

	Reimbursement Policy Manual		Policy #:	RPM007
Policy Title:	Modifier 22 - Increased Procedural Services			
Section:	Modifiers	Subsection:	Surgery	
<p>Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:</p> <p>Companies: <input checked="" type="checkbox"/> All Companies: Moda Partners, Inc. and its subsidiaries & affiliates <input type="checkbox"/> Moda Health Plan <input type="checkbox"/> Moda Assurance Company <input type="checkbox"/> Summit Health Plan <input type="checkbox"/> Eastern Oregon Coordinated Care Organization (EOCCO) <input type="checkbox"/> OHSU Health IDS</p> <p>Types of Business: <input checked="" type="checkbox"/> All Types <input type="checkbox"/> Commercial Group <input type="checkbox"/> Commercial Individual <input type="checkbox"/> Commercial Marketplace/Exchange <input type="checkbox"/> Commercial Self-funded <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Short Term <input type="checkbox"/> Other: _____</p> <p>States: <input checked="" type="checkbox"/> All States <input type="checkbox"/> Alaska <input type="checkbox"/> Idaho <input type="checkbox"/> Oregon <input type="checkbox"/> Texas <input type="checkbox"/> Washington</p> <p>Claim forms: <input checked="" type="checkbox"/> CMS1500 <input checked="" type="checkbox"/> CMS1450/UB (or the electronic equivalent or successor forms)</p> <p>Date: <input checked="" type="checkbox"/> All dates <input type="checkbox"/> Specific date(s): _____ <input type="checkbox"/> Date of Service; For Facilities: <input type="checkbox"/> n/a <input type="checkbox"/> Facility admission <input type="checkbox"/> Facility discharge <input type="checkbox"/> Date of processing</p> <p>Provider Contract Status: <input checked="" type="checkbox"/> Contracted directly, any/all networks <input checked="" type="checkbox"/> Contracted with a secondary network <input checked="" type="checkbox"/> Out of Network</p>				
Originally Effective:	1/1/2000	Initially Published:	7/27/2011	
Last Updated:	6/9/2023	Last Reviewed:	6/14/2023	
Last update payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?			No	
Last Update Effective Date for Texas:		6/14/2023		

Reimbursement Guidelines

A. General

1. It would be possible but unlikely that a procedure would be performed that involved significantly increased procedural services, complexity, or difficulty sufficient to warrant an increased reimbursement allowance.
 - a. CMS sets the RVU for each procedure code based on a range of work effort required or difficulty encountered when the service is performed. (CMS²)
 - b. The allowable amount for the procedure code includes circumstances within this range of greater or lesser effort and difficulty.
 - c. Per CMS, it is appropriate to increase the allowance for procedures for increased procedural services:
 - i. Only under very unusual circumstances, and
 - ii. Only after manual review of medical records and other documentation. (CMS²)
 - d. Our medical director experience reviewing modifier 22 claims and medical records confirms the above CMS information. The very unusual circumstances which warrant additional reimbursement for modifier 22 occur extremely infrequently.

2. Additional reimbursement for procedure codes submitted with modifier 22 for increased procedural services is possible for some categories of procedure codes upon medical director manual review of medical records and the provider's written summary of the increased complexity of the surgical procedure. The stage at which this manual review occurs varies by line of business.

B. Modifier 22 is Invalid

Modifier 22 is considered invalid for use with procedure codes that do not have a global days indicator of 000, 010, or 090 on the Medicare Physician Fee Schedule. If submitted with modifier 22, the line items will be denied.

1. Exception, certain procedure codes with a global days indicator of MMM (maternity-related) with a delivery component will be considered for an increased allowance. See [Criteria for Maternity/Delivery Surgical Codes](#).
2. For anesthesia codes there are other methods of obtaining reimbursement for additional time or extra difficulty:
 - a. Additional time units are used to report the duration of the procedure.
 - b. Additional effort and complexity connected with severe disease or unstable conditions are reported using physical status modifiers:
 - i. Medicare Advantage claims - Physical status modifiers are not separately reimbursed per CMS policy.
 - ii. Medicaid claims - Physical status modifiers are not separately reimbursed per Medicaid policy.
 - iii. Commercial claims - Additional reimbursement is allowed for physical status modifiers P3, P4, & P5 only. (Moda^C)
3. Unlisted procedure codes, including unlisted surgical procedures.

