ACTION

☒ New Policy
☐ Repealed Policy Date: _____
☐ Superseded Policy Number: _____

The most current version of the reimbursement policies can be found on www.jhhc.com.

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Johns Hopkins HealthCare (JHHC) benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services must be billed with ICD-10 codes, CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Johns Hopkins HealthCare (JHHC) may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHC reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHC strives to minimize these variations.

JHHC reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on www.jhhc.com.

POLICY:

Johns Hopkins HealthCare LLC allows increased reimbursement for procedures appended with modifier 22, meeting criteria, and not to exceed