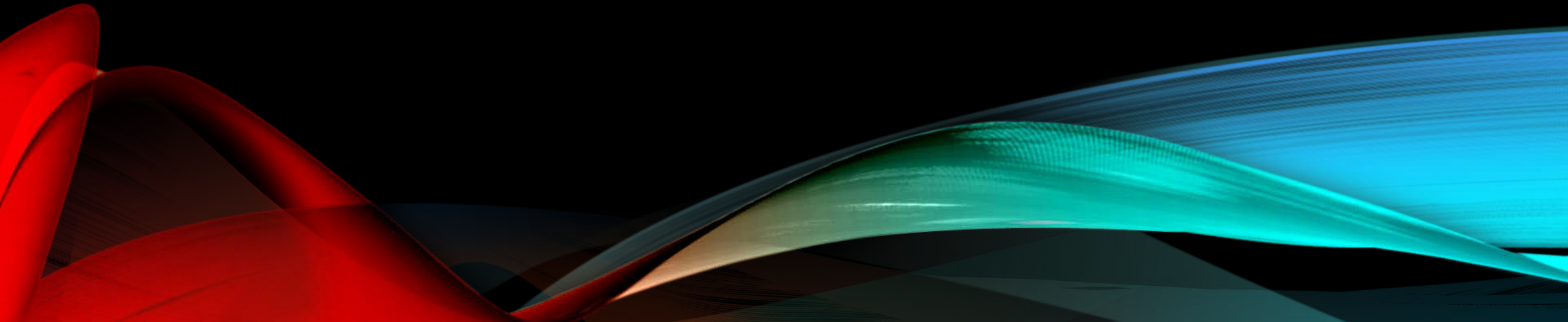




#moreNEEDEDtomodify

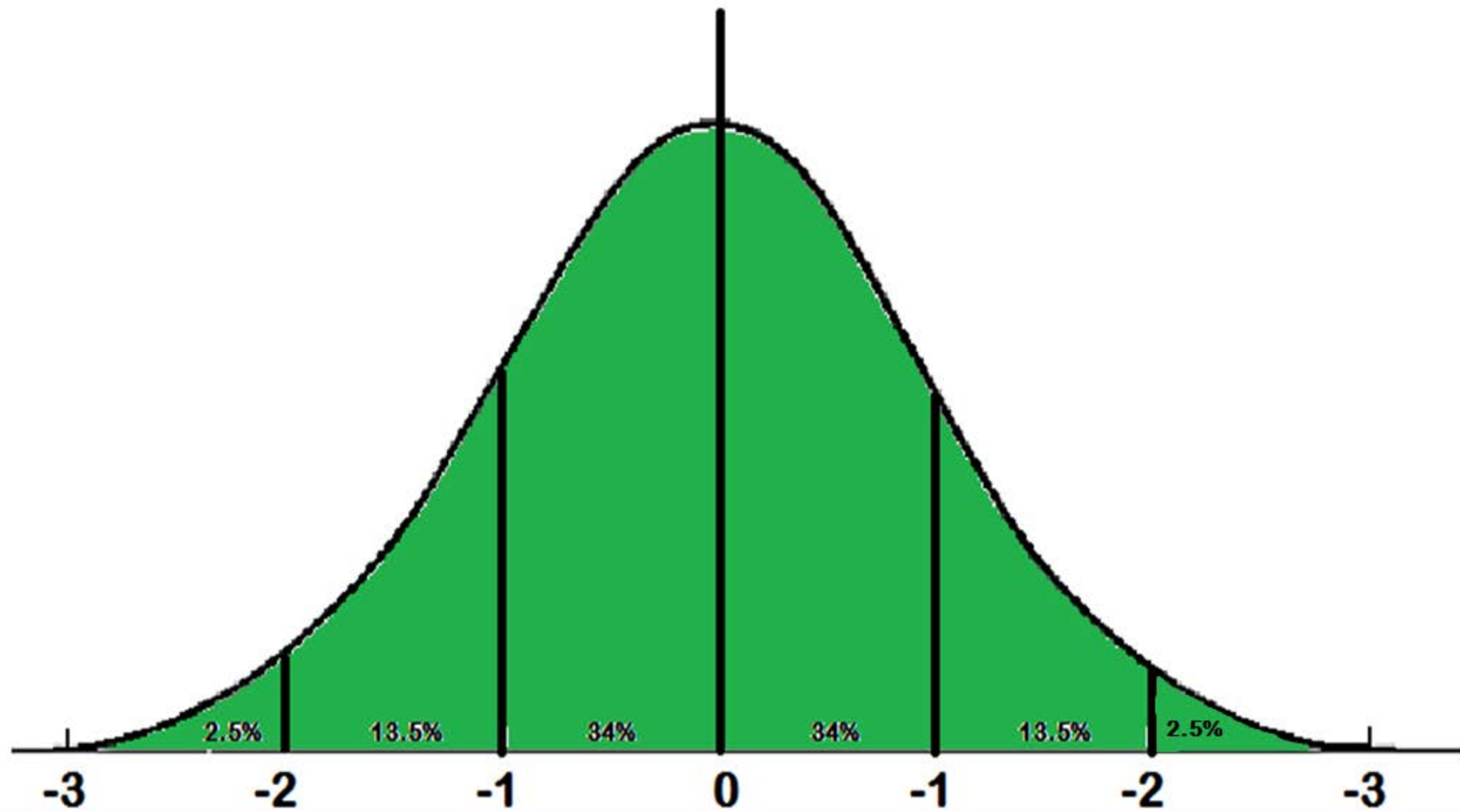
Justifying Additional
Reimbursement

Modifier 22

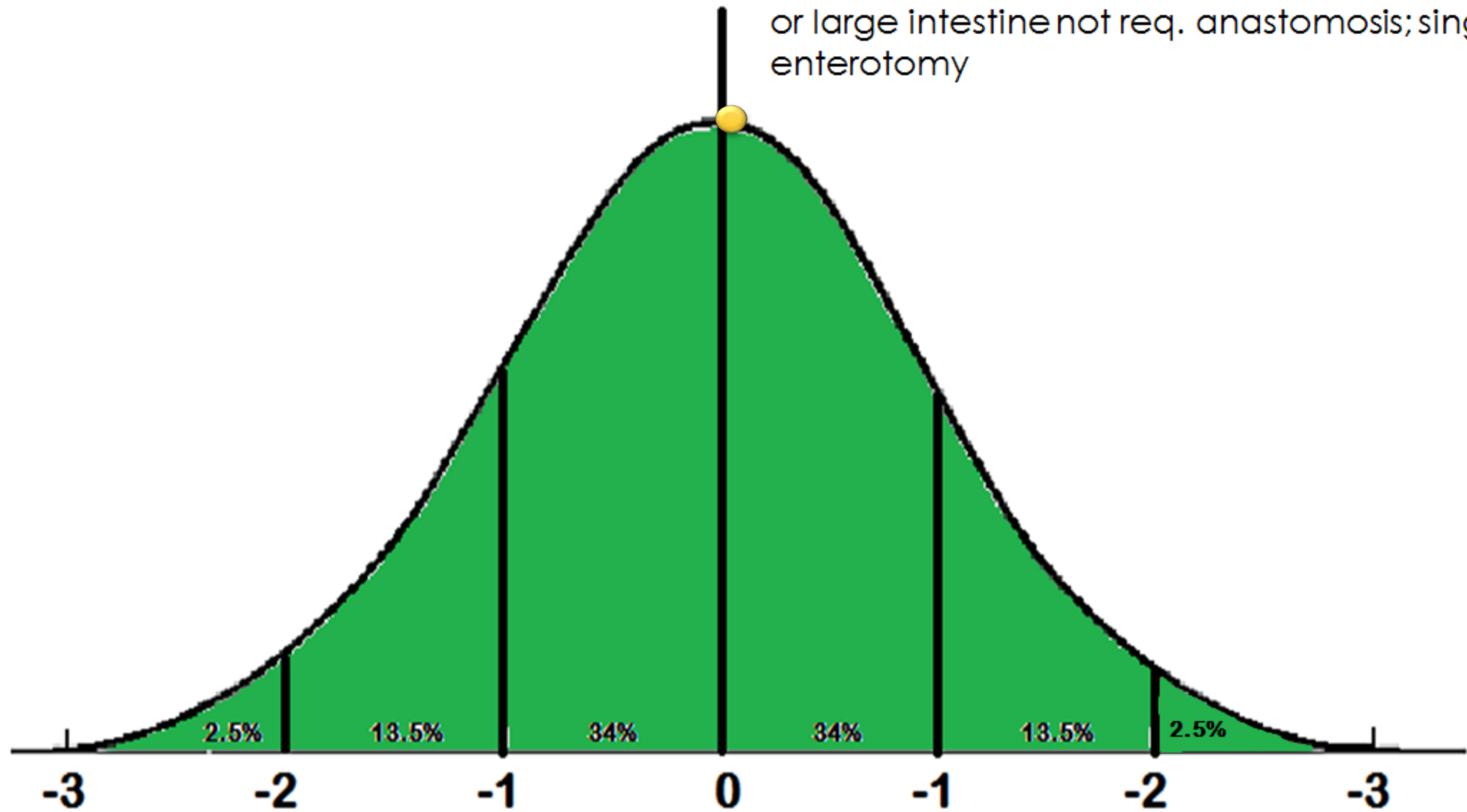