The billing office is required to supply a description for the unlisted procedure code on the submitted claim that is specific to this surgical case. All effort and complexity involved must be addressed in the special report with details and comparable codes.

C. Additional Reimbursement Not Allowed

Additional reimbursement is not allowed on procedure codes with a global days indicator of 000, 010, or 090 on the Medicare Physician Fee Schedule for:

1. When the contracted fee allowance is based on a percentage of billed charges, regardless of the procedure code or circumstances.
2. Facility claims with modifier 22. Includes:
 - a. Claims from Ambulatory Surgery Centers.
 - b. Facility fees for surgical or professional services.
 - c. All Cxxxx procedure codes.

3. **Maternity/delivery codes** modifier 22 is considered invalid for the following and will be denied to provider liability:
- a. The following items or procedures. These are considered part of the global maternity package, and payment is included in the RVU allowance for the delivery/global maternity procedure codes [This list is not exhaustive; see RPM020. (Moda^B)]:
 - i. An episiotomy and repair with a vaginal delivery.
 - ii. Repair of cervical, vaginal or perineal lacerations, regardless of the extent or degree of lacerations. (AMA^{14, 15, 16})
 - iii. Exploration of the uterus.
 - iv. Artificial rupture of membranes (AROM) before delivery.
 - v. Induction of labor with pitocin or oxytocin.
 - vi. A rapid or precipitous delivery.
 - b. The vaginal delivery of twins, triplets, or other multiple gestations. Appropriate maternity procedure codes are available for use to properly report this situation. (Moda^B)
 - c. A combination of vaginal delivery of at least one fetus followed by cesarean delivery of one or more additional gestations. Appropriate maternity procedure codes are available for use to properly report this situation. (Moda^B)
 - d. Modifier 22 may not be added to the code for Cesarean delivery simply because there are multiple babies.
 - i. Delivery of multiple gestations (e.g., twins, triplets, etc.) with a failed VBAC and delivery of all babies by cesarean (59618). The RVU for 59618 includes consideration for the additional time, work, and risk of the failed VBAC delivery.
 - ii. Delivery of one or more babies delivered vaginally followed by one or more babies delivered by cesarean. See [Maternity RPM020](#), section K. (Moda^B)
 - e. A high-risk pregnancy.

High-risk pregnancies generate additional antepartum visits above the standard antepartum schedule which are separately reportable, and additional diagnostic procedures which are separately reported. See RPM020, sections for High-Risk Pregnancy and/or Complications of Pregnancy and Delivery of High-Risk Pregnancy. (Moda^B)
 - f. Any non-delivery maternity code with a global days indicator of MMM:
 - i. Antepartum care-only (59425, 59426)
 - ii. Post-partum care-only (59430)
 - iii. External cephalic version (59412)
 - iv. Delivery of placenta 959414)

D. Reimbursement for increased procedural services:

1. Commercial claims.

- a. Additional reimbursement for increased procedural services is possible for surgical procedure codes upon written appeal review.
 - i. Unlisted surgical procedure codes are not eligible.
 - ii. Medical director review will determine if requirements are met for an additional allowance for modifier 22.

Note: This review occurs at the written appeal stage due to extensive analysis by Healthcare Services of past modifier 22 claims showing it is extremely rare for the requirements for increased allowance in this policy to be met and documented in the medical records and summary of the increased complexity of the surgical procedure.

- b. If the review determines that an additional allowance is warranted, the procedure will be reimbursed at 125% of the normal allowance (contracted fee or maximum plan allowable).

