If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Oklahoma may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSOK has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Increased Procedural Services, Modifier 22- Professional Provider

Policy Number: CPCP013

Version: 1.0

Clinical Payment and Coding Policy Committee Approval Date: April 7, 2025

Plan Effective Date: April 15, 2025

Description

This policy is intended to serve as a general reference for billing and coding for increased procedural services. Providers are expected to exercise independent medical judgement in providing care to members. This policy is not intended to impact care decisions or medical practice.

This policy is not applicable to services billed on the UB-04 Claim Form.

Reimbursement Information

The plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement.

Modifier 22- Increased procedural services. Append modifier to indicate a service or procedure provided was substantially greater than typically required for that service.

Additional reimbursement may be considered in circumstances when the work effort is "substantially greater" than usually required. Usage of modifier 22 is a provider's representation that the service(s) rendered on the date of service(s) was substantially greater than usually required. Appending modifier 22 does not guarantee additional reimbursement.

Appropriateness & Documentation

Thorough documentation indicating the substantial amount of additional work and reason for this work is required to support the use of modifier 22.

For example, the operative report should be detailed and specify how the procedure was more complex than usual and also quantify how much more complex the procedure was as compared to the usual. A brief letter or statement that is not a part of the medical record is not sufficient to justify the use of modifier 22.

Reasons for additional work may include:

- Increased intensity
- Increased time
- Technical difficulty of procedure
- Severity of the patient's condition
- Physical and mental effort that was required

Modifier 22 is not justified by generalized or conclusory statements, such as:

- Surgery took an additional two hours
- This was a difficult procedure
- Surgery for an obese patient

Modifier 22 for Field Avoidance

Modifier 22 may be appended to claims for field avoidance when access to the airway is limited, **and** the anesthesia work required is substantially greater compared to the typical patient. There is no modifier that identifies field avoidance. Documentation must support the substantial additional work and the reason for the additional work. Additional payment secondary to field avoidance is subject to the following:

- The documentation must be included in the member's anesthesia record.
- The base unit is less than 5 units, and
- The procedure is performed around the head, neck, or shoulder girdle, and/or
- The position requires a position other than supine.

Inappropriate use of Modifier 22

The following is a list of examples where modifier 22 should **not be appended.** This is not an all-inclusive list:

- If the additional work performed has a specific procedure code.
- Procedures that are prolonged or complicated by the surgeon's choice of approach, e.g., difficulty gaining access, or a vein that is hard to find.
- Procedures delayed or otherwise impacted due to equipment malfunction, e.g., lighting, or malfunctioning scope.
- If a procedure code does not have a global period of 0, 10, or 90 days.
- E/M services
- Anesthesia services (with the exception of field avoidance as noted above).
- DME services
- Unlisted codes because their descriptions lack specific definitions.

Additional Resources

Clinical Payment and Coding Policy

CPCP010 Anesthesia Information

CPCP023 Modifier Reference Policy

References

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Centers for Medicare and Medicaid Services (CMS). Physician Fee Schedule Relative Value Files. Accessed 12/24/2024.

Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing. Chapter 12- Physicians/Nonphysician Practitioners. Section 40.2 Billing Requirements for Global Surgeries. 10 Unusual Circumstances. Accessed 12/24/2024.

Policy Update History

Approval Date	Description
02/24/2022	New Policy
05/03/2023	Annual Review
01/12/2024	Annual Review
04/07/2025	Annual Review; Grammatical updates; References updated.