INCREASED PROCEDURAL SERVICES

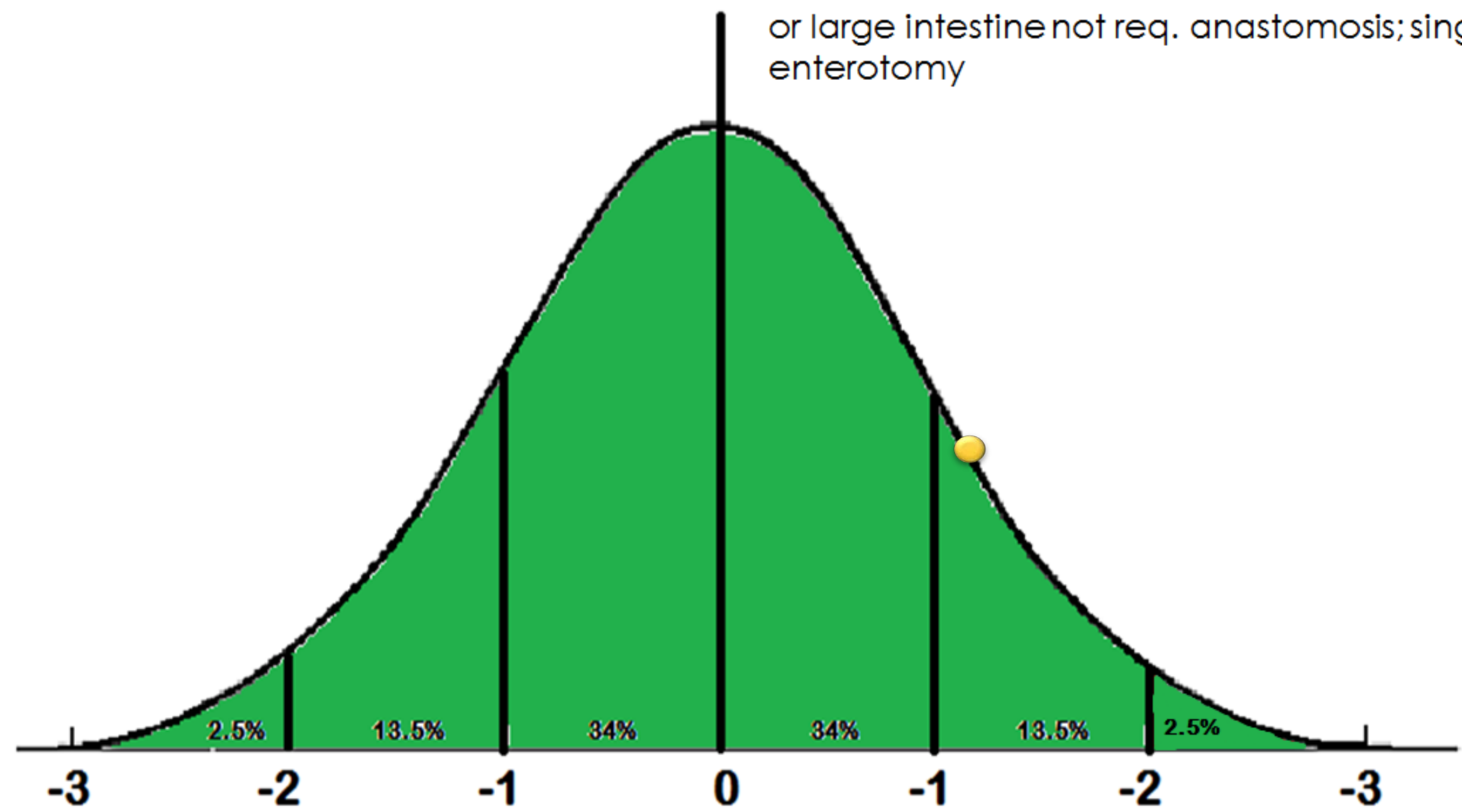
- Work required to perform a service is “substantially greater” than typically required
- Topics to address
 - What does “substantially greater” mean?
 - When is it appropriate to use?
 - What documentation is required?
 - How do we gain additional reimbursement?



