PAYMENT POLICY ID NUMBER: 10-034

Original Effective Date: 06/29/2010

Revised: 06/13/2024

Increased Procedural Services (Modifier 22)

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO BCBSF MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

The term "increased procedural services" designates a service provided by a physician or other healthcare professional that is substantially greater than typically required for the procedure or service as defined in the Current Procedure Terminology (CPT®) book. Increased procedural services are reported by appending Modifier 22 to the usual procedure code.

Modifier 22 should only be reported with procedures that have a 0, 10, or 90 day global period that required a level of work far more extensive than usually necessary for the listed procedure. To identify those procedures which have a 0, 10, or 90 day global period, please refer to the Medicare Physician Fee Schedule Database (MPFSDB).

Modifier 22 should not be appended to codes for Evaluation and Management (E/M) services (99202-99499).

REIMBURSEMENT INFORMATION:

For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. There are times when the work effort may be less than typically warranted and times when the work effort may be more. Florida Blue may increase the payment for a service only under very unusual circumstances based upon review of medical records and other documentation when the work effort is "substantially greater" than the usual case. Submission of Modifier 22 does not assure coverage or additional reimbursement.

Two or more of the following factors should be present:

- Unusually lengthy procedure.
- Excessive blood loss during the procedure.
- Presence of an excessively large surgical specimen (especially in abdominal surgery).
- Trauma extensive enough to complicate the 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 Healthcare Common Procedure Coding System (HCPCS) code.

Modifier 22 should not be used to report the following:

- Increased complexity due to a surgeon's choice of approach
- Use of a specialized or new technology
- Describing a re-operation
- Describing a weight reduction surgery
- Describing the use of robotic assistance
- An unspecified procedure code.

Covered services submitted with Modifier 22 will be reimbursed initially based on the regular fee schedule amount. If the provider feels additional reimbursement is appropriate, they must appeal for additional payment by submitting medical documentation to support the appeal. Two items are required:

- A concise statement regarding how the service differs from the usual procedure or service and
- The operative report

In order to qualify for additional reimbursement, any clinical records or reports must clearly document the substantial, additional work performed and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, and severity of patient's condition, physical and mental effort required). Generalized statements such as "difficult surgery" or "took an extra hour" without a specific explanation of why the procedure was unusual will not be accepted as appropriate documentation. Depending on the circumstances surrounding the procedure(s), Florida Blue may allow an additional amount, not to exceed an additional 20% or billed charges, whichever is less.

BILLING/CODING INFORMATION:

The following codes may be used to describe Increased Procedural Services:

HCPCS Coding/Modifiers:

22	Increased Procedural Services

REFERENCES:

1. American Medical Association, *Current Procedural Terminology (CPT®), Professional Edition.*
2. Centers for Medicare and Medicaid Services: Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners, Sec. 40.2.A.10
3. Centers for Medicare and Medicaid Services: Physician Fee Schedule Relative Value File at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html

GUIDELINE UPDATE INFORMATION:

06/29/2010	New policy
05/31/2012	Revised – Changed name from BCBSF to Florida Blue
06/16/2016	Annual Review – updated Reimbursement Information and References
06/15/2017	Annual Review – no changes
06/14/2018	Annual Review – no changes
06/20/2019	Annual Review – no changes
06/11/2020	Annual Review – no changes
06/10/2021	Annual Review – E/M range changed to 99202-99499
06/16/2022	Annual Review – no changes
06/08/2023	Annual Review – References reviewed and updated.
06/13/2024	Annual Review – References reviewed and updated.