

Corporate Payment Policy 6 -22 MODIFIER PAYMENT POLICY

Updated effective June 1, 2021

Background & Description

Modifiers are essential tools in the coding process. The American Medical Association (AMA) developed Healthcare Common Procedure Coding System Level I (HCPCS) modifiers, which are numeric. The Centers for Medicare and Medicaid Services (CMS) developed HCPCS Level II alphabetic modifiers. The Current Procedural Terminology (CPT®) and HCPCS Level II code sets nomenclature use modifiers as an integral part of their structure. A modifier provides a means of reporting specific circumstances that further defines or alters the reported code but does not change the definition of the procedure and/or service performed.

Modifiers are used to report or to indicate information, such as the anatomical site, discontinued procedure, state-supplied vaccine, rental item, or performance by more than one physician and/or in more than one location to the code. Additionally, modifiers help to eliminate the appearance of duplicate billing and unbundling. Modifiers are used to increase accuracy in reimbursement, coding consistency, editing, and to capture payment data.

Modifiers do not guarantee reimbursement. Some modifiers may increase or reduce reimbursement, whereas some are only informational. There may be times when a procedure requires less effort than typically warranted and other times a procedure may require some additional effort.

Modifiers are important in accurate coding and communication between the practitioner and BCBSVT.

The focus of this policy is **CPT® Modifier -22** (Increased Procedural Services), which is to be appended to the normal procedure code for a service when the work required to provide that service is substantially greater than what is typically required.

Policy

Modifier -22 should be used only when additional work factors requiring the practitioner's technical skill involve significantly increased work, time, and complexity than when the procedure is normally performed. The procedure and/or service may be surgical or non-surgical. Reimbursement already accounts for the possibility that sometimes the procedure will be simpler and other times more difficult than normal. However, there are times when a procedure can be significantly more difficult.

Procedure codes submitted with a modifier -22 **may be eligible** for increased reimbursement to the extent they follow the guidelines set forth in this policy.

Modifier -22 may only be used with procedures that have a global period of 0, 10, or 90-days. To check the global period of a given procedure code, refer to the clear claim connect tool, located on our secure provider portal. Details on how to use the tool are located in the online provider handbook.

Eligible Services

Circumstances where BCBSVT considers it appropriate to use modifier -22, when thoroughly documented, include but are not limited to:

- Excessive blood loss during the actual procedure performed.
- Unusually lengthy procedure.
- Presence of an excessively large surgical specimen.
- Trauma extensive enough to complicate the procedure and not billed as separate procedure codes.
- Other pathologies, tumors, malformations (genetic, traumatic, surgical) that increase the complexity of the procedure and 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 Level II code and the provider is unable to report a secondary procedure for the additional work.
- Anatomical variants.
- Services eligible for assistant at surgery where the procedure involves significantly more work than usual (to check what codes are eligible for assistant surgery, refer to the clear claim connect tool, located on our secure provider portal. Details on how to use the tool are located in the online provider handbook).
- Modifier -22 is generally not appended to radiology or laboratory/pathology codes. If a rare circumstance does occur, submit detailed documentation with a cover letter from the radiologist, pathologist, or other provider.
- Modifier -22 is used with the following codes in the medicine section of CPT®, when unusual circumstances are well documented. The following list **is not** all-inclusive:
 - hemodialysis procedure codes 90935, 90937, and 90939
 - peritoneal dialysis procedure codes 90945, 90947, and 90997
 - gastroenterology procedure codes 91000 – 91299
 - cardiovascular procedure codes 92950 – 92998

Not Eligible for Payment

Circumstances where BCBSVT **does not** consider it appropriate to use modifier -22 include, but **are not** limited to:

- If another CPT® code (including an unlisted procedure code) more accurately describes the performed procedure.

- If the cause of the increased work results from the surgeon's choice of approach (e.g., open vs. laparoscopic, elected a vaginal approach for hysterectomy that would not have been considered an 'unusual procedural service' if performed abdominally, etc.).
- To describe an average amount of lysis or division of adhesions between organs and adjacent structures (routine lysis of adhesions is considered an integral and inclusive part of the procedure).
- If the additional work or procedure is included in the primary procedure or another procedure and is not separately reimbursable.
- Mentioning that the patient was obese without describing how the obesity created need for additional work.
- If the sole purpose for use of the modifier is due to a 'reoperation' where the patient has had a prior surgery which does not significantly increase the difficulty of the current surgery.
- If the code is an Evaluation and Management (E/M) service.
- Appending surgery codes with modifier -22 to indicate robotic or computer-assisted surgery in order to receive separate or additional reimbursement for the use of robotic or computer systems (see CPP_04 Robotic & Computer Assistive Devices Payment Policy for complete guidelines).
- Using modifier -22 to indicate that the radiology, laboratory/pathology or medicine procedure was performed by a specialist; specialty designation does not warrant use of the -22 modifier.
- Using modifier -22 when more x-ray views are taken than actually specified by the CPT® code description. This is incorrect, especially when the code descriptor reads 'complete' (e.g., 70130, 70321, 73110, etc.). 'Complete' means any number of views taken of the body site.
- Modifier -22 and modifier -63 (Procedure performed on infants less than 4 kg) cannot be billed together on the same procedure code (CPT® or HCPCS Level II).

Benefit Determination Guidance

Payment for services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit. Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A

member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's benefits prior to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Provider Billing Guidelines and Documentation

Practitioners may be eligible for increased reimbursement to the extent that they follow the payment policy guidelines and clinical review has confirmed appropriate use of the -22 modifier.

See Addendum A (Coding Table) for -22 modifier reimbursement guidelines. See also Addendum B for a decision tree providers may use to help determine when the use of the modifier is appropriate.

Claims submitted with the -22 modifier **require** documentation (e.g., operative, medical, radiology, or laboratory/pathology reports). If the documentation provided **does not** clearly demonstrate the additional work performed, additional information **will not** be requested. In this circumstance reimbursement for the surgical or non-surgical procedure submitted with the -22 modifier **will not be eligible** for increased reimbursement.

Claims submitted with the -22 modifier, with no supporting documentation **will not be considered eligible** for a clinical review or increased reimbursement.

Documentation (e.g., operative, medical, radiology, or laboratory/pathology reports) should contain a concise statement about how the service differed from the usual, and it must support the substantial additional work and the reason for the additional work such as intensity, time, and technical difficulty, severity of patient's condition and/or physical and mental effort required for the practitioner. It **is not** sufficient to simply document the extent of the patient's illness or co-morbid condition(s) that caused the additional work. The documentation must describe the additional work performed.

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal <http://www.bcbsvt.com/provider-home> latest news and communications.

Other Information

The -22 modifier may be used with codes in the following section for the CPT® Code set: Anesthesia, Surgery, Radiology, Laboratory/Pathology, and Medicine.

Claims for services submitted with the -22 modifier are accepted on the CMS-1500 (HIPPA compliant 837P) format for professional claims.

Claims for services submitted with the -22 modifier are accepted on the UB-04 (HIPPA compliant 837I) format for institutional claims.

Eligible Providers

Policy applies to all providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

Employer Group Exclusion(s): N/A

Audit Information:

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Legislative Guidelines: N/A

References

Linker, R. & Grider, D. (2020). *Coding with modifiers: a guide to correct CPT® and HCPCS level II modifier usage*. Chicago: American Medical Association.

Related Policies

CPP_04 Robotic & Computer Assistive Devices Payment Policy – *guidelines specific to use of the -22 modifier*.

Document Precedence

BCBSVT Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts or employer benefit documents, provider contracts, BCBSVT corporate medical policies, and BCBSVT's claim editing solution. Document precedence is as follows:

1. To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract/employer benefit document language takes precedence.

2. To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3. To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4. To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and BCBSVT's claim editing solution, BCBSVT's claim editing solution takes precedence.

Policy Implementation/Update Information

New Policy effective September 2014

Updated effective June 1, 2021, for formatting and to clarify that the maximum allowed amount for reimbursement will be provider's allowed charges (see Addendum A).

Approved by

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Addendum A

Coding Table¹²

Please Note: Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Modifier (reimbursement)	
-22 Modifier	Increased Procedural Services
When documentation is submitted and the clinical review has confirmed appropriate use of -22 modifier, the allowed amount will be the lesser of (a) 120% of the fee schedule or contracted amount for the usual service (same CPT [®] /HCPCS code without the modifier) or (b) the provider's allowed charges.	
When documentation is not submitted, no clinical review will be conducted. The claims will not be eligible for increased reimbursement. The allowed amount will be the lesser of (a) 100% of the fee schedule or contracted amount for the usual service (same CPT [®] /HCPCS code without the modifier) or (b) the provider's allowed charges.	

¹Current Procedural Terminology CPT[™] codes and descriptions are the property of the American Medical Association.

²Healthcare Common Procedure Coding System (HCPCS) code set and descriptions are the property of CMS.

Decision Tree: Modifier -22

UNUSUAL PROCEDURAL SERVICES

