Head & Neck Reimbursement Guide

Modifier 22

CHECKPOINT® Head & Neck

Checkpoint is a handheld, single use device that provides useful intra-operative feedback regarding the location, identification and excitability of nerves and muscles for surgeons.

Checkpoint
Head & Neck™

Introduction

The information contained in this document is provided to assist hospitals and providers to understand reimbursement guidelines related to various surgical procedures. It is not intended to increase or maximize reimbursement.

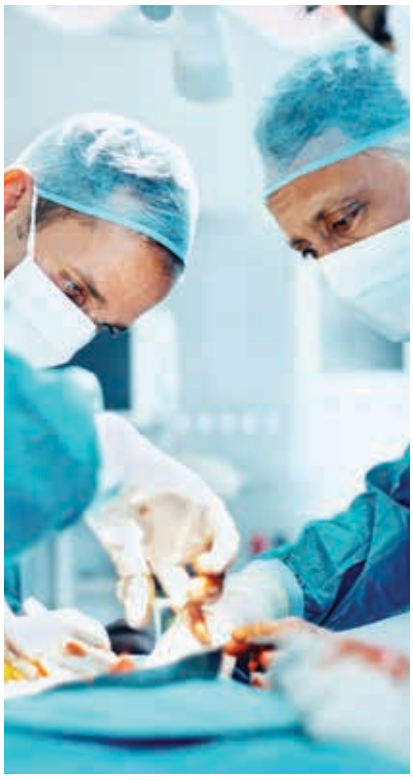
The information referenced is based upon coding experience and research of current coding practices, professional society recommendations and published payer policies. They are based upon commonly used codes and procedures. The final decision for coding of any procedure must be made by the provider of care considering the medical necessity of the services and supplies provided, the regulations of insurance Medicare Administrative Contractors (MACs) and any local, state or federal laws that apply to the supplies and services rendered.

Although a particular service/supply may be considered medically necessary, the final coverage decision is based upon a review of the available clinical information and does not mean the service or supply will be covered. Each payer provides its own specific provisions for coverage and exclusions. Please consult individual payers to determine policy specific guidelines and determine if any exclusions or benefit limitations are applicable.

- > Always code appropriately based upon procedures performed and medical necessity
- > Be aware of local coverage policies and correct coding initiative quarterly updates
- > Actual reimbursement will vary by geographic region and payer
- > Contact payers and Medicare Administrative Contractors for specific coding guidelines/limitations
- > This information is provided for educational purposes only

Use of Modifier 22

Increased Procedural Service requiring work substantially greater than typically required



When performing a procedure that is substantially more difficult, more time consuming, or more intense than normally expected, and there is no alternative CPT codes that better describe the procedure performed, modifier 22 (increased procedural service) may be considered. Charges for the procedure should be adjusted to reflect the additional cost associated with the procedure. Payers may consider additional payment if the procedure is clearly out of the range of ordinary difficulty, representing an unusual circumstance. These claims are considered by the payer, on a case by case basis. There is no established percentage of additional reimbursement and reimbursement will be determined based upon documentation describing the unusual difficulty encountered. Additional reimbursement may, or may not be, approved.

Modifier 22

Modifiers should be used only when additional work factors requiring the physician's technical skill involve significantly increased physician work, time, and complexity than when the procedure is normally performed. Additional time alone is not a reason to report the modifier 22.

There are four reasons that a surgical procedure would warrant the use of modifier 22. Medical records must reflect the increased involvement of the physician and/or the extra physical or mental effort required by the surgeon.

1. **Increased intensity:** Document the additional percentage of intensity necessary that supports the use of the device during surgery.
2. **Increased surgical time:** Procedures that typically support the use of the modifier have increased surgical (OR) time of 20-50%.
3. **Increased technical difficulty:** If the surgeon utilizes a technique that has a higher degree of difficulty and is not the procedure normally performed, and the procedure requires this technique to support an improved patient outcome, document the reason in the clinical record to support the use of modifier 22.
4. **Increased severity of patient's condition:** If the use requires the surgeon to exert more physical and/or mental effort to reach positive outcome for the patient, the modifier 22 may apply. Anatomical variants may support the use of the modifier for a patient.