2. Medicare Advantage claims.

- a. Additional reimbursement for increased procedural services is possible for surgical procedure codes upon review of medical records and summary of the increased complexity of the procedure.
 - i. Unlisted surgical procedure codes are not eligible.
 - ii. Medical director review will determine if requirements are met for an additional allowance for modifier 22.
- b. If the review determines that an additional allowance is warranted, the procedure will be reimbursed at 125% of the normal allowance (contracted fee or maximum plan allowable).

3. Medicaid claims.

- a. Additional reimbursement for increased procedural services is possible for surgical procedure codes upon written appeal review.
 - i. Unlisted surgical procedure codes are not eligible.
 - ii. Medical director review will determine if requirements are met for an additional allowance for modifier 22.

Note: This review occurs at the written appeal stage due to extensive analysis by Healthcare Services of past modifier 22 claims showing it is extremely rare for the requirements for increased allowance in this policy to be met and documented in the medical records and summary of the increased complexity of the surgical procedure.

- b. If the review determines that an additional allowance is warranted, the procedure will be reimbursed at 125% of the normal allowance (contracted fee or maximum plan allowable).

E. Criteria for Non-maternity Surgical Codes

1. The surgical case must be correctly coded (all codes for the case).
2. An increased allowance (for modifier 22) will not be considered/allowed for any of the following situations or circumstances:
 - a. Not separately reportable under correct coding guidelines (e.g., unbundling).
 - b. Are correctly reported under a different procedure code (e.g., reoperation procedure codes, more extensive procedure codes, etc).
 - c. Otherwise not accurately reporting the services provided/documented.
 - d. The use of a robotic assisted surgery device.
 - e. Use of computer assisted navigation device.
 - f. Lysis of adhesions in the absence of any other factors. Lysis or division of an average amount of adhesions is included in the RVU for surgical procedures. Thus, the allowance for the primary surgical procedure(s) includes the work involved in lysis of adhesions.
 - g. Solely for a complication.
 - h. Solely for a lengthy procedure due to the surgeon's choice of approach.
 - i. If the original approach fails and must be converted to another approach, then only the successful approach is reportable (CMS¹⁷, Grider¹²), and the increased work and time due to the first attempted approach does not warrant an increased allowance. (CMS¹⁸)

Example:
The surgeon elects a laparoscopic cholecystectomy but is unable to complete the procedure laparoscopically and must convert to an open cholecystectomy. The increased time spent on the attempted laparoscopic approach does not warrant an increased allowance.
 - ii. If the original approach does not fail but proves more difficult and requires additional time and effort to complete without converting to another approach, or otherwise results in an intraoperative complication, then the increased work due to the surgeon's choice of approach does not warrant an increased allowance.

Example:
If the surgeon elects a vaginal approach for a hysterectomy which results in additional work that would not have been considered increased procedural work substantially greater than typically required for an abdominal hysterectomy, then the increased work due to the vaginal approach does not warrant an increased allowance.
 - i. A "reoperation" when the patient has had a prior surgery which does not significantly increase the difficulty of the current surgery.
 - j. A "reoperation" when a specific procedure code is available to specify that the procedure is a reoperation.
 - k. Modifier 63 and modifier 22 may not be reported on the same code. (Moda^E)

- I. A procedure code that does not have a global days indicator of 000, 010, or 090 on the Medicare Physician Fee Schedule. (CMS¹⁹)
3. **To qualify for an increased allowance** for surgical codes with a global indicator of 000, 010, or 090 **two or more of the following factors** must be present:
 - a. Unusually lengthy procedure.
 - b. Excessive blood loss during the procedure.
 - c. Presence of an excessively large body habitus, e.g., BMI \geq 40 (especially in abdominal surgery).
 - d. Trauma extensive enough to complicate the procedure *and not billed as separate procedure codes*. Documentation must specify how the procedure was complicated.
 - e. Other pathologies, tumors, malformations (genetic, traumatic, surgical) that directly interfere with the procedure *but are not billed as separate procedure codes*. Documentation must specify how these pathologies interfered with the procedure.
 - f. The services rendered are significantly more complex than described for the submitted CPT or HCPCS code, and there is not another, more appropriate code that describes the additional work or complexity involved.
 4. The operative report must document the additional complexity. See "[Documentation Requirements for Increased Procedural Services](#)".