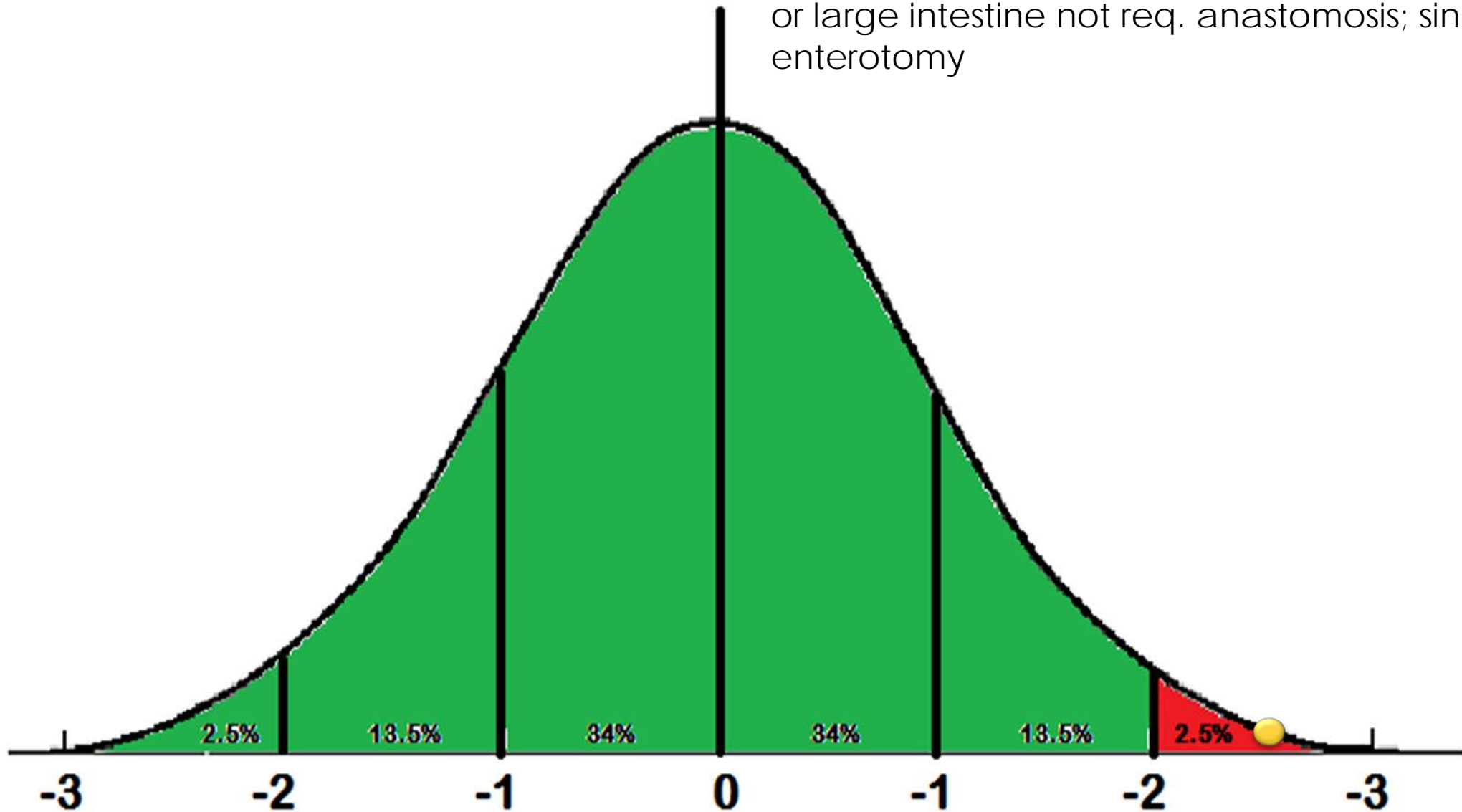
CPT 44110 – Excision of 1 more lesions of small or large intestine not req. anastomosis; single enterotomy



CPT 44110 – Excision of 1 more lesions of small or large intestine not req. anastomosis; single enterotomy



CPT 44110 – Excision of 1 more lesions of small or large intestine not req. anastomosis; single enterotomy



USE SPARINGLY

- CMS indicates that situations that warrant the modifier 22 happen infrequently among procedures that cannot be described by another CPT code
- Dissect the operative report to ensure that the additional work cannot be reported by an add-on code, or a more comprehensive code all together

WHEN IS IT APPROPRIATE?

- When additional work, not often found and not described by another code is performed with a procedure
- Procedures requiring 'substantial' additional work due to complications or intra-operative emergencies
- Examples:
 - Excessive blood loss
 - Exceptionally large tumors
 - Extensive complications
 - Resulting in increased time to perform
 - Not identified by additional codes

NCCI RULES

- Do not use 22 modifier for bundled codes
 - Use NCCI associated modifier first
 - Explore appropriateness

Code 44110



Code 44110(column 1) has a CCI conflict with code 44005(column 2). A modifier is not allowed to override this relationship.

Code	Description	Fee	Work RVU	PE RVU	MP RVU	Total RVU	Fee Type	Reason	Modifier	Primary or Secondary
44110	Excision of 1 or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy	\$885.73	14.04	7.49	3.15	24.68	Non Facility	CPT "separate procedure" definition	Not Allowed	Primary
44005	Enterolysis (freeing of intestinal adhesion) (separate procedure)	\$1,138.75	18.46	9.01	4.26	31.73	Non Facility	CPT "separate procedure" definition	Not Allowed	Secondary

WHAT SHOULD BE INCLUDED?

