BlueCross BlueShield Minnesota

COMMERCIAL REIMBURSEMENT POLICY

Modifier 22

Active

Policy Number: Surgery/Interventional Procedure – 004
Policy Title: Modifier 22
Section: Surgery/Interventional Procedure
Effective Date: 07/05/23

Description

This policy addresses reimbursement for services that are submitted with a 22 modifier.

Definitions

Modifier 22: Increased Procedural Services. This modifier is used to identify a service that requires significantly greater effort, such as increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required, than is usually needed for that procedure. Examples include surgery complicated by extensive scarring and adhesions throughout the operative field or surgical access markedly impeded in a morbidly obese patient.

Policy Statement

Increased procedural services are submitted by appending modifier 22 to the procedure code. Modifier 22 should only be reported with procedure codes that have a global period assignment of 0,10, 90 or MMM in the National Physician Fee Schedule (NPFS).

Submission of a claim using the 22 modifier requires adequate documentation of the rendered services, as outlined in the "Documentation Submission" section of this policy.

Upon receipt of the required documents, a review will be conducted to determine if the information supports an additional payment of up to 20% of the allowable amount for the unmodified procedure (not to exceed billed charges).

The procedures submitted with the 22 modifier will be individually reviewed; however, not all services submitted with 22 will be considered eligible for additional reimbursement.

Inappropriate use of modifier 22:
Examples in which appending the 22 modifier are not appropriate for use include but are not limited to the following:

- Evaluation and management (E/M) services
- Anesthesia services
- DME services
- Unlisted codes, which should not be submitted with modifier 22. As an unlisted code, the service already lacks specific definition and as such, will be reviewed for payment consideration

- Procedures that are prolonged or complicated by the surgeon's choice of approach
- Situations where the extent of adhesions requiring lysis is average or expected, which should be included as part of the primary procedure
- Use of the 22 modifier based solely on performance of a robotic-assisted procedure or other specialized technique
- Use of the 22 modifier to indicate that a specialist performed the service
- Patient's BMI when no significant complications or difficulties were encountered during the procedure

In addition, if the service submitted with the 22 modifier could have been reported with a more definitive code describing services performed, the procedure submitted with the 22 modifier will be denied because the more definitive procedure code should have been submitted.

Documentation Submission

An operative/procedure report supporting the level of complexity and a statement clearly explaining why the service required substantially increased work and/or complexity, are required to support the request for additional reimbursement.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	22
ICD-10 Diagnosis:	N/A
ICD-10 Procedure:	N/A
CPT/HCPCS:	N/A

Revenue Codes: N/A

Resources
Current Procedural Terminology (CPT®)
Medicare Claims Processing Manual. Chapter 12 – Sections 40.2, 40.4

Policy History	
12/04/2014	Initial Committee Approval
11/07/2019	Annual Policy Review
01/26/2021	Annual Policy Review
11/29/2021	Revised
06/27/2023	Revised