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Modifier Coding Alert

Documentation: Pump Up the Notes When Using Modifier 22

You could increase your reimbursement by as much as 50 percent.

When your doctor performs a procedure that is substantially more difficult, time consuming, or intense than normally expected, and there's no alternative CPT® code that better describes the procedure, you should use modifier 22 (Increased procedural services). But if you overuse this modifier you risk drawing the attention of auditors.

Read on to see when you should and shouldn't attach modifier 22, plus how your provider's documentation can make or break your claim success.

Discover Why a Procedure Might Go From Typical to Intense

As the American Medical Association's (AMA's) CPT® Changes from 2008 explains, "This modifier should be used only when additional work factors requiring the physician's technical skill involve significantly increased physician work, time, and complexity than when the procedure is normally performed."

There are four possible reasons a surgical procedure could warrant the use of modifier 22. With any of these reasons, the records need to reflect the increased involvement of the physician and/or the extra physical or mental effort required of the surgeon.

1. Increased intensity. "The standard we use for cases of increased intensity is that typically they take 30-50 percent or more time than what is considered normal and expected," explains **Charlotte T. Tweed, RHIA, CPC**, coding auditor, GME interim compliance manager/privacy officer, and certified ICD-10 instructor at the Florida Hospital Graduate Medical Education Department of Coding & Auditing in Orlando, Fla.

2. Increased surgical time. Some payers say the procedure must take at least 25 percent more time than usual, while others say 50 percent more.

3. Increased technical difficulty. Beware that surgeons can't just use new equipment or techniques and claim the procedure had higher technical difficulty. "That said, if the surgeon chose a more technically difficult technique in order to get a better patient outcome, she must state that reason in the documentation and modifier 22 would be justified," Tweed explains.

"Sometimes our surgeons will attempt a laparoscopic method because it will be better for the patient, but due to patient body habitus, it makes the procedure more technically difficult. The surgeon understands the procedure will be more difficult, but is willing to use, or at least attempt to use, this method for the benefit of their patient," says Tweed.

4. Increased severity of patient's condition. Increased severity of a case can occur, for example, with the "loss of anatomical landmarks due to morbid obesity," Tweed adds. "The severity of the case is increased and more difficult requiring the surgeon to exert more physical and/or mental effort to reach positive outcomes." A patient needing emergency surgery may also increase the severity of a case.

Experts suggest a few specific instances where you may need to append modifier 22:

- Scarring from a previous injury or surgery
- Excessive patient blood loss
- Trauma extensive enough to complicate the procedure (but doesn't need to be billed with additional procedure codes)
- Anatomical variants.

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Detail the Documentation to Support Your Claim

Documentation is key when using modifier 22. Your physician should include the following details in his notes if they exist:

- Detailed description of the procedure
- Additional diagnoses
- Pre-existing conditions
- Unexpected findings
- Complications
- Effort spent.

Many payers will not pay your modifier 22 claim without requesting documentation to review. Supporting your modifier 22 use relies on the strength and detail of the provider's documentation. Documentation must support the substantial additional work and the reason for the additional work (such as, increased intensity, time, technical difficulty of procedure, severity of patient's condition, and/or physical and mental effort required).

Experts advise that when your payer asks for documentation for your modifier 22 claim you include a cover letter with the operative notes, which explains the procedure and extenuating circumstances in clear, concise language giving as much detail as possible.

The final step: Recommend an appropriate payment in your comments. If the surgical procedure took twice as long as usual, ask for an increase of 50 percent on the intra-operative portion of the payment. You may not get it all but it's like the adage, "You don't know until you ask."

Don't Jump to Conclusions

There are situations when the additional time or extra effort doesn't warrant using modifier 22.

Example: "The procedure took an extra 10 minutes longer because the surgeon is new at doing the procedure a new way, using new equipment, or it was more difficult and look longer because the surgeon was teaching a resident or other surgeon, does not meet the standard of a modifier 22," suggests Tweed.

Watch out: Morbid obesity is not an automatic call to use modifier 22. Even though more work may be involved during a procedure because of morbid obesity, that isn't enough to justify the modifier's use.

ICD-9 defines morbid obesity as "increased weight beyond limits of skeletal and physical requirements (125 percent or more over ideal body weight), as a result of excess fat in subcutaneous connective tissues."

If your physician feels that more work was involved in a procedure due to the patient's obesity, additional information should be added to the narrative such as difficulties positioning the patient, the depth of incision, the need for specialized instruments, the number of extra people assisting, etc.

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