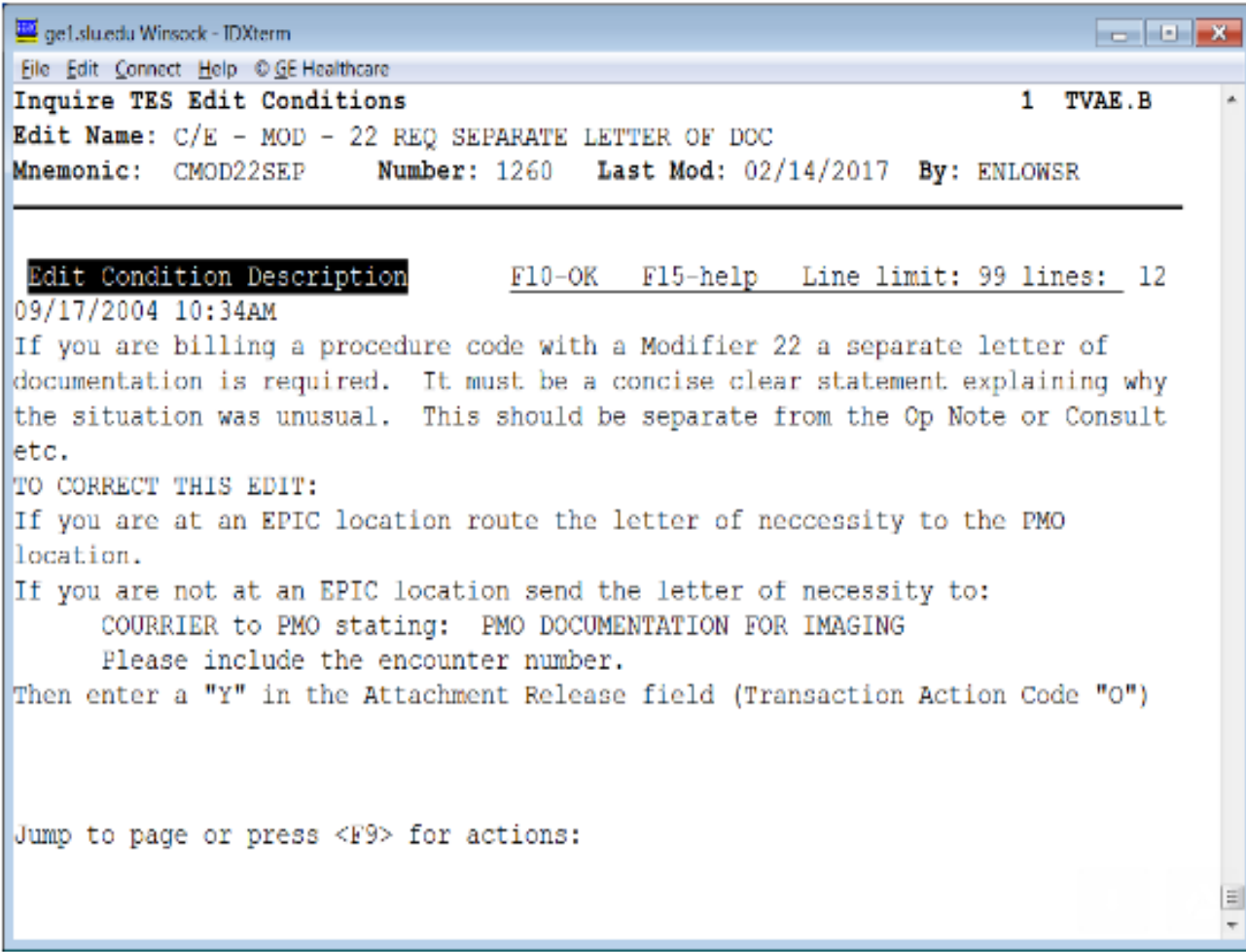
- Additional diagnoses/Co-morbidities
 - Severity of the patient's condition
- Indications for procedure
 - Including any special circumstances
- Unexpected findings
- Complications
- Increased intensity
 - Technical difficulty
 - Physical/Mental effort required

EXAMPLES

- Patient's large body habitus (320 lbs at 5'2) made the procedure technically more arduous. This made the paravertebral muscles more complicated to retract and the tumor especially difficult to access; additional staff had to be used to retract muscle properly so as to not cause injury to the spine (AAPC)
- A physician performs colonoscopy on a patient with a tortuous colon. Instead of taking the usual 30-40 minutes to complete, the gastroenterologist spends 90 minutes navigating the scope through the twists and turns of the patient's lower intestine (The Coding Institute)

BILLING PROCESS

- Modifier 22 entered on claim/charge
- Edit in IDX
- Cover letter sent to PMO
- Letter is held in imaging system until documentation request letter is received from the payer
- Cover letter and operative note sent to payer
- Medical review dept. determines amount of reimbursement is received



```
gel.slu.edu Winsock - IDXterm
File Edit Connect Help © GE Healthcare
Inquire TES Edit Conditions 1 TVAE.B
Edit Name: C/E - MOD - 22 REQ SEPARATE LETTER OF DOC
Mnemonic: CMOD22SEP Number: 1260 Last Mod: 02/14/2017 By: ENLOWSR

Edit Condition Description F10-OK F15-help Line limit: 99 lines: 12
09/17/2004 10:34AM
If you are billing a procedure code with a Modifier 22 a separate letter of
documentation is required. It must be a concise clear statement explaining why
the situation was unusual. This should be separate from the Op Note or Consult
etc.
TO CORRECT THIS EDIT:
If you are at an EPIC location route the letter of necessity to the PMO
location.
If you are not at an EPIC location send the letter of necessity to:
COURRIER to PMO stating: PMO DOCUMENTATION FOR IMAGING
Please include the encounter number.
Then enter a "Y" in the Attachment Release field (Transaction Action Code "O")

Jump to page or press <F9> for actions:
```