Documentation

Documentation is the key to successful use of modifier 22. The surgeon may include the following details in the patient's clinical record:

- Detailed description of the procedure
- Additional diagnosis
- Pre-existing conditions
- Unexpected findings
- Complications
- Additional effort required

Documentation may be requested by the payer and must support the substantial work and reason for the additional work (such as increased intensity, time, technical difficulty, severity of patient's condition, and/or physical or mental effort required).

When providing documentation to the payer, submit it with a cover letter outlining the procedure and extenuating circumstances that support the use of the modifier 22. In the letter, recommend the appropriate cost for the additional work effort and provide supporting documentation when available.

On the CMS-1500 form, indicate "additional information available upon request" in the narrative section (field 19 or loop 2300 NTE for claim level or loop 2400 NTE for line item) in the electronic claim.

Generally, the payer will send a request for additional information. Documentation requested may include the operative report and a statement indicating how the procedure/surgery differs from the usual service reported by this CPT code.

Coding Methodology

The Physicians' Current Procedural Terminology (CPT) developed by the American Medical Association (AMA) and HCPCS Level II codes developed by the Centers for Medicare and Medicaid Services (CMS) are listings of descriptive and identifying codes for medical services and procedures performed by health care providers and reported to third party MACs. The codes in the CPT Manual are copyrighted by the AMA, and updated annually by the CPT Editorial Panel.

Third party payers have adopted the CPT coding system for use by providers to communicate payable services. Therefore, it is important to identify the various potential combinations of services to accurately adjudicate claims.

In order for this system to be effective, it is essential the coding description accurately describes what actually transpired at the patient encounter. Because many physician activities are so integral to a procedure, it is impractical and unnecessary to list every event common to all procedures of a similar nature as part of the narrative description for a code. Many of these common activities reflect simply normal principles of medical/surgical care.

Precertification/Prior Authorization

Since coverage is based upon the patient's individual plan, regardless if there is a published medical policy, we highly recommend precertification with all commercial payers to not only verify the individual benefits, but to also determine if prior authorization or predetermination is a requirement for the surgical procedure performed.

Correct Coding Initiative

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (CCI) to ensure that payment policies and procedures were standardized for all MACs and to promote national correct coding methodologies. The coding policies developed are based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practice and reviews of current coding practice.

Procedures should be reported with the CPT/HCPCS codes that most accurately and comprehensively describe the services performed.

Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code or when a single payment episode is split into two or more episodes so multiple payments can be collected.

The National CCI edits have been developed for application to services billed by a single provider for a single patient on the same date of service. The National Correct Coding Initiative represents a more comprehensive approach to unifying coding practices. Quarterly updates are available for hospitals and physicians. Updates can be located on the web at: http://www.cms.hhs.gov/NationalCorrectCodInitEd/

Commonly Reported Head & Neck Codes

CPT Code	Short Description
21013	Exc face tum deep < 2 cm
21014	Exc face tum deep 2 cm/>
21015	Resect face tum < 2 cm
21016	Resect face tum 2 cm/>
21025	Excision of bone lower jaw
21026	Excision of facial bone(s)
21030	Excise max/zygoma b9 tumor
21034	Excise max/zygoma mal tumor
21040	Excise mandible lesion
21044	Removal of jaw bone lesion
21045	Extensive jaw surgery
21047	Excise lwr jaw cyst w/repair
21240	Reconstruction of tmj wwo autograft
21242	Reconstruction of tmj, with allograt
21243	Reconstruction of tmj, with prosthetic joint replacement
21244	Reconstruction of mandible
21299	Unlisted, Cranio/maxillofacial surgery
21554	Exc neck tum deep 5 cm/>
21556	Exc neck tum deep < 5 cm
21557	Resect neck tum < 5 cm
21558	Resect neck tum 5 cm/>
21899	Neck/chest surgery procedure
38510	Biopsy/removal, open, deep cervical
38520	Biopsy/removal, open, deep cervical w/ exc. Scalene fat pad
38542	Dissection, deep jugular
38555	With deep neurovascular dissection
38745	Axillary lymphadenectomy; complete
42410	Excise parotid gland/lesion, lateral lobe;
42415	Lateral lobe, with dissection and preservation of facial nerve
42420	Total, with dissection and preservation of facial nerve
42425	Total, en bloc removal with sacrifice of facial nerve

