If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP 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. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Increased Procedural Services (Modifier 22)

Policy Number: CPCP013

Version: 2.0

Clinical Payment and Coding Policy Committee Approval Date: April 30, 2021

Plan Effective Date: August 12, 2021 (Blue Cross and Blue Shield of Texas Only)

This Clinical Payment and Coding Policy is intended to serve as a general reference guide for increased procedural services. Health care providers (i.e., facilities, physicians and other qualified health care professionals) are expected to exercise independent medical judgement in providing care to members. This policy is not intended to impact care decisions or medical practice.

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 the American Medical Association's (AMA) Current Procedural Technology (CPT) as identifying an increased procedural service. 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 (E/M) services.

Reimbursement Information:

Additional payment for services may be considered in circumstances when the work effort is "substantially greater" than usually required. Use modifier 22 in such an instance. Use of modifier 22 is a representation by the provider that the treatment rendered on the date of services was substantially greater than usually required. 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. The medical record documentation must clearly indicate the additional work required to support the use of Modifier 22. Reasons for additional work may include:

- Increased intensity
- Increased time
- Technical difficulty of procedure
- Severity of the patient's condition
- Physical and mental effort that was required

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 or conclusory statements including but not limited to the following:

- Surgery took an additional two hours
- This was a difficult procedure
- Surgery for an obese patient

Additional Information:

- The additional difficulty of the procedure, how the service differs from the usual, should be detailed in the body of the operative report.
- Modifier 22 should not be appended to a procedure/service if the additional work performed has a specific procedure code.
- Modifier 22 should only be reported with procedure codes that have a global period of 0, 10, or 90 days.

The plan reserves the right to request supporting documentation. Claims may be reviewed on a case-by-case basis. For additional information related to this policy, please refer to the Plan's website or contact your Network Management Office.

References:

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

Centers for Medicare and Medicaid Services (CMS). Pub 100-04 Medicare Claims Processing https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2997CP.pdf

Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual. Chapter 12, Physicians/Nonphysicians Practitioners https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Policy Update History:

Approval Date	Description
02/28/2018	New Policy
02/08/2019	Annual Review
04/02/2020	Annual Review, Disclaimer update
04/30/2021	Annual Review

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