THE K.I.S.S LETTER

- The provider should be clear and concise as to why the case is deserving of the 22 modifier
- Do not use generalized statements
 - See operative report for details
 - Patient was morbidly obese
 - Surgery took longer than usual
- Use key terms, comparative language and details
 - Be careful not to over-explain

THE K.I.S.S. LETTER

- Operative note should support the details of the letter
- AMA recommends "Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service."
- If you don't ask for it, you won't get it!
 - How much more work did it take?
 - Name the expected price

K.I.S.S LETTER EXAMPLES

Patient Name: Regina Phalange

DOB: 12/15/1953

DOS: 01/03/2017

Member ID: 123456789

Claim Amount: \$12,859.00

To Whom It May Concern:

I am writing to request consideration for additional reimbursement for the aforementioned patient and their claim.

Ms. Regina Phalange underwent a complicated abdominal surgery that included a Colectomy with end colostomy; take down of the splenic flexure and an extensive lysis of abdominal adhesions. Ms. Phalange has several co-morbidities including COPD, hypotension, and is morbidly obese. Due to the patient's obesity and extensiveness of her adhesions the case took 4 hours to perform than the usual 2 hours.

We are asking for an additional 50% reimbursement totaling \$2,453.00. Please do not hesitate to contact my office should you have any additional questions.

Sincerely,

Dr. Drake Ramoray

K.I.S.S LETTER EXAMPLES

Patient Name: Kennedy Adams

DOB: 12/15/1985

DOS: 02/1/2017

Member ID: 987654321

Claim Amount: \$7,582.00

To Whom It May Concern:

I am writing to request consideration for an additional 30% in reimbursement for the aforementioned patient and their claim. I have enclosed the operative and pathology reports with this letter for reconsideration.

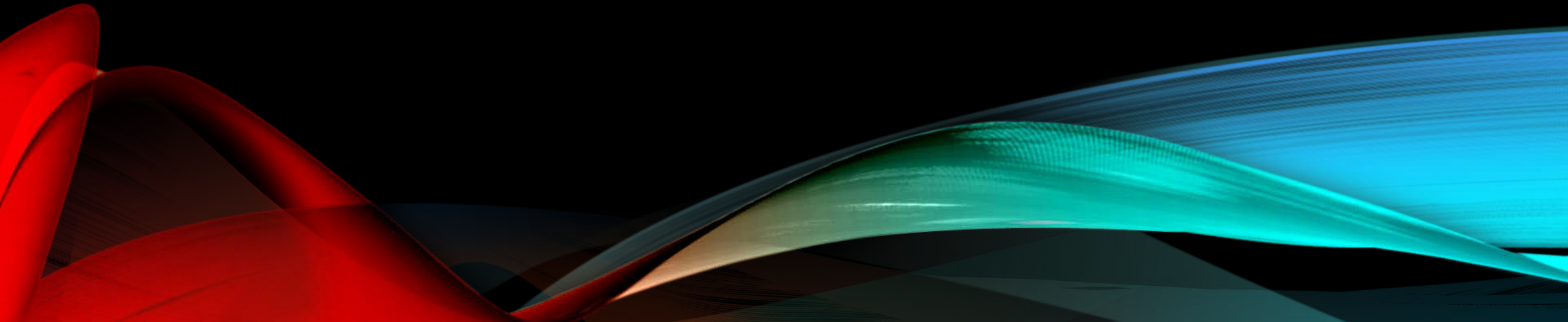
This patient was a nulligravida patient with a uterus weighing 230 grams. The average uterus size is 70 to 100 grams. Because of the uterus size it had to be removed in 23 pieces. This procedure took over 2 hours, more than twice the usual time of 45 minutes.

Thank you for your time and attention to this matter, please contact me at the number below should there be any additional questions.

