Select Health

CODING/REIMBURSEMENT POLICY

MODIFIER 22

Policy # 24

Implementation Date: 01/01/02
Review Date:
Revision Dates: 01/01/06, 09/24/14, 10/4/18

Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Modifier 22 is reported by providers to identify the procedural service(s) performed is "greater than that usually required for the listed procedure."

"22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate."

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

- Anesthesia services billed for "an altered surgical field" can be reported by appending modifier 22. If base units for the code are less than 5 units then the 22 modifier will increase the base units to 5. If the base units are 5 then no additional reimbursement will be allowed.
- An operative report must be submitted for review whenever a modifier 22 is appended to a surgical code(s).
- The operative report (documentation) must support the unusual nature of the service (e.g., unusual, difficult, complex, took significant additional time). The amount of additional significant time (generally 30-45 minutes or longer) must be documented to show the additional work involved for the service provided. It is not necessary for the provider to submit a cover letter justifying the unusual service; the operative report documentation must stand on "its own". The provider may wish to submit a cover letter to justify a request for a specific percentage or amount of extra payment above the usual fee for the service.
- The routine reporting of modifier 22 for each procedural service by a provider will result in the denial of additional reimbursement (e.g., using modifier 22 to indicate the service was performed by a specialist).
- Modifier 22 cannot be used with procedural codes that have a global period of "XXX" (Per the National Physician Fee Schedule Relative Value File). Procedural codes with the "XXX" designation include Evaluation and Management codes (99201-99499), Anesthesia codes (00100-01999), and most Laboratory and Radiology codes.

SELECT HEALTH ADVANTAGE (MEDICARE/CMS)

Select Health Advantage **will follow the commercial plan policy.**

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SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care **will follow the commercial plan policy.**

Applicable Codes

This policy applies to all procedure codes with a 0, 10, or 90-day global period (The Centers for Medicare and Medicaid Services).

Sources

1. *Current Procedural Terminology (CPT®),* (2014) – American Medical Association
2. ICD-9-CM Coding Guidelines. (2013, January 1). Retrieved July 8, 2014, from https://www.encoderpro.com/epro/physicianDoc/pdf/i9v1/i9_guidelines.pdf
3. NCCI. (2014, January 1). General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare Services Chapter 1. Retrieved September 17, 2014.
4. CPT® Assistant October 2013, pp. 18, *Frequently Asked Questions*

Disclaimer

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The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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