Part B Insider (Multispecialty) Coding Alert

MODIFIERS: Throw Out The 25-Percent Rule For Modifier 22

Beef up your documentation for the 59 modifier

Heads up: The requirements for modifier 22 are becoming much stricter in January.

Old rules: You use the 22 modifier when your physician provides a service that is -greater than that usually required for the listed procedure.- A report on the reason for the modifier -may also be appropriate.-

New rules: Your physician's work must be -substantially greater than typically required.- And your documentation must support the -substantial additional work.- You also must list the reasons why the doctor had to work harder, such as increased intensity, added time, technical difficulty of the procedure, severity of the patient's condition, or physical and mental effort required.

The new language sounds a lot tougher than the old wording, but you-ll have to wait for guidance on what -substantially greater- means, says **Barbara Cobuzzi**, director of outreach for the **American Academy of Professional Coders** in Salt Lake City, UT.

Currently, experts teach that you should use the 22 modifier whenever the physician spends about 25 percent more time or effort than usual for a procedure. But Medicare may not consider 25 percent -substantially greater- than normal, Cobuzzi warns.

-What's the difference in -unusual- and -increased?-- asks **Dianne Wilkinson**, compliance officer and quality manager with **MedSouth Healthcare** in Dyersburg, TN.

-Repeated reviews by Medicare have shown that doctors are not supporting [modifier 22] well enough in their documentation,- Wilkinson adds. So the CPT update is beefing up the documentation requirements to encourage you to do what you should already be doing, she adds.

The new descriptor provides some great pointers on things to look for when you audit your use of this modifier, Wilkinson points out.

More changes: You-ll no longer use the 51 modifier (Multiple procedures) for physical medicine, rehab or vaccinations. This is good news, because it means you can get full reimbursement for multiple rehab services, says Wilkinson. The only downside would be if Medicare decides to bundle some of these services, which could lead to less reimbursement than before.

The 58 modifier will apply to staged or related procedures that were -planned or anticipated- at the time of the original surgery, not just ones that your doctor planned in advance. Many coders were already using modifier 58 when the doctor only anticipated the possibility of surgery instead of planning it, says Cobuzzi. This change will just make those coders -more comfortable- with that usage, she says.

Also, you-ll use the 58 modifier for surgical procedures, not diagnostic ones, which -seems reasonable,- says Wilkinson. These changes may make it easier to decide between the 58, 76 and 78 modifiers.

The description for the 59 modifier now says -documentation **must** support- that there was a separate session or distinct service. Cobuzzi says she's been teaching all along that your documentation must support the 59 modifier. -They-re just clarifying it because there's been so much abuse on 59.-

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