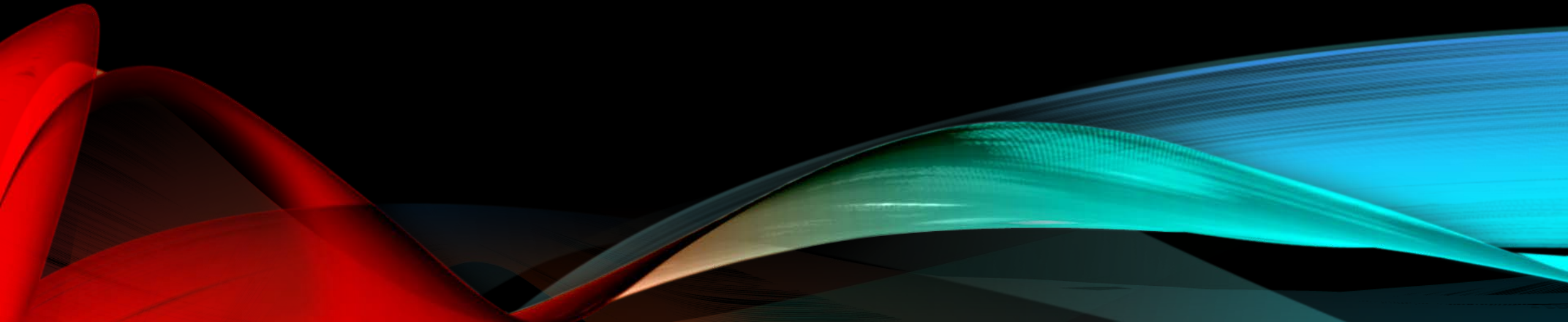
Sincerely,

Dr. Robert Bobby

Questions?



Modifiers:
80, 81, 82, AS

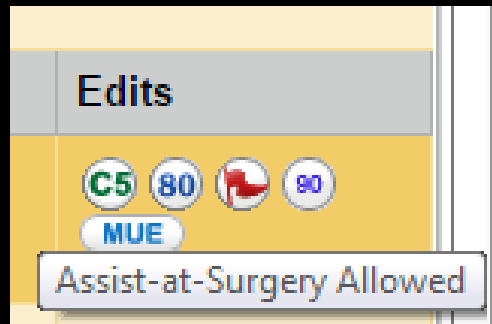


ASSISTANTS AT SURGERY

- Modifier -80 "Assistant Surgeon"
 - Apply when services are performed by a non-resident physician
- Modifier -81 "Minimum Assistant Surgeon"
 - Apply when the assistant at surgery is not present for the entire procedure
- Modifier -82 "Assistant Surgeon (when qualified resident surgeon not available)"
- Modifier – AS "Assistant at Surgery"
 - Apply when services are provided by a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS)

PAYMENT POLICY INDICATORS

- Certain procedure are payable for assistant surgeon charges
- Find payment policy indicators on MPFSD and Encoderpro.com
 - 2 – payments restrictions do not apply
 - 0 – payment restrictions DO apply, supporting documentation needed
 - 1 – Statutory payment restrictions apply, no payment will be made



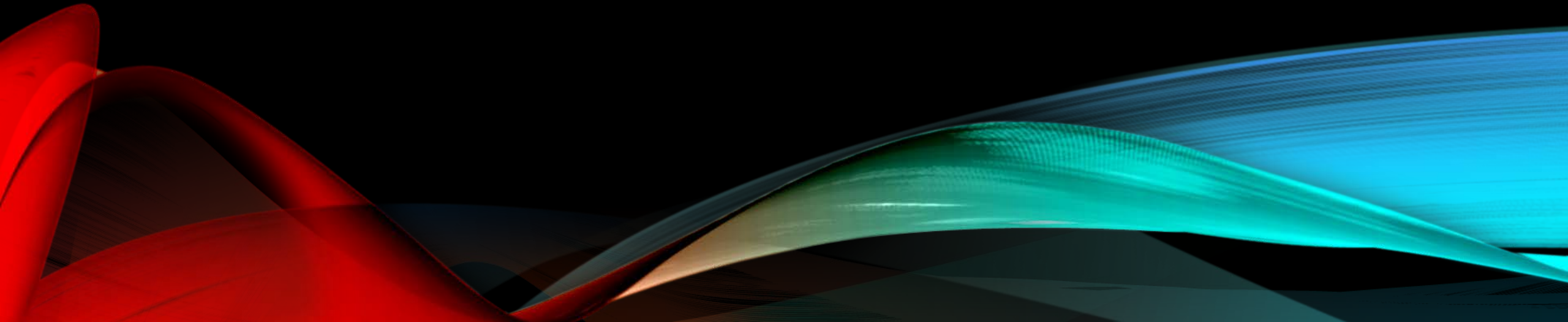
DOCUMENTATION REQUIRED

- Documentation must support the services and medical necessity of the assistant surgeon
- Operative report should describe
 - Name and credentials of assistant
 - Assistant's role and activities during surgery
- Assistant Surgeon does NOT need to document their own account of the case

