Dynamic Chiropractic

BILLING & FEES

Can You Bill for Extra Effort?

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WHAT YOU NEED TO KNOW

- Modifer 22 is used to identify a service that requires significantly greater effort, such as increased intensity, time, technical difficulty of the procedure, the severity of the patient's condition, and physical and mental effort required.
- Examples include chiropractic manipulation markedly impeded in a morbidly obese patient for which there is extensive more time required to position and perform a sufficient manipulation service.
- To be considered for additional reimbursement when reporting modifier 22, the provider is required to provide a concise statement about how the service differs from the usual.

Question: I have a patient with significant underlying conditions and comorbidities requiring an extraordinary amount of time to perform manipulation. I must use an assistant to get the patient on the table, and positioning and the adjustment can take up to 20 minutes. Is there any code or way to get added reimbursement for this additional time?

This is a unique issue, particularly as the chiropractic manipulative therapy (CMT) adjustment is not a timed service; its value and fee are based on the performance of the service regardless of time. Like any unattended service, the maximum that may be billed is one unit. However, is there a way to address this when there is extraordinary time spent? Yes.

Standard CMT Elements

What is included in the CMT is the *pre-service* time, which includes assessment and management time – medical record review, direct contact with the patient, assessment of the patient's progress since the previous visit, and time required to establish clinical judgment for the treatment session.

In addition, there is the inclusion of *intra-service* time, which is the hands-on treatment. *Post-service* time includes the assessment of treatment effectiveness, communication with the patient / caregiver including education / instruction / counseling / advising, professional communications, the clinical judgment required for treatment planning for the next treatment session, and documentation while the patient is present.

These inclusive factors are the reason for the use of the *modifier 25* to distinguish when there is an initial examination or subsequent evaluation above and beyond the day-to-day evaluation associated with the CMT.

This is not what you are addressing and is based on issues requiring extraordinary time and effort. There is a little-known protocol and modifier to address this.

Adding Modifier 22 for “Increased Procedural Services”

This modifier is used to identify a service that requires significantly greater effort, such as increased intensity, time, technical difficulty of the procedure, the severity of the patient’s condition, and physical and mental effort required, than is usually needed for that procedure.

Examples include chiropractic manipulation markedly impeded in a morbidly obese patient for which there is extensive more time required to position and perform a sufficient manipulation service.

Appropriate Documentation

To be considered for additional reimbursement when reporting modifier 22, the provider is required to provide a concise statement about how the service differs from the usual. The concise statement may be documented in the record.

This documentation must indicate the substantial additional work performed and the reason for the additional work. Such documentation should achieve the following:

- Support substantial additional work that is far beyond the difficulty of other procedures of the same type, such as a) increased intensity or time; b) the technical difficulty of the procedure not described by a more comprehensive code; c) severity of the patient’s condition; or d) the increased physical and mental effort required
- Indicate and explain the difficulty of the procedure beyond the norm. *Best practice*: Include a separate paragraph or note titled “Increased Procedural Services” or “Unusual Procedure.” Do not append modifier 22 without any indication in the medical record that an increased or unusual procedural service occurred.

The use of this modifier will increase the value of the service and most payers will reimburse as a percentage of their allowed rate. Optum Health, for example, increases the value by 50%.

Note: If you are contracted with a payer for a set fee allowance, the use of this modifier may not increase reimbursement and will depend on how your contract defines reimbursement.

Also note that this modifier does not apply to E&M. For added time for E&M, choose the code that is higher to meet the time spent. If you go beyond the time of 99205, then you would add 99417 for each additional block of 15 minutes.It is also not to be used for timed services (therapies), as the added time is accounted for by the units that may be billed.

Editor’s Note: Have a billing question? Submit it via email to Sam at sam@hjrossnetwork.com.

Your question may be the subject of a future column. Note that submission of a question is acknowledgment that it may be referenced (anonymously) in his column.

MAY 2023

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