Payment Policy:	**Modifier 22 - Increased Procedural Services**	
Original Date Approved: 7/12/2019	**Effective Date:** 01/01/2019	**Date Revised:** N/A
Scope: Commonwealth Care Alliance (CCA) Product Lines: ☒ Senior Care Options ☒ One Care		

PAYMENT POLICY SUMMARY:

As defined by AMA CPT: When the work required to provide a service is substantially greater than typically required, it may be identified by appending modifier 22 to the procedure code. Modifier 22 may be appended to the following procedure codes: Surgery, Radiology, Medicine, Pathology, Laboratory, and Anesthesia.

MODIFIER 22 REQUIREMENTS:

CCA will consider approval for additional reimbursement of a procedure billed with modifier 22 when submitted with supporting documentation under the following circumstances :

- Documentation descriptively detailing increased intensity, time, or technical difficulty of the procedure
- Documentation detailing the severity of patient's illness
- Documentation containing details on the physical and mental effort required (beyond the normal scope of the procedure)
- Excessive blood loss during the procedure
- Morbid Obesity interfering with the procedure performed, BMI >40
- Significant trauma that is extensive enough to complicate the procedure
- Substantial factors (ex: Tumors) directly interfering with the procedure
- The procedure is 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.

The required supporting documentation is the operative or procedure note as well as underlining the portion of the report that identifies the use and support of the modifier. (Required information must be legible, clearly marked, and must corroborate medical necessity.)

Do not append modifier 22 to Evaluation & Management codes, Unlisted Procedure codes, Add-on codes, or procedure codes that do not have a global period of 0, 10, or 90 days.

REIMBURSEMENT

Upon review of clinical documentation and determination that the services performed are supported, CCA will reimburse an additional 20% of the allowed amount.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

Medicare 100-04 Chapter 12 20.4.6

Commonwealth Care Alliance

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POLICY TIMELINE DETAILS

1. April 2019 drafted