URMC Compliance Office
Guidance for Use of Modifier 22
Increased Procedural Services

Modifier 22 Increased Procedural Services: use Modifier 22 "When the work required to provide a service is substantially greater than typically required." It is added to the usual procedure code. "Documentation must support the substantial additional work and the reason for the additional work" (i.e. increased intensity, time, technical difficulty of procedure, severity of patient's condition). Note: This modifier should not be appended to an E/M service. (CPT, 2011)

Modifier 22 is appropriate in reporting increased procedural cases, such as

- Trauma extensive enough to complicate the particular procedure and that cannot be billed with additional procedure codes.
- Significant scarring requiring extra time and work.
- Extra work resulting from morbid obesity or other unusual anatomic anomalies.
- Increased time resulting from extra work by the physician.
- Additional work and time involved in managing a patient's co-morbid conditions throughout the procedure.
- When work associated with bundled procedures is more extensive than normal.

Documentation Requirements

The physician does not have to make a specific "modifier 22 statement" that the service was more complex. However, the documentation should reflect the extra problems, effort, extent or additional not-separately-codeable services that were required to treat the patient. The information can be documented anywhere in the note but should be sufficiently detailed that the additional time and/or complexity is clearly demonstrated. It is not sufficient to simply state that the procedure is a reoperation or a revision of a previous procedure, or simply document the extent of the patient's illness or co-morbid conditions that might cause additional work (the documentation must describe additional work performed); or state the specific skills and credentials of the provider that might make them uniquely qualified to perform the service.

Modifier 22 is not appropriate unless the work involved substantially exceeds the work described by the CPT procedure code for the service.

Modifiers should never be added to claims unless the documentation has been reviewed and the use of the modifier is appropriate based on the documentation.

Modifier 22 Examples

- Splenectomy for trauma patient with abdominal trauma and hemoperitoneum. The entire bowel was run and the abdomen inspected for bleeding prior to the Splenectomy requiring 50% more effort than normal. 38100-22
- Colectomy for patient with long history of Crohn's disease and extensive intra-abdominal adhesions requiring 3 hours of careful dissection and lysis. 44150-22
- Craniotomy for excision of a supratentorial brain tumor is performed. Physician describes additional 90 minutes of time dissecting tumor that has extended into the horns of the cistern. 61510-22
- Vaginal delivery after 10 hours of labor for patient with brittle diabetes requiring IV insulin titrated throughout the labor and serial monitoring of blood sugars. 59400-22

Non Modifier 22 Examples

- Reoperation of coronary bypass grafting x 3, 1 year after previous procedure. Procedure included substantial time finding appropriate bypass grafts, dissecting scar tissue, and examining previous grafts for patency. 33512, 33530
- Open revision of previous fundoplication. The procedure was performed without documented issues or complications. 43324

References

CPT 2011 Professional Edition, AMA
CPT 2008 Changes, An Insider's View, AMA

September 2011