How useful is the 22-modifier?

By George V. Russell Jr, MD

Current Procedure Terminology (CPT) codes can be modified to “…report or indicate that a service or procedure which has been performed has been altered by some specific circumstance but not changed in its definition or code,” according to the American Medical Association (AMA), which developed the system. (See “A short history of CPT coding.”)

The 22-modifier documents work required to provide a service that is substantially greater than the work typically required. Documentation must demonstrate the substantial additional work and the reason for the additional work. For example, the 22-modifier may be supported by additional documentation indicating increased intensity, time, technical difficulty, or severity of the patient’s condition.

But does it work?

Very little has been written about the usefulness of the 22-modifier. A study examining the use of the 22-modifier for various urological procedures (excluding charity care) found that it led to increased reimbursement in 31 percent of cases, to equal reimbursement in 36 percent of cases, and to less reimbursement than the contracted level in 33 percent of cases. The obvious conclusion is that the 22-modifier does not provide consistent additional reimbursement for complex surgery.

Another problem with the 22-modifier was highlighted in a study evaluating tertiary vascular procedures. Although the work effort—reflected by operating room and total care times—for the “tertiary” procedures was higher than the effort required for “primary” procedures, the estimated reimbursement was significantly less per surgeon. Additionally, although providing more complex care was associated with marginal losses for the department, it was profitable to the hospital. This clearly reflects a conflict of interest between provider and hospital in providing care to patients with complicated problems.

In orthopaedics, the use of the 22-modifier to increase provider compensation is similarly ineffective. An evaluation of the use of the 22-modifier in 93 morbidly obese patients (body mass index of 40 or greater) who had Medicare as their primary insurer found that reimbursement was increased in only three cases. A second study on morbidly obese patients
undergoing arthroplasty procedures found that the use of the 22-modifier was successful in increasing reimbursement from Medicare in only one of 60 patients.

**A difficult documentation**

Although designed to improve compensation for more difficult procedures, the 22-modifier often requires substantial supporting evidence. Problems arise in distinguishing a “hard case” from one that meets the standard of an “unusual procedural service.” Adequately describing the increased intensity or technical difficulty of a procedure is also challenging. Another problem is that insurance carriers have no agreed upon amount or percentage increase for a claim with a 22-modifier.

The usefulness of the 22-modifier in improving compensation to surgeons for providing unusual procedural services has not been substantiated. Studies have shown that using a 22-modifier does not ensure increased payment, particularly where Medicare is the payer. More work must be done to ensure the effectiveness of the 22-modifier in providing equitable payment to surgeons who treat patients requiring difficult and unusual procedures.

**A short history of CPT coding**

Current Procedure Terminology (CPT) codes were introduced by the American Medical Association in 1966 to encourage use of standard terms to document procedures in the medical record, to communicate accurate information about procedures to agencies concerned with insurance claims, and to provide basic information for actuarial and statistical purposes. The first series covered primarily surgical procedures.

The number of CPT codes was expanded in 1970 to designate diagnostic and therapeutic procedures in surgery, medicine, and other specialties, and the codes were changed from four to five digits.

In 1983, CPT was adopted by the Centers for Medicare & Medicaid Services (CMS), and their use was mandated for reporting services for Part B of the Medicare Program. In 1986, CMS required state Medicaid agencies to use the codes, and in 1987, mandated the use of CPT for reporting outpatient hospital surgical procedures.

In 2000, the Department of Health and Human Services named CPT (including codes and modifiers) as the procedure code set for physician services, physical and occupational therapy services, radiological procedures, and clinical laboratory tests. It also named the International Classification of Diseases-9th revision-Clinical Modification (ICD-9-CM) volume 1 and 2 as the code set for diagnosis codes and ICD-9-CM volume 3 as the national standard for inpatient hospital services.

Today, CPT is used extensively throughout the United States as the preferred system of coding and describing healthcare services.
George V. Russell Jr, MD
An assistant professor, department of orthopedic surgery and rehabilitation, at the University of Mississippi Medical Center, Dr. Russell is a graduate of the AAOS Leadership Fellows Program and a member of the AAOS Practice Management Committee. He can be reached at gvrussell@umc.edu

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