F. Criteria for Maternity/Delivery Surgical Codes

An increased allowance for maternity/delivery codes is sometimes, but not always, considered warranted for a cesarean delivery (not VBAC attempt) of multiple gestations (e.g., twins, triplets, etc.).

1. Modifier 22 may not be added to the cesarean delivery code simply because there are multiple gestations. CPT code 59510 (*Routine obstetric care including antepartum care, cesarean delivery, and postpartum care*) includes delivery of all babies in multiple gestations, according to instructions from the AMA. (AMA¹⁴, Moda^B)
2. There must be significant extra difficulty involved with delivering the additional baby/babies to append modifier -22.
 - a. The extra difficulty will most often involve a combination of [the factors required for other non-maternity surgical procedures](#).
 - b. The operative report must support and document the significant extra difficulty involved. (AMA¹⁴, Moda^B) [See section F](#).
3. The written appeal must contain an explanation of the significant extra difficulty involved and include a copy of the operative report.

G. Documentation Requirements for Increased Procedural Services

The operative report must support and document the nature, extent, and details of the increased procedural services in simple “layman’s terminology.”

1. The conclusion of the report needs to briefly specify and summarize how this procedure was more complex than usual (which qualifying criteria were met) and quantify how much more complex this procedure was as compared to the usual.
2. Details supporting this statement must be contained in the description of the procedure located in the body of the operative report.
3. Examples:
 - a. For “unusually lengthy” - Document the duration/time of procedure as compared with the usual range of duration.
 - b. For “excessive blood loss” – Document the amount of blood loss as compared with the usual range of blood loss for this procedure, and any treatments or procedures needed to treat the blood loss.
 - c. For extensive trauma complicating the procedure – Clearly document how the trauma complicated the procedure and estimate how much more complex the case was from the usual.

H. Submitting A Modifier 22 Reconsideration Request (Written Appeal)

1. When modifier -22 is reported to indicate increased procedural services, a written appeal with documentation must be submitted for manual review before any adjustment to increase the fee allowance can be considered.
 - a. The billing office must supply both of the following items:
 - i. An appeal cover letter containing a concise statement about how the service differs from the usual and indicating the factors contributing to the increased difficulty of the procedure.
 - ii. The operative report for the service with clear documentation. See “[Documentation Requirements for Increased Procedural Services](#)”.
 - b. The appeal cover letter is not a part of the medical record. This statement alone is not sufficient to support the need for an increased allowance but assists in the review process by summarizing and directing the reviewer’s attention to what will be found in the operative report. The operative report must also be supplied and the increased difficulty and the reasons for it must be clearly documented in the operative report. (Moda ^D)
 - c. It is the responsibility of the surgeon’s billing office to submit all necessary documentation.
2. If the nature, extent, and reasons for the increased work of the procedural service are not clearly documented in the record or if the documentation submitted is incomplete, the service will be reimbursed at the normal allowance (contracted fee or maximum plan allowance).

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
AROM	=	Artificial Rupture Of Membranes
BMI	=	Body Mass Index
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit
UB	=	Uniform Bill
VBAC	=	Vaginal Birth After Cesarean

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier 22	<p>Increased Procedural Services: 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. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).</p> <p>Note: This modifier should not be appended to an E/M service.</p>

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

Modifier -22 identifies a service that required substantially greater effort than usually required and well outside of the range typically needed.

Per the AMA, any time the modifier -22 is used, when filing an insurance claim, the operative report is to be sent along with the claim to indicate and justify the unusual service. (AMA⁴) The medical record documentation must support both the substantial additional work and the reason for the additional work (e.g., increased intensity, time, technical difficulty of procedure, severity of the patient's condition, physical and mental effort required).

