Payment Policy | Modifier 22 Procedures

EFFECTIVE DATE: 09|01|2018
POLICY LAST UPDATED: 10|05|2022

OVERVIEW
This policy documents the BCBSRI's position on reporting and reimbursement of services reported with modifier 22.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Prior authorization review is not required.

POLICY STATEMENT
Medicare Advantage Plans and Commercial Products
Claims filed with modifier 22 are approved for additional reimbursement when submitted with a completed Modifier 22 Unusual Procedure Form (see below) and the operative note clearly defining the increased intra-service time and when one of the following criteria is met:

- Significant and extensive adhesions
- Extensive trauma, scarring, hemorrhaging, cardiac or respiratory arrest complicating the procedure
- Presence of an excessively large specimen (tumor)
- Complications relating to morbid obesity (body mass index (BMI) is >40)

According to CPT, a provider's documentation (e.g., the operative report) must support the substantial additional work and the reason for the additional work such as intensity, time, and technical difficulty, severity of the patient's condition and/or the physical and mental effort required of the provider. Supporting documentation must compare the median intra-service time as published by CMS versus the time required to complete the increased procedure based on the patient's complexities and/or complications that the provider encountered during the increased procedure. In order to be approved, the time indicated on the form must be >120% of the median intra-service time according to CMS.

Claims approved will be reimbursed at 120% of the allowed for service.

Modifier 22 Unusual Procedural Service Code

COVERAGE
Not applicable

BACKGROUND
A modifier is made up of a two-character alpha/numeric indicator that is appended to a Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS Level II) code. A modifier is used as a means of reporting a specific circumstance that further defines or alters the reported code but does not change the definition of the procedure performed.

Modifier 22 is described by 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.

The BCBSRI's reimbursement for a surgical procedure takes into account the average work effort required to perform the surgical procedure based on the CMS published Relative Value Units (RVUs). The RVUs account for the average work resources associated with the procedure. There may be times when a surgical procedure requires less effort than typically warranted and other times a procedure may require some additional effort.

The BCBSRI recognizes there may be times when the work RVU does not account for the individual clinical circumstances that are above and beyond the average work resources associated with the surgical procedure. In these instances, BCBSRI accepts modifier 22 on those surgical procedures.

CODING
Not applicable

RELATED POLICIES
Not applicable

PUBLISHED
Provider Update, January 2022
Provider Update, August 2018

REFERENCES
1. Current Procedural Terminology, cpt® 2018, Professional Edition, pg. 751
2. CMS.gov: CY 2018 PFS Final Rule Physician Time

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