

Pain Management Coding Alert

Modifiers: Check Out These 5 Steps to Modifier -22 Success

The modifier won't add extra pay, but the extra time involved could.

When your pain management specialist is involved with a procedure that becomes more extensive than expected, you might be justified in adding modifier 22 (Increased procedural services) to the claim - but it shouldn't be your automatic answer. Read on for expert advice on knowing when modifier 22 can apply and how it can affect your bottom line.

Step 1: Understand What -22 Represents

According to CPT® coding guidelines, appending modifier 22 indicates that "the work required to provide a service is substantially greater than typically required." The provider's documentation must support the "substantial additional work" and the reason for the additional work.

Acceptable reasons can include increased intensity, technical difficulty, or time associated with the procedure. The severity of the patient's condition or the physical and mental effort required by the physician can also help justify modifier 22.

Guideline: CPT® does not provide specific direction on how much time and/or percentage of increased time or work the provider must document to merit modifier 22. The rule of thumb, however, is your provider must spend at least 50 percent more time and/or put in at least 50 percent more effort than normal for you to append modifier 22.

Step 2: Encourage Thorough Documentation

One effective way to demonstrate a procedure's increased nature is to compare the actual time, effort, or circumstances to your physician's typical time and effort for that particular procedure.

First: Check whether the payer has specific guidelines regarding documentation requirements for reporting modifier 22. For example, Regence Blue Shield's recommendation for documentation states, "In order to be considered for increased reimbursement, documentation from the patient's record that will support the significantly greater effort performed must be submitted with the claim. It is not sufficient to simply document the extent of the patient's illness or comorbid conditions that caused additional work. The documentation must describe additional work performed."

Example: A note such as, "The procedure required 90 minutes to complete, instead of the usual 35-45 minutes" can be helpful. Remind your providers to clearly document the reason(s) for the increased time and effort in the patient's record.

Backup: Claims with modifier 22 usually go through manual review or appeal to determine the claim's legitimacy and whether it merits extra payment. Ensure that your providers specify details in their operative notes that justify modifier 22. Some experts recommend including an additional letter from the physician (in layman's terms) explaining the case and why modifier 22 is necessary to help the insurer better understand the situation.

Step 3: Watch for -22 Opportunities

Although no procedure automatically merits modifier 22, these types of scenarios might involve additional time or effort from your physician:

- Extreme obesity that significantly complicates surgery
- Co-morbidities that can cause complications during surgery
- Revisions or removals of prior operative work that are unusually complex or difficult and for which there's not

another procedure code.

Tip: It might be beneficial to report any additional ICD-9 codes that support the circumstances surrounding the prolonged service. For example, your physician might document "Placement of tunneled lumbar intrathecal catheter and programmable infusion pump for lumbar post-laminectomy pain in morbidly obese patient (BMI 40.0). This required an additional 2 hours of surgical time due to patient size."

Step 4: Get the Payer's Input

If you think the case might justify modifier 22, talking with your payer before submitting the claim could be a good move.

"I believe before submitting the claim with the -22 and the documentation to support it - which is a must - that it's worth the extra time to call the insurance representative to explain the coding scenario and ask how the rep wants the claim sent to obtain greater reimbursement than the normal CPT® code for the procedure," says **Catherine Brink, BS, CMM, CPC, CMSCS**, president of Healthcare Resource Management, Inc., in Spring Lake, N.J.

Tip: "Always document who the coder talked to and what transpired for future reference," Brink advises.

Step 5: Know Your Payment Might Not Change

Even if you talk to a payer representative and include all the supporting documentation, studies have shown that reporting modifier 22 might - or might not - affect reimbursement.

For example, information from the American Academy of Orthopedic Surgeons states that a study watching the use of modifier 22 for various procedures (excluding charity care) showed higher reimbursement in 31 percent of cases, equal reimbursement in 36 percent of cases, and less reimbursement than the contracted level in 33 percent of cases. "The obvious conclusion is that the 22 modifier does not provide consistent additional reimbursement for complex surgery," the AAOS states.

Your call: "In my opinion, it's still worth the effort to obtain additional reimbursement to use the -22 on prolonged or unusual procedures," says Brink.