Inappropriate Use of Modifier -22

- Do not use when a listed procedure code is available to describe the service performed.
- Do not use modifier 22 in combination with an E/M service.
- Do not use modifier 22 in combination with an unlisted procedure code.
- Do not use modifier 22 in combination with anesthesia codes. Additional time units are used to report the duration of the procedure. Additional effort and complexity are otherwise reported using anesthesia physical status modifiers.

Cross References

- A. ["Global Surgery Package for Professional Claims"](#), Moda Health Reimbursement Policy Manual, RPM011.
- B. ["Maternity Care."](#) Moda Health Reimbursement Policy Manual, RPM020.
- C. ["Anesthesia Physical Status Modifiers \(P1 - P6\)."](#) Moda Health Reimbursement Policy Manual, RPM032.
- D. ["Medical Records Documentation Standards."](#) Moda Health Reimbursement Policy Manual, RPM039.
- E. ["Modifier 63 - Procedure Performed on Infants Less Than 4 kg."](#) Moda Health Reimbursement Policy Manual, RPM062.

References & Resources

1. American Medical Association. "Appendix A – Modifiers." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.4.4, 20.4.6.
3. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 40.2.A.10.

4. American Medical Association. "Modifiers". *CPT Assistant*. Chicago: AMA Press, Spring 1991, p. 7.
5. American Medical Association. "Modifiers Used with Surgical Procedures". *CPT Assistant*. Chicago: AMA Press, Fall 1992, p. 15.
6. American Medical Association. "Modifiers". *CPT Assistant*. Chicago: AMA Press, November 1996, p. 19.
7. American Medical Association. "Modifiers, Modifiers, Modifiers: A Comprehensive Review". *CPT Assistant*. Chicago: AMA Press, May 1997, p. 1.
8. American Medical Association. "Modifiers". *CPT Assistant*. Chicago: AMA Press, January 2000, p. 5.
9. American Medical Association. "Modifier Update-New and Revised Modifiers for Outpatient Use". *CPT Assistant*. Chicago: AMA Press, May 2000, p. 1.
10. American Medical Association. "Modifiers, to Unlisted Codes (Q & A)". *CPT Assistant*. Chicago: AMA Press, February 2002, p. 10.
11. American Medical Association. "Coding Communication: Modifiers". *CPT Assistant*. Chicago: AMA Press, January 2007, p. 30.
12. Grider, Deborah J. *Coding with Modifiers: A Guide to Correct CPT and HCPCS Level II Modifier Usage*. Chicago: AMA Press, 2004, pp. 38-43.
13. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § C.9-10, "Medical/Surgical Package", page I-10.
14. American Medical Association. "Maternity Care – Conception to Delivery". *CPT Assistant*. Chicago: AMA Press, August 2002, p. 1.
15. American Medical Association. "Maternity Care and Delivery/Surgery, 59400 (Q&A)". *CPT Assistant*. Chicago: AMA Press, February 2003, p. 15.
16. American Medical Association. "Maternity Care and Delivery, 59400 (Q&A)". *CPT Assistant*. Chicago: AMA Press, April 1998, p. 15.
17. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § C, 10 & 11.
18. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § E.1.a.)"
19. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 40.2.A.10 & 40.4.

Background Information

Modifiers

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g., T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

RVUs and Fee Allowances

The RBRVU and fee allowance for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. (CMS²) For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. Thus, the payment for a service should be increased only under very unusual circumstances based upon review of medical records and other documentation. (CMS²)

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other

professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
6/14/2023	Clarification/Update: Sections B.9, B.10 , & E: clarification update. References & Resources: 1 entry added.
12/14/22	Formatting/Update Scope: Idaho added. Cross References: Hyperlinks added.
6/8/2022	Formatting/Update: Change to new header. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
7/27/2011	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on CMS policy on Payment Due to Unusual Circumstances (Modifiers “-22” and “-52”) (CMS ²)