

Policy Number: 1001	
Subject: Modifier 22	
Impact: Reimbursement impacting all lines	
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Policy: Modifier 22—Increased Procedural Services

Purpose

The purpose of this Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes. Claims should be coded appropriately according to industry standard coding guidelines (including, but not limited to, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits, and other CMS guidelines).

Fee determinations will be based on the applicable provider contract language and WPS/Arise/Aspirus Arise reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.

Reimbursement Requirements

WPS/Arise/Aspirus Arise allows additional reimbursement for increased procedural services on all applicable procedure codes, and only after manual 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 110% of the normal allowance (contracted fee or maximum plan allowable).

When modifier 22 is used to indicate increased procedural services on claims, (facilities, physicians, and other professionals) the documentation must be submitted for manual review before any adjustment to increase the fee allowance can be considered.

- The billing office should supply an operative report with a concise statement indicating the factors contributing to the increased difficulty of the procedure.
- The concise statement or brief cover letter is not required to be part of the medical record. This statement alone is not sufficient to support the need for an increased allowance but assists in the review process by summarizing and directing our attention to what will be found in the operative report. The operative report must also be supplied, and the increased difficulty and the reasons for it must be documented in the operative report.
- It is the responsibility of the facility's billing office to submit all necessary documentation.
- The billing office may choose to submit claims with modifier 22 manually with the required supporting documentation attached or submit the claims electronically and submit the required documentation for review upon request.

- A prompt response to requests for medical records or additional information required for review will help to avoid unnecessary delays in adjudication of the claim.

If the nature, extent, and reasons for the increased work of the procedural service are not clearly documented in the record, or if the documentation submitted is incomplete, the service will be reimbursed at the normal allowance (contracted fee or maximum plan allowance).

AMA Specific Information

Codes and Definitions

Modifier 22 Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (e.g., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).

Note: This modifier should not be appended to an E/M service.

Coding Guidelines

Modifier 22 identifies a service that required substantially greater effort than usually required and well outside of the range typically needed.

Per the AMA, any time the modifier 22 is used when filing an insurance claim, the operative report should be sent along with the claim to indicate and justify the unusual service. The medical record documentation must support both the substantial additional work and the reason for the additional work (e.g., increased intensity, time, technical difficulty of procedure, severity of the patient's condition, physical and mental effort required).

Inappropriate Use of Modifier 22

- Do not use when a listed procedure code is available to describe the service performed.
- Do not use modifier 22 in combination with an E/M service.
- Do not use modifier 22 in combination with an unlisted procedure code.

In the event that you receive a denial for the use of modifier 22, justification may be requested on a claim-by-claim basis.

