

	Increased Procedural Services (Modifier22)	
	Policy Number: POL-PP-228	Original Creation Date 2/1/2022
	Version Number: 004	Version Effective Date 2/1/2022
	Policy Status: Active	Next Review Date 2/1/2027

NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROFESSIONAL	FACILITY	DME	AMBULATORY SURGERY	LAB	OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMERCIAL	BLUE MEDICARE ADVANTAGE	ACA QHP¹	SMALL GROUP ACA	JAA²	FEP³	DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.

Description/Application

Modifier 22 should be appended to the appropriate CPT/HCPCS code to indicate the work required providing the service was substantially greater than typically required for the procedure or service billed.

Policy

Modifier 22 should only be reported with procedure codes that have a global period of 0, 10, or 90 day and is not appropriate for evaluation and management (E&M) codes.

Medical records, chart notes, or operative report(s) must contain a clear and concise statement indicating the substantial extra work rendered. The extra work documented should include such information as, but not limited to, the following:

- The increased intensity of the work that is above and beyond those service 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.

If documentation does not support increased intensity/time, technical difficulty, or physical/mental effort above and beyond the normal performance of the procedure, additional reimbursement may be denied.

Coding

Codes	Description
N/A	N/A

References and Resources

Blue KC Provide Reference Guide
American Medical Association

Related Documents

POL-PP-108 Modifiers

Revision History

Version	Date	Summary of Revisions
001	2/1/2022	Initial Version
002	2/1/2023	Annual review, there were no changes or updates made to the policy.

003	2/1/2024	Annual review, there were no changes or updates made to the policy.
004	2/1/2025	Annual review, updated policy to say; If documentation does not support increased intensity/time, technical difficulty, or physical/mental effort above and beyond the normal performance of the procedure, additional reimbursement may be denied.
005	2/1/2026	Annual review, there were no changes or updates made to the policy.