April 17, 2014

Montana Health Care Programs Notice

Professional Claim (CMS-1500) Billers

Modifier Changes

Effective July 1, 2014, there will be reimbursement changes to what is known as "by-report" modifiers. By using a "by-report" modifier on the claim line, the line is priced at a percentage of the charges rather than a percentage of the fee for that service. Montana Medicaid has two "by-report" modifiers: 66 (Surgical Team) and 22 (Increased Procedural Services).

Modifier 66 – Surgical Team

This modifier is rarely used and when used, the "by-report" reimbursement methodology creates confusion in the provider community. This modifier will now be used for informational purposes only thereby allowing reimbursement to be the fee for the service that was provided.

Modifier 22 – Increased Procedural Services

When the work required to provide a service is **substantially greater** than typically required, it may be identified by adding Modifier 22 to the procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, and physical and mental effort required). This modifier should not be appended to an evaluation and management service.

This modifier should be used only when **significantly more** work, time, and complexity than normal is required for a procedure. The reimbursement for a procedure without Modifier 22 already takes into account that sometimes the procedure will require more work, time, and complexity than normal but not **significantly more** work, time, and complexity than normal.

In some circumstances, surgeons perform services or procedures that entail significantly greater physician work than described by the CPT code descriptor. In many cases, there are not additional or add-on codes to describe the significantly increased complexity of the services. In these cases Modifier 22 should be appended to the CPT code.

Modifier 22 is appropriate in reporting unusual operative cases, such as:

- Trauma extensive enough to complicate the particular procedure and cannot be billed with additional procedures; or
- Significant scarring requiring extra time and work.

Modifier 22 **is not** appropriate in the following cases, such as:

- Use of Modifier 22 is prohibited for mental health services. On January 1, 2013, the CPT manual added two codes specifically for crisis with instructions and guidance for providers.
- If the cause of the complication results from the surgeon's choice of approach (e.g., open versus laparoscopic).

Effective July 1, 2014, when Modifier 22 is appended to a procedure code, the service will be reimbursed at one hundred ten percent (110%) of the fee for that service. This method of reimbursement will allow consistent enhanced reimbursement for a service that requires substantially more work by the provider.

Notes are not required to be attached to the claim when it is submitted with Modifier 22 appended to a procedure code. However notes will be requested if the claim is selected for post payment review.

As always, code appropriately.

Contact Information

If you have any questions concerning this provider notice, please contact the Physician Services Program Officer at 406-444-3995.

For claims questions or additional information, contact Provider Relations at 1-800-624-3958 (toll-free, in/out of state) or 406-442-1837 (Helena) or via e-mail at MTPRHelpdesk@xerox.com.

Visit the Provider Information website at http://medicaidprovider.hhs.mt.gov.