Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Do Your Services Warrant Modifier 22? Find the Truth Behind These 3 Myths Before You Answer

If you assume you can always append modifier 22 in certain situations, you're headed toward an audit.

If you overuse modifier 22 (Increased procedural services) you may face increased scrutiny 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 physician deserves.

How it works: When a procedure requires significant additional time or effort that falls outside the normal 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 do not merit the use of an additional or alternative CPT code but instead when used will raise the reimbursement for a given procedure.

Take a look at these three 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 always 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 should consider 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 without the documentation to back it up, do not automatically append modifier 22. 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 (Overweight and obesity) 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 for that particular procedure. A statement such as "The procedure required 90 minutes to complete, instead of the usual 35-45 minutes" can be helpful. Your physician should document clearly in the medical records the reason(s) for the increased effort and time spent.

For example, if a typical radical nephrectomy (50230, Nephrectomy, including partial ureterectomy, any open approach including rib resection; radical, with regional lymphadenectomy and/or vena caval thrombectomy) usually takes one and a half hours to complete, but the doctor spent four and a half hours because of the patient's morbid obesity which made it extremely more difficult to remove the kidney, you should compare the procedure times in your modifier 22 documentation.

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."

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.

Myth #3: Assume Lysis of Adhesions Warrants 22

You can't assume lysis of average adhesions always merits modifier 22. "Lysis of adhesions is inherent in most procedures, particularly after a previous surgery," Mac says. The mere presence of adhesions does not mean you can use modifier 22.

"Everyone has adhesions and there is an expectation that you will lyse them when you encounter them during surgery," Bucknam agrees. "But when the adhesions are dense due to previous surgeries or chronic disease, that's when you're looking at modifier 22 work."

In fact: Many payers tend to deny payment for lysis of adhesions when the physician performs the lysis with other procedures. The reason is that the physician normally destroys the adhesions to gain access to the surgical field, which is a standard surgical technique.

On the other hand, when adhesions are dense, very vascular, anatomy-distorting, and require extensive work to remove, the payer may consider payment. In those cases, you should append modifier 22 to the primary procedure rather than billing separately for lysis of adhesions using codes such as 44005 (Enterolysis, [freeing of intestinal adhesion] [separate procedure]) or 44180 (Laparoscopy, surgical, enterolysis [freeing of intestinal adhesion] [separate procedure]).