Using Modifier 22 Correctly

When applied properly, modifier 22 "unusual procedural service," allows a provider to recover reimbursement above and beyond the regular payment for a difficult or time-consuming procedure.

Only those surgeries "for which services performed are significantly greater than usually required" justify the use of modifier 22, according to the Centers for Medicare & Medicaid Services (CMS) Medicare Carriers Manual (section 4822, A.10). Appendix A of the CPT® Manual likewise advises that modifier 22 is appropriate "when the work required to provide a service is substantially greater than typically required."

Specific circumstances that may support modifier 22 include:

- Excessive blood loss relative to the procedure
- Presence of excessively large surgical specimen (especially in abdominal surgery)
- Trauma extensive enough to complicate the particular procedure and not billed as additional procedure codes
- Other pathologies, tumors, or malformations (genetic, traumatic, surgical) that interfere directly with the procedure but are not billed separately
- Services rendered that are significantly more complex than described for the CPT® code in question.

Other factors that might support modifier 22 include morbid obesity, low birth weight, converting a laparoscopic procedure to an open approach or severe scarring or adhesions from previous trauma.

CPT® guidelines require that documentation support "the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of the procedure, severity of patient's condition, physician and mental effort required.)" The provider should explain and identify additional diagnoses, pre-existing conditions or unexpected findings or complicating factors that contributed to the extra time and effort.

Use "comparative language" to clarify how the particular procedure differed from a more typical procedure, using quantifiable criteria. For example: "The patient lost 1,000 cc's of blood rather than the more usual 100-200 cc's of blood for a procedure of this type." The documentation should also explain what steps the provider took to control the blood loss.

Time is another, easily quantifiable criterion. For instance, the provider might note that a surgery took four hours instead of the usual two hours.

Payers may request a full operative report to verify the unusual nature of the coded procedure. Some electronic software will allow you to append a copy of an
electronic note as an attachment. Supporting documentation should be immediately available, regardless if it is submitted with the initial claim.

Payers won't automatically increase reimbursement for a modifier 22 claim. When submitting the claim you must ask for additional compensation. Fee increases should be reasonable, based on the "over and above" work the provider performed. Many practices increase fees by 20-25 percent when submitting a code with modifier 22, unless the treating provider specifies otherwise.

Some payers routinely reject or refuse additional reimbursement for modifier 22 claims upon initial submission. If the procedure note is thorough and clearly demonstrates that additional compensation is warranted due to an unusual service, appeal the decision.

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