Part B Insider (Multispecialty) Coding Alert

Modifiers: This MAC Will Ask for Additional Documentation if You Append Modifier 22

Make sure the physician documents the extra work, and doesn't just say "see op report."

Citing "confusion" about how to properly use modifier 22, one Medicare carrier issued new rules on this modifier in 2012 that you must follow if you want to collect the extra pay that comes with this "increased procedural services" modifier.

WPS Medicare, the Part B payer for Illinois, Minnesota, and Wisconsin, reminded practices that modifier 22 should only be used for "additional work that is not typically part of the procedure," but can't be described by another CPT®, HCPCS, or add-on code. In addition, WPS added, modifier 22 should never be used for an E/M code.

Instead, WPS added, you should use modifier 22 "when a procedure is truly more complicated than the standard one, although it is not necessarily harder in the usual sense." For instance, if the physician is performing a laparoscopic takedown of a prior hiatal hernia repair and then performs a separate type of hernia repair thereafter. "There is obviously more work involved in this 'double surgery,'" WPS notes.

If you do append modifier 22 to a code, WPS requires you to include the statement, "additional documentation available upon request" on your claim, and the payer will then will send a letter asking for more information that includes the operative report and a statement indicating the substantial additional work. "Please do not merely state, 'See report,'" WPS says. Once the MAC reads the documentation, it will determine whether you deserve extra payment for your claim.

To be sure you are appending modifier 22 appropriately, follow these six tips:

1. Know How to Define 'Unusual'

No payer will allow additional payment for a procedure unless you can provide convincing evidence that the service/procedure the physician provided was truly out of the ordinary and significantly more difficult or time-consuming than usual.

The basics: The time to append modifier 22 is when the service(s) the physician provides are greater than that usually required for the listed procedure, according to CPT®.

CPT® codes describe a range of services. In other words, although one procedure may go smoothly, the next procedure of the same type may take longer or prove to be more difficult. The fee schedule amounts assigned to individual codes assume that the easy and hard procedures will average out over time.

In some cases, however, the surgery may require significant additional time or effort that falls outside the range of services described by a particular CPT® code. When you encounter such circumstances--and no other CPT® code better describes the work involved in the procedure--you should consider modifier 22 to be an option.

2. 'Increased' Means Just That

Key idea: Recognize that truly increased services required of modifier 22 circumstances will occur in only a minority of cases.

CMS guidelines stipulate that you should apply modifier 22 to indicate services that are "significantly greater than usually required."

3. Document the Evidence

Collecting additional reimbursement for increased services with modifier 22 hinges primarily on your documentation's strength. Documentation is ultimately what demonstrates the special circumstances--such as extra time or highly complex trauma--that warrant modifier 22 and additional payment.

Best advice: Some electronic software systems will allow you to append a copy of an electronic operative note (which justifies your use of modifier 22) as an attachment, and many payers like that. Other payers would prefer just the part of the note that justifies modifier 22.

The op report should clearly identify additional diagnoses, pre-existing conditions or any unexpected findings or complicating factors that contributed to the extra time and effort spent performing the procedure.

The documentation should also include a separate section entitled "special circumstances" or something similar that precisely explains, in clear language, how much, and why, additional difficulty and/or effort was necessary.

Hint: Avoid medical jargon and state in concise language the reason for the surgery's difficult nature. You should do your best to translate what went on in the operating room into easy-to-interpret information.

4. Compare and Contrast

One of the most effective ways to demonstrate the increased nature of a procedure is to compare the actual time, effort or circumstances to those the physician typically needs or encounters.

The bottom line: Don't bother to submit a claim for modifier 22 if you don't have the documentation--because you're not going to recover any additional fee.

5. Give Concrete Reasons for 22

When explaining or defending the reasons for modifier 22, offer concrete reasons, rather than just saying it was more difficult or time-consuming. Clearly indicate when there has been a change in technique during the procedure and, more important, why there was a change in technique.

6. Ask for the Money

Payers won't automatically increase your payments for modifier 22 claims. You have to ask for the money. You can include this request as a portion of the cover letter that explains the unusual nature of the procedure.

For instance, you might say that because the surgeon encountered extensive scarring in the surgical field, the procedure took an hour longer than the typical procedure of this type, and you are therefore requesting 20 percent additional reimbursement in this case.

Resource: To read the WPS letter about modifier 22, visit www.wpsmedicare.com/part_b/claims/submission/2009_0608_modifier22.shtml.