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Dermatology Coding Alert

Modifiers: Document Increased Derm Services for Modifier 22 Success

If excessive wart removal leads to longer operational time, you may have a case for reporting increased procedural services.

If you overuse modifier 22 (Increased procedural services) your dermatology practice may wind up facing scrutiny -- or worse -- from your payers or even the Office of Inspector General (OIG). But if you avoid the modifier entirely, you're likely missing out on reimbursement your dermatologist deserves.

How it works: When a procedure requires significant additional time or effort that falls outside the range of services described by a particular CPT® code -- and no other CPT® code better describes the work involved in the procedure -- you should look to modifier 22. Modifier 22 represents those extenuating circumstances that don't merit the use of an additional or alternative CPT® code but instead raise the reimbursement for a given procedure.

Take a look at these two myths -- and the realities -- to ensure you don't fall victim to the modifier 22 catch-22.

Myth #1: Morbid Obesity Means Automatic 22

While morbid obesity is sometimes an appropriate reason to use modifier 22, it's not appropriate to assume that just because the patient is morbidly obese you can append modifier 22. "Modifier 22 is about extra procedural work and, although morbid obesity might lead to extra work, it is not enough in itself," says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC,** manager of compliance education for the University of Washington Physicians Compliance Program in Seattle.

"Unless time is significant or the intensity of the procedure is increased due to the obesity, then modifier 22 should not be appended," warns **Maggie Mac, CPC, CEMC, CHC, CMM, ICCE,** director of best practices -- network operations at Mount Sinai Hospital in New York City.

There are some scenarios where you usually should be considering whether modifier 22 is appropriate -- such as reoperations, unusual body habitus (obesity, unusually thin, tall, short, etc.), altered anatomy (congenital or due to trauma or previous surgery), and very extensive injury or disease -- but do not automatically append modifier 22 without the documentation to back it up. You'll only be able to append modifier 22 when a procedure requires substantially greater additional time or effort because of the patient's obesity.

Check the notes: To support appending the modifier, your physician should document how the patient's obesity increased the complexity of that particular case. CPT® specifically recommends that surgeons document the reason for the additional effort, such as "increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required."

"Although you can (in theory) add modifier 22 based only on the description of the work in the body of the note, practically it is impossible to get paid if you don't quantify the extra effort," Bucknam warns.

Don't forget: Indicate the patient's body mass index (BMI) in the documentation and on the claim to support your modifier 22 use as well. Use the appropriate code from the 278.0x (Obesity and other hyperalimentation) range and the matching V code (V85.0-V85.54, Body Mass Index ...).

Myth #2: A Little Extra Time Means Extra Pay

"CPT® does not provide specific direction as to the specific amount of time and/or percentage increase of time or work required to compliantly report modifier 22," says **Marvel J. Hammer, RN, CPC, CHCO,** president of MJH Consulting in

Denver. The typical rule of thumb, however, is your physician 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. "There should be documentation of at least a 50 percent increase in work and/or time to justify use of modifier 22," Bucknam confirms. "Twice as much is better."

Pointer: 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 on the procedure. A statement such as "The procedure required 90 minutes to complete, instead of the usual 35-45 minutes" can be helpful.

Caution: "It is not enough to simply add a statement that 'the procedure took twice as long due to dense adhesions or something like that," Bucknam says. "The body of the operative report must also describe that extra work as well. The description of the procedure needs to match the modifier 22 statement. This is particularly a problem when the surgeon is using a documentation template and coders need to beware situations where the modifier 22 statement conflicts with the information documented in the body of the record."

Example: A male patient presents with 10 large condyloma acuminata (8-10 cm each). The dermatologist surgically reduced each lesion to the skin surface, then treated them with cryosurgery. Normally, treating 10 condyloma would take 15-30 minutes total operative time for the procedure itself, but total operative time for this service was 90 minutes. Report 54065 (Destruction of lesion[s], penis [e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle], extensive [e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery]) with modifier 22 appended.

Detail matters: "Since these claims usually require manual review or an appeal in order to obtain additional payment, be sure the operative note is detailed and specific to support the medical necessity and reasons for the use of this modifier," Mac says. "An additional letter from the surgeon to present the case and the reasons for requesting additional payment that is written in layman's terms will help to appeal the claim."

Bottom line: "Coders should look to the specific payer for published directives regarding their coverage policy and requirements for reporting modifier 22," Hammer advises.