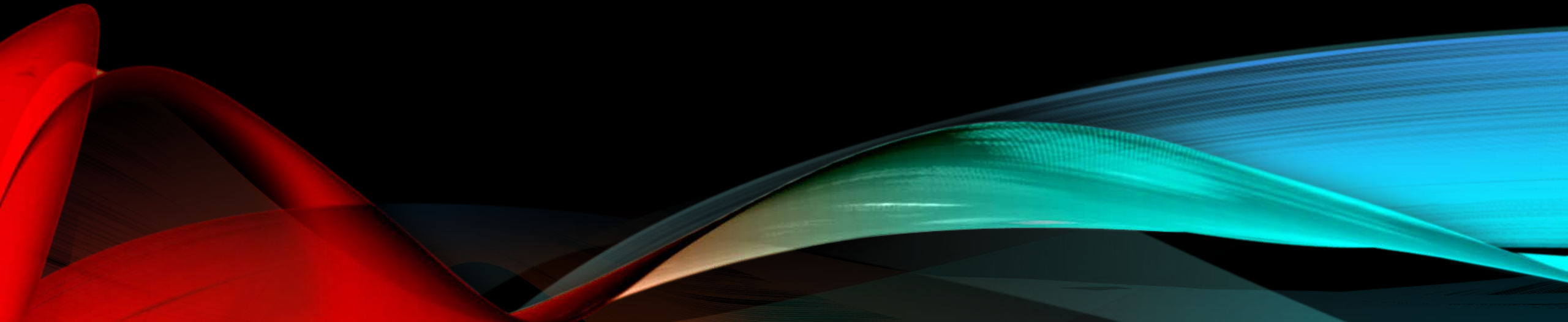
THE TEACHING PHYSICIAN ENVIRONMENT

- CMS IOM states:
 - Carriers will not pay for an assistant surgeon's charges if the teaching hospital has a training program related to the medical specialty require for the surgical procedure and a qualified resident is available unless certain criteria are met:
- Exceptional Circumstances
 - Emergency life-threatening situations
- Physicians Do Not Involve Residents in Patient Care
 - Preoperative, operative or post-operative care
- Multiple Physician Specialties Involved in Surgery
 - Team surgeries

Questions?



Modifier 62



CO-SURGERY

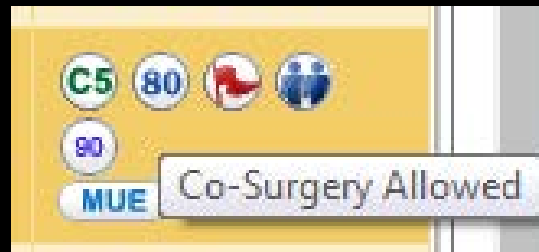
- When two surgeons work together to perform distinct portions of a procedure, each surgeon reports the same CPT code with modifier 62
- Example:
 - Surgeon A is called to perform the opening and closing of the operative field during a procedure
 - Surgeon B performs the definitive procedure

DO NOT USE IF...

- Physicians are of the same specialty
- When surgeons of different specialties are each performing a different procedure
- When a co-surgeon acts as an assistant at surgery

PAYMENT POLICY INDICATORS

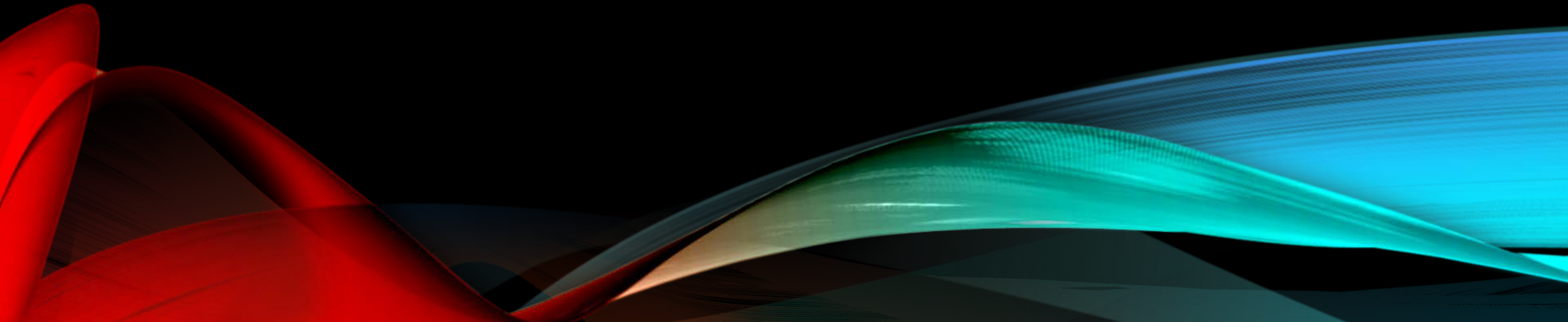
- Certain procedure are payable for co-surgery charges
 - Know your payers
- Find payment policy indicators on MPFSD and Encoderpro.com
 - 1 – Co-surgery allowed with documentation
 - 2 – Co-surgery allowed if each surgeon is of a different specialty
 - 0 or 9 – Co-surgery is not allowed



BILLING AND DOCUMENTATION REQUIREMENTS

- Each surgeon bills the same CPT code
 - Append 62 modifier
- Each surgeon will provide their own documentation of the portion of the procedure they performed
 - Documentation should support the medical necessity and need of two surgeons
- Does not apply when two surgeons, regardless of their specialties, perform distinct procedures (different codes)

Questions?



RESOURCES

- American Academy of Professional Coders Knowledge Center
- Centers for Medicare and Medicaid Services
- Optum 360: 2017 Auditor's Desk Reference
- The Coding Institute (supercoder.com)
- www.wpsgha.com