In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. Billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Increased Procedural Services (Modifier 22)

Policy Number: CPCP013

Version: 4.0

Clinical Payment and Coding Policy Committee Approval Date: 02/08/2019

Effective Date: February 20, 2019 (Blue Cross and Blue Shield of Texas)

This policy was created to serve as a general reference guide to coding and payment for increased procedural services. Health care providers (i.e., facilities, physicians and other health care professionals) are expected to exercise independent medical judgement in providing care to patients. This policy is not intended to impact care decisions or medical practice.

Modifications to this policy may be made at any time. Any updates will result in an updated publication of this policy.

Description:

Modifier 22 is described by Current Procedural Technology (CPT) as identifying an increased procedural service. Appendix A of the CPT codebook states that “When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code.” In addition, CPT states that modifier 22 should not be reported with evaluation and management services.

Reimbursement Information:

Additional payment for services may be considered in very unusual circumstances when the work effort is "substantially greater" than typically required. Use modifier 22 in such an instance. Use of modifier 22 is a representation by the provider that the treatment rendered on the date of services was substantially greater than typically required. The use of modifier 22 does not guarantee additional reimbursement. Thorough documentation indicating the substantial amount of additional work and reason for this work will be required for the review. Reasons for additional work may include:

- Increased intensity
- Increased time
- Technical difficulty
- The severity of the patient's condition
- Physical and mental effort

Documentation must support what made the procedure more intense, take longer or have more difficulty. A brief letter or statement is not a part of the medical record and is not sufficient to justify the use of modifier 22. Modifier 22 is not justified by generalized or conclusory statements including but not limited to the following:

- The surgery took an additional two hours
- This was a difficult procedure
- Surgery for an obese patient

The additional difficulty of the procedure should be detailed in the body of the operative report. If the nature, extent, and reasons for the increased work of the procedure are not clearly apparent in the operative report, the consideration for modifier 22 will result in a denial. If modifier 22 is approved, additional payment is 25% of the applicable allowable amount.

However, if the additional work performed has a specific procedure code, then that procedure code should be used and modifier 22 is not warranted. (CPT coding guidelines state that Modifier 22 should not be appended to an E/M service.)

References:

American Medical Association. Current Procedural Terminology (CPT). https://www.ama-assn.org/practice-management/cpt

Centers for Medicare and Medicaid Services (CMS). Physician Fee Schedule Relative Value Files. https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched/pfs-relative-value-files.html

Policy Update History:

Approval Date	Description
02/28/2018	New Policy
02/08/2019	Annual Review