



**Manual:** Reimbursement Policy

**Policy Title:** **Modifier 22 - Increased Procedural Services**

**Section:** Modifiers

**Subsection:** None

**Date of Origin:** 1/1/2000                      **Policy Number:** RPM007

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### **Scope**

This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/EOCCO plans.

### **Reimbursement Guidelines**

Moda Health does not allow additional reimbursement for increased procedural services when the contracted fee allowance is based on a percentage of billed charges.

Moda Health allows additional reimbursement at specific reimbursement rates for certain chemical dependency services only when specified in the Moda Health provider contract and requirements specified in the contract are met.

Moda Health does not allow additional reimbursement for increased procedural services on non-surgical procedure codes (with limited chemical dependency exceptions noted above). Non-surgical procedures (e.g. laboratory, radiology, medical codes, etc.) submitted with modifier 22 for increased procedural services are reimbursed at the normal allowance (contracted fee or maximum plan allowance).

Moda Health does not allow additional reimbursement for increased procedural services for anesthesia codes.

Moda Health allows additional reimbursement for increased procedural services on surgical procedure codes, and only after manual review to determine if an additional allowance is warranted. 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).

When modifier -22 is used to indicate increased procedural services, the documentation must be submitted for manual review before any adjustment to increase the fee allowance can be considered.

- The billing office should supply *both* of the following items:
  - A concise statement about how the service differs from the usual and indicating the factors contributing to the increased difficulty of the procedure.
  - The operative report for the service.
- The concise statement or brief 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 our 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 documented in the operative report.
- It is the responsibility of the surgeon's billing office to submit all necessary documentation.
- The billing office may choose to submit claims with modifier 22 manually with the required supporting documentation attached, or submit the claims electronically and submit the required documentation for review upon request.
- A prompt response to requests for medical records or additional information required for review will help to avoid unnecessary delays in adjudication of the claim.

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).

An increased allowance for surgical codes is considered warranted when:

Two or more of the following factors are present:

- Unusually lengthy procedure.  
(Duration/time of procedure as compared with usual must be documented in the operative report, not merely on a cover letter.)
- Excessive blood loss during the procedure.
- Presence of an excessively large body habitus, e.g. BMI  $\geq 40$  (especially in abdominal surgery).
- The delivery of twins, triplets, or other multiple gestations via cesarean delivery only of all gestations, and only if significant additional difficulty is encountered.
- Trauma extensive enough to complicate the procedure *and not billed as separate procedure codes*.
- Other pathologies, tumors, malformations (genetic, traumatic, surgical) that 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 code, and there is not another, more appropriate code that describes the additional work or complexity involved.

An increased allowance for surgical codes is NOT considered warranted for:

- The use of a robotic assisted surgery device.
- Use of computer assisted navigation device.

- 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.
- The vaginal delivery of twins, triplets, or other multiple gestations, or 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.
- Solely for a complication.
- Solely for a lengthy procedure due to the surgeon's choice of approach.
  - If the original approach fails and must be converted to another approach, then only the successful approach is reportable<sup>12</sup>, and the increased work and time due to the first attempted approach does not warrant an increased allowance.
 

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.
  - 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.
- A "reoperation" when the patient has had a prior surgery which does not significantly increase the difficulty of the current surgery.
- A "reoperation" when a specific procedure code is available to specify that the procedure is a reoperation.

## **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. (CMS<sup>2</sup>) 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. (CMS<sup>2</sup>)

### **Codes and Definitions**

Modifier **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).

**Note:** This modifier should not be appended to an E/M service.

## Coding Guidelines

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 should be sent along with the claim to indicate and justify the unusual service. 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.

## 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.

## **IMPORTANT STATEMENT**

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should 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 applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health

reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.