represents those extenuating circumstances that don't merit the use of an additional or alternative CPT code, but instead raise the reimbursement for a given procedure, explains **Cheryl A. Schad, BA, CPCM, CPC**, owner of Schad Medical Management in Mullica, N.J.

For example, a patient presents for joint injections (20600-20610) to six sites due to osteoarthrosis (715.0x, Osteoarthrosis, generalized). Because most carriers limit practices to five joint injections per day per patient, you should append modifier -22 to your claim, along with an explanation of why the patient required more than five injections.

Utah Medicare's joint injection policy, for example, states, "Additional procedures, beyond five, may be allowed when the code(s) is billed with a -22 modifier and the documentation submitted with the claim (or in the narrative free form area) adequately explains the patient's history and the extenuating condition, which would warrant additional coverage."

Most payers - including Medicare - subscribe to the policy that unusual operative cases can result from the following circumstances outlined by The Regence Group, a Blue Cross Blue Shield carrier association:
1. Excessive blood loss for the particular procedure
2. Presence of excessively large surgical specimen
3. Trauma extensive enough to complicate the particular procedure and not billed as additional procedure codes
4. Other pathologies, tumors, malformation (genetic, traumatic, surgical) that directly interfere with the procedure but are not billed separately
5. Services rendered that are significantly more complex than described for the CPT code in question.

Other circumstances that may merit the use of modifier -22 include morbid obesity and significant scarring or adhesions, experts say.

If the procedure performed meets any of these criteria, you may want to consider appending modifier -22 to the CPT

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code representing the service that was adversely affected or prolonged by unusual circumstances. Whether you decide to append modifier -22 will depend on what you find in the documentation.

2. Document the Evidence

"The key to collecting additional reimbursement for unusual or extended services is all in the documentation," Schad says.

Sometimes a physician will tell you to append modifier -22 to a procedure because he did "x, y and z," she says, but when you look at the documentation, the support just isn't there.

Suppose your physiatrist performs a facet joint injection for a patient who is under anesthesia. If the physiatrist encounters difficulty performing the injection due to excessive scarring at the injection site and spent 40 percent more time than usual with the patient, he might consider reporting 64470-22 (Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level).

For every claim with modifier -22, you should submit a paper claim and procedure report, Schad instructs coders. The procedure 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, Morrow adds.

Morrow recommends that every operative note have a separate section such as a "Special Circumstances" section in which the physician must indicate when a procedure is significantly more difficult than anticipated.

The hitch: There's a good chance that the person employed by the insurance carrier to review your claim is not a medical professional. So you have to translate what your physician performed into quantifiable terms, Schad says. Getting a claim for modifier -22 "is very subjective, and it depends on the utilization reviewer or the claims reviewer," Schad says. And there is a good chance that the reviewer isn't as well versed as you in the medical profession, she adds.

3. ... in Payer Lingo

Your chart notes do not have to cater to the carrier receiving the claim, but an additional note from the physician to the insurance carrier should. Some carriers have specific forms for the physician to fill out and send with claims using modifier -22. Georgia Medicare, for example, provides practices with a "Modifier -22 Explanation Form" that will "help in reviewing your claim."

If your carrier does not have a form specifically for modifier -22 claims, the physician should write a letter explaining the unusual amount of work in layman's terms.

The letter should state the patient's name, health insurance identification number, the procedure date, the requested percent increase for the procedure fee, and the circumstances behind the request to justify the percentage increase above the customary fee. You should also use two or three paragraphs to justify why the procedure was unusual using "simple medical explanations and terminology, realizing that the letter will (hopefully) be read by a nurse or other reviewer."

You should also include the typical average circumstances or time for completion and compare it to the actual circumstances. Schad recommends that you send two procedure reports: one for the unusual procedure, and another for the same procedure but that would not be considered unusual. The reviewer can then compare a typical facet joint injection, for example, to the one you are trying to have paid.

You should refer to the following factors when trying to convey unusual procedural services to a non-medical professional:

1. Time: Time is quantifiable, making it easy for a carrier to convert into additional reimbursement. For example, statements such as "50 percent more time than usual was required to perform debridement because of the patient's

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obesity, making the total procedure 1.5 hours instead of 30 minutes" can be very effective.

2. Blood loss: Document the quantity of blood lost during the procedure and compare it to what is typically lost during the same type of procedure. For example, include statements like "1,000 ccs of blood, rather than the standard 100 ccs of blood, were lost during the procedure."
3. Special instruments: Compare the instruments or equipment used to perform the procedure to those typically used.
4. Technique: Clearly indicate when there has been a change in technique during the procedure and, more important, why there was a change in technique.

4. Wait for the Verdict

Don't be surprised if your claim takes a long time to be processed - and brace yourself, because there is a definite possibility that your request for additional reimbursement will be denied.

Even though you may not receive what you request, "it is very important to increase your fee commensurate with the extra work value," when submitting claims for modifier -22, Morrow advises coders.

If the fee you request is low, carriers may gladly pay it, but if you ask for a fee they consider too high, they may consider the request absurd, Schad says.

Ask for an additional percentage: For example, if the usual practice fee is $100 and you decide the fee should be increased by 30 percent, ask for $130, Morrow says. "Some practices prefer to request an additional fixed dollar amount, for example $30 in the prior example." She lets coders in on the secret that "many practices have negotiated into their managed-care contracts a fixed percentage for additional reimbursement." For example, modifier -22 might be pegged for a 40 percent fee increase when submitted and approved for complicated cases.

Insurance companies inevitably take longer to process paper claims than electronic ones. And getting claims for modifier -22 approved can make for a laborious process, Schad says. The bottom line: "Don't bother to submit a claim for modifier -22 if you don't have the documentation - you're wasting your time and spinning your wheels because you're not going to get paid," Schad says.

5. Check Your List of Do's and Don'ts

Last but not least, make sure you run through your list of do's and don'ts before submitting your claim for payment and/or into review process:

Do include a copy of the procedure report with your claim.

Do check your carrier's local medical review policy before submitting a claim for modifier -22 - not all private payers honor this modifier.

Do use critical care codes instead of modifier -22 when appropriate.

Do be sure at least 25 percent more time/effort than usual was required to perform the procedure.

Do submit your claim on paper - claims for modifier -22 cannot be submitted electronically.

Do append modifier -22 to assistant-at-surgery procedures.

Don't append modifier -22 to secondary procedure codes.

Don't append modifier -22 to E/M codes, because you can use it only with procedural services.

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Don't use modifier -22 for re-operations.

Don't report modifier -22 simply because the physician performs a procedure via a lesser-preferred approach.

Don't substitute an unlisted-procedure code instead for modifier -22 to avoid carrier denials.

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