In the event of 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 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.

Increased Procedural Services (Modifier 22)

Policy Number: CPCP013

Version: 4.0

Clinical Payment and Coding Policy Committee Approval Date: 02/28/2018

Effective Date: 05/30/2018

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. Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for service rendered using valid codes from HIPAA-approved code sets. Claims are subject to the code auditing protocols for services/procedures billed. This policy does not address all situations that may occur and in certain circumstances these situations may override the criteria within this policy.

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. 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 review. Reasons for additional work may include:

- Increased intensity
- Increased time
- Technical difficulty
- Severity of the patient's condition

- Physical and mental effort

Documentation must support *why* the procedure was more intense, took longer, or was more difficult. 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 statements including but not limited to the following:

- Surgery took 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 be denied. 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.

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