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Origination: September 2014
Last Review: October 17, 2024
Next Review: October 17, 2025
Effective Date: February 01, 2025

Description

Provide a payment policy statement that addresses the payment for services submitted with a -22 modifier.

Policy & Guidelines

Definition

Modifier -22 [Increased procedural services].

The use of -22 modifier is considered medically necessary for additional payment when the modifier -22 should be used when additional work factors requiring the provider's technical skill involves significantly increased work, time, and complexity than when the procedure is normally performed. The procedure and/or service may be surgical or non-surgical. Payment methodology typically accounts for the possibility that sometimes a procedure will be simpler and other times more difficult than normal. However, there are times when a procedure can be significantly more difficult.

Policy Statement

Effective with dates of service on or after December 01, 2014, Blue Cross and Blue Shield of Vermont (Blue Cross VT) will allow payment for services with procedure codes submitted with a modifier -22 ***as eligible*** for increased reimbursement to the extent they follow the guidelines set forth in this payment policy.

Eligible

Blue Cross VT considers it appropriate to use modifier -22, when thoroughly documented, include but are not limited to:

- Excessive blood loss during the actual procedure performed.
- Unusually lengthy procedure.

- Presence of an excessively large surgical specimen.
- Trauma extensive enough to complicate the procedure and not billed as separate procedure codes.
- Other pathologies, tumors, malformations (genetic, traumatic, surgical) that increase the complexity of the procedure and directly interfere with the procedure but are not billed as separate procedure codes.
- The services rendered are significantly more complex than described for the submitted CPT® or HCPCS Level II code and the provider is unable to report a secondary procedure for the additional work.
- Anatomical variants.
- Services eligible for assistant at surgery where the procedure involves significantly more work than usual.

Not Eligible

Circumstances that are not considered appropriate use of modifier -22 include, but are not limited to:

- If another CPT® code (including an unlisted procedure code) more accurately describes the performed procedure.
- Unlisted codes, which should not be submitted with modifier -22. As an unlisted code, the service already lacks specific definition and as such, will be reviewed for coverage and payment consideration.
- Using modifier -22 on anesthesia services (except for field avoidance noted below):
  Modifier - 22 may be appended to claims when access to the airway is limited (e.g., field avoidance), and the anesthesia work required is substantially greater compared to the typical patient. There is no modifier that identifies field avoidance. Documentation must support the substantial additional work and the reason for the additional work. Additional payment secondary to field avoidance is subject to the following:
    - The documentation must be included in the member's anesthesia record.
    - The base unit is less than 5 units, and
    - The procedure is performed around the head, neck, or shoulder girdle, and/or
    - The position requires a position other than supine.
- Using modifier -22 on DME services.
- If the cause of the increased work results from the providers choice of approach (e.g., open vs. laparoscopic, elected a vaginal approach for hysterectomy that would not have been considered an 'unusual procedural service' if performed abdominally, etc.).
- To describe an average amount of lysis or division of adhesions between organs and adjacent structures (routine lysis of adhesions is considered an integral and inclusive part of the procedure).
- If the additional work or procedure is included in the primary procedure or another

procedure and is not separately reimbursable.

- Mentioning that the member was obese without describing how the obesity created need for additional work.
- If the sole purpose for use of the modifier is due to a 'reoperation' where the member has had a prior surgery which does not significantly increase the difficulty of the current surgery.
- If the code is an Evaluation and Management (E/M) service.
- Appending surgery codes with modifier -22 to indicate robotic or computer-assisted surgery in order to receive separate or additional reimbursement for the use of robotic or computer systems (see CPP_04 Robotic & Computer Assistive Devices Payment Policy for complete guidelines).
- Using modifier -22 to indicate that the radiology, laboratory/pathology or medicine procedure was performed by a specialist; specialty designation does not warrant use of the -22 modifier.
- Using modifier -22 when more x-ray views are taken than actually specified by the CPT® code description. This is incorrect, especially when the code descriptor reads 'complete' (e.g., 70130, 70321, 73110, etc.). 'Complete' means any number of views taken of the body site.
- Modifier -22 and modifier -63 (Procedure performed on infants less than 4 kg) cannot be billed together on the same procedure code (CPT® or HCPCS Level II).

Provider Billing Guidelines and Documentation

Providers may be eligible for increased reimbursement to the extent that they follow the payment policy guidelines and clinical review has confirmed appropriate use of the -22 modifier.

Refer to Addendum A (Modifier Payment Table) for -22 modifier reimbursement guidelines. Refer also Addendum B (Modifier Decision Tree) that providers may use to help determine when the use of the modifier is appropriate.

Claims submitted with the -22 modifier **require** documentation (e.g., operative, medical, radiology, or laboratory/pathology reports). If the documentation provided **does not** clearly demonstrate the additional work performed, additional information **will not** be requested. In this circumstance reimbursement for the surgical or non-surgical procedure submitted with the -22 modifier ***will not be eligible*** for increased reimbursement.

Claims submitted with the -22 modifier, with no supporting documentation ***will not be considered eligible*** for a clinical review or increased reimbursement.

Documentation (e.g., operative, medical, radiology, or laboratory/pathology reports) should contain a concise statement about how the service differed from the usual, and it must support the substantial additional work and the reason for the additional work such as

intensity, time, and technical difficulty, severity of patient's condition and/or physical and mental effort required for the provider. It is not sufficient to simply document the extent of the member's illness or co-morbid condition(s) that caused the additional work. The documentation must describe the additional work performed.

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

N/A

Related Policies

CPP_04 Robotic & Computer Assistive Devices Payment Policy (Guidelines specific to use of the -22 modifier)

CPP_16 Global Maternity/Obstetric Package (Excluding Home Births) Payment Policy (Guidelines specific to use of the -22 modifier)

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.

4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

References

American Medical Association. (2024). *CPT®: Current Procedural Terminology (Professional*). Chicago IL: American Medical Association.

Grider, Deborah J. (2004). *Coding with Modifiers: A Guide to Correct CPT® and level II Modifier Usage.* Chicago IL: American Medical Association.

Policy Implementation/Update Information

This policy was originally implemented on December 01, 2014

Date of Change	Effective Date	Overview of Change
June 1, 2021	June 1, 2021	Updated for formatting and to clarify that the maximum allowed amount for reimbursement will be provider's allowed charges (see Addendum A).
October 17, 2024	February 01, 2025	Payment policy updated new template format, references and related policies added. Minor editorial refinements to policy statements; intent unchanged.

Approved by **Update Approved: 10/17/2024**

Tom Weigel, MD, Chief Medical Officer

Addendum A

Modifier Payment Table

Modifier	
-22 Modifier	**[Increased Procedural Services]**
When documentation **is** submitted and the clinical review has confirmed appropriate use of -22 modifier, the allowed amount will be the lesser of (a.) 120% of the fee schedule or contracted amount for the usual service (same CPT®/ HCPCS code without the modifier) or (b.) the provider's allowed charges.	
When documentation **is NOT** submitted, **NO** clinical review will be conducted. The claims ***will not be eligible*** for increased reimbursement. The allowed amount will be the less of (a.) 100% of the fee schedule or contracted amount for the usual service (same CPT®/ HCPCS code without the modifier) or (b.) the provider's allowed charges.	

Addendum B

Modifier Decision Tree