Coding Policy **Policy and Procedure**		
SUBJECT: Coding Policy 10.0 Modifier 22 (Increased Procedural Services)	DEPARTMENT: **Health Care Services**	
ORIGINAL EFFECTIVE DATE: 05/1990	DATE(S) REVIEWED/REVISED: 11/92-01/10, 01/11, 01/12, 01/13, 01/14, 01/15, 01/16, 01/17, 01/18, 01/19, 07/19, 01/20, 08/20, 01/21, 01/22, 6/22	
APPROVED BY: Coding Policy Review Committee	NUMBER: **MC 10.0**	PAGE: **1 of 3**

SCOPE:
Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
Health Plan Providers, Professional Charges Only
All Lines of Business

POLICY:
Modifier 22: Increased Procedural Services
When the work required to perform a service is substantially greater than typically required, Modifier 22 may be added to the usual procedure code. Documentation must show substantial additional work, as well as the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).

Subject to billing guidelines below, additional reimbursement may be provided to the surgeon for procedures that are significantly more complex than usual for the listed procedure.

Company does not allow additional reimbursement for increased procedural services when the contracted fee allowance is based on a percentage of billed charges. Modifier 22 is allowed only for professional charges. Modifier 22 is not recognized on facility claims.

Company allows additional reimbursement for increased procedural services on surgical procedure codes only after medical 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).

PROCEDURE:
Documentation must be submitted for medical review for all codes billed with Modifier 22. Company will not consider an increase in the payment amount without supporting documentation.

The billing office must supply ***both*** of the following items:

- A concise statement written by the surgeon explaining how the service differs from the usual and indicating the factors contributing to the increased difficulty of the procedure.
- The operative note for the service.

Claims submitted without documentation are processed at the allowable fee with no additional reimbursement.
Modifier 22 is allowed only with procedure codes with global periods of 0, 10, or 90 days as designated on the Medicare Physician Fee Schedule (MPFS).

Codes with global periods "XXX" (E/M codes, Anesthesia, Radiology, Laboratory and Pathology, and most Medicine codes), "YYY" (unlisted codes) and "ZZZ" (add-on codes) may not be billed with Modifier 22.

For procedures with global period "MMM" (maternity codes), see Coding Policy 07.0 (Global Payment for Obstetrical Care).

An increased allowance for surgical codes may be 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 note, not merely on a cover letter.
- Excessive blood loss during the procedure.
- Presence of an excessively large body habitus, e.g., BMI greater than or equal to 40 (especially in abdominal surgery).
- Presence of an excessively large surgical specimen (especially in abdominal surgery).
- Trauma extensive enough to complicate the particular 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.

If a third or fourth degree laceration occurs during a vaginal delivery, modifier -22 will be considered valid. However, the additional reimbursement will be made based on the delivery-only code. See Coding Policy 07.0 (Global Payment for Obstetrical Care).

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

- The use of 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.
- 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, only the successful approach is reportable, and the increased work and time due to the first attempted 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.
- 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.
- Obesity other than described above (BMI greater than or equal to 40).

REFERENCE:

Current Procedural Terminology (CPT)
CMS/Medicare Rules and Regulations
Providence Health Plan Coding Edits