CPT Code	Short Description
42426	Total, with unilateral radical neck dissection
42440	Excision of submandibular gland
64864	Repair of facial nerve, extracranial;
64865	Infratemporal, wwo grafting
64868	Fusion of facial/other nerve ; facial-hypoglossal
69955	Release facial nerve, and/or repair (may include graft)
60200	Remove thyroid lesion
60210	Partial thyroid lobectomy, unilateral; with or without isthmusectomy;
60212	; with contralateral subtotal lobectomy, including isthmusectomy
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy;
60225	; with contralateral subtotal lobectomy, including isthmusectomy
60240	Thyroidectomy, total or complete
60252	Thyroidectomy, total or complete for malignancy; with limited neck dissection;
60254	; with radical neck dissection
60260	Repeat thyroid surgery
60270	Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach;
60271	Thyroidectomy, including substernal thyroid; cervical approach
60500	Parathyroidectomy or exploration of parathyroid(s);
60502	Parathyroidectomy or exploration of parathyroid(s); re-exploration
64716	Neuroplasty and/or transposition; cranial nerve (specify)
64722	Decompression, unspecified nerve(s) (specify)
64727	Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)

Sample Operative Note Key Points Checkpoint Stimulator

Introduction

The following sample operative notes are provided as an educational tool that references how the use of the Checkpoint Stimulator may be outlined. When procedures require the use of stimulation the following key elements should be included in the dictation:

- Description of the patient's clinical condition and complicating factors may necessitate the need to use the Checkpoint Stimulator (i.e. indication)
- Detailed description of why and how the Checkpoint Stimulator was used during surgery

Sample Dictation

Procedure

Neurolysis, right radial nerve

Indications

The patient was indicated for an open reduction and internal fixation of the right shoulder, which was severely affected by rheumatoid arthritis. Because of the patient's previous surgery on the humerus fracture, a microvascular and peripheral nerve expert was requested to prevent damage to the nerve.

Procedure

The patient was prepped and taken to the operating room, and was carefully placed in the beach chair position. The initial deltopectoral shoulder approach was performed by the physician and the team. The incision was then extended distally and posteriorly. Blunt subcutaneous dissection was performed with the littler scissors.

There was considerable scarring and distortion of the anatomy owing to the patient's previous surgery. A very careful dissection was performed distally to identify the area of the radial nerve. A Checkpoint Nerve Stimulator device was utilized to 2 milliamps setting to help localize the area of the nerve but the nerve was heavily encased in scar tissue. However, preoperatively, the patient did have normal nerve function and therefore, extensive dissection and complete mobilization of the nerve was undesirable as this could cause damage within the nerve. Therefore, the stimulator was required during the procedure and used to map the course of the nerve across the lateral aspect of the humerus and then posteriorly as the nerve continued to course through the spiral groove.

Having utilized the stimulator, the nerve was located and sufficiently mobilized, the anterolateral and posterior plates were visualized and the screws, which required removal and shortening, could be accessed. We removed two small unicortical plugs and they were replaced. The nerve stimulator was then required to stimulate the brachial plexus proximally. A normal response was noted in the deltoid as well as the triceps and forearm wrist and finger extensors indicating continuity of the nerve. At this point, the procedure was turned back to the shoulder team for completion of the arthroplasty. Blood loss for this portion of the procedure was less than 50mL.

Checkpoint Surgical, Inc.
22901 Millcreek Blvd., Suite 110
Cleveland, Ohio 44122
Toll-free: 877.478.9106
Local: 216.378.9107
Fax: 216.378.9116
Email: info@checkpointsurgical.com

www.checkpointsurgical.com

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