LifeWise
Health Plan of Washington

Payment Policy

cmi_051711

Title	**Modifier 22 – Increased Procedural Services**		
Number	**CP.PP.145.v3.3**		
Last Approval Date	05/14/24	**Original Effective Date**	11/01/00
Replaces	N/A		
Cross Reference	• *Modifier 63 – Procedure performed on Infants less than 4kg* • *Modifier 52 – Reduced Services* • *Anesthesia Guidelines* • *Maternity Services*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes procedures submitted with Modifier 22 – Increased Procedural Services that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products. Medicare Advantage products are not subject to this policy.
Policy	The Plan recognizes Modifier 22 appended to a service to indicate that the work required to provide the service is **greater than** typically required for the procedure or service billed. Modifier 22 may be reported with any code from the Surgery, Radiology, or Medicine Sections of the CPT codebook if the performance of the procedure required greater work than is typically required. Modifier 22 is **not** appropriate for evaluation and management (E&M) and anesthesia codes. For increased anesthesia service, additional time units or physical status modifiers to identify that additional work was required to render the anesthesia service should be billed instead of Modifier 22. Medical records, chart notes, or operative report(s) are required for the claim to be processed correctly. Upon receipt of the records, the claim will be reviewed and reprocessed, if appropriate. The documentation must contain a clear and concise statement indicating the substantial extra work rendered. The extra work documented should include information such as, but not limited to, the following: • The increased intensity of the work that is above and beyond those services that would be rendered for the non-modified surgery procedure and a description of the reason for the additional work • The technical difficulty and additional time involved in the procedure that is not described by another more comprehensive code • The severity of the patient's condition

- The physical and mental effort involved above and beyond the regular performance of the procedure.

Clinical staff will review the medical records, chart notes or operative reports to determine whether the additional reimbursement is fully documented and supported. If the documentation reviewed by the clinical staff does not support the need for modifier 22, no increased payment will be added to the provider's contractual allowed amount for the procedure code. When supporting documentation is not received via any method, reimbursement of the procedure will be at the provider's contractual allowed amount with no increase. No review of the appended procedure will occur, and no additional reimbursement will be made until documentation and supporting records have been received and reviewed.

Services within the code range 20100-69990 when rendered to neonates and infants with a body weight of less than 4 kg should not be billed with Modifier 22. Modifier 63 – *Procedure performed on Infants less than 4kg* should be used on these services that require greater work on the physician's part.

Modifier 22 should not be billed with Modifier 52 - *Reduced Services*.

Reimbursement for procedures appended with Modifier 22 will be 125% of the provider's applicable Fee Schedule allowed amount upon Medical Review determination.

Maternity Complications Services and High-Risk Pregnancies

Maternity complications of pregnancy and problems complicating labor and delivery management may require additional resources.

In the event that maternity complications develop as part of the delivery that necessitate additional work **greater than typically required** to perform the delivery, whether vaginal or caesarean section, Modifier 22- *Increased Procedural Services* **may be appended to the delivery code** (e.g., global maternity code, delivery only code or delivery and postpartum procedure codes). A diagnosis which reflects the related maternity complication or increased delivery services is required to be included on the claim to support the need for Modifier 22.

The documentation should contain clear, concise statements indicating the substantial extra work rendered and the specific complication encountered during the pregnancy.

Some examples of maternity complications where Modifier 22 may be appended to the **delivery code**, when supported by the documentation, include, but are not limited to, the following:

- Gestational diabetes affecting delivery
- Placenta previa/placenta accreta
- Maternal sepsis
- Maternal severe hypertension/preeclampsia of pregnancy, including Hemolysis, Elevated Liver enzymes and Low Platelets (HELLP) Syndrome
- Cesarean-section delivery of twins/multiples when billed by a global cesarean maternity code

	• Delivery of a single fetus which required **substantial additional work** and **delivery only code** was submitted
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be appropriate to the seriousness of the violation and shall be determined at Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	**Oregon providers:** Reimbursement will be 130% of the provider's applicable Fee Schedule allowed amount
Laws, Regulations & Standards	None
References	• American Medical Association's Current Procedural Terminology (AMA/CPT) codebook • Centers for Medicare and Medicaid Services (CMS) • American College of Obstetricians and Gynecologists OB/GYN Coding Manual

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	05/14/24; 12/13/23; 01/17/23; 02/10/22; 04/16/21; 04/30/20; 05/24/19; 06/05/18; 08/11/17; 09/14/16; 11/15/15; 11/23/14; 12/15/13; 01/13/13; 01/26/12; 01/27/11; 03/04/10; 05/11/09; 07/21/08; 06/09/07; 05/05/06; 08/29/05; 05/31/05; 10/08/04; 04/14/04; 12/20/02	
Version History	06/05/18	Clarified third paragraph to indicate who will be reviewing medical records to determine if increase in reimbursement is warranted
	05/24/19	Annual review; no changes
	04/30/20	Annual review; no changes
	04/16/21	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P electronic claim forms. Added second paragraph in Policy section to identify which codes can and cannot be appended with modifier 22.
	02/10/22	Clarified that the correct way to code for additional work required for anesthesia services is to bill with additional time units or physical status modifiers rather than appending modifier 22 to the anesthesia service
	01/17/23	Clarified that modifier 22 should not be appended to services rendered to neonates and infants with a body weight of less than 4 kg.
	12/13/23	In the Policy section, revised the second paragraph to identify which codes are valid with modifier 22; revised the fourth paragraph to indicate that medical records are required in order for the claim to be processed correctly; revised the sixth paragraph to indicate that if chart notes/medical records do not support the increased work, no increased reimbursement will be allowed and if documentation is not received at all, the appended procedure will not be reimbursed. Added a new

		section on the billing of maternity services which may be appended with modifier 22.
	05/14/24	• Revised the sixth paragraph in the Policy to indicate that if supporting documentation for Modifier 22 is not received, reimbursement will be made at the provider's contractual allowed amount with no increase. • Added a new section at the end of the Policy "Maternity Complication Services and High-Risk Pregnancies" which discusses scenarios where appending Modifier 22 would be appropriate.

This policy was published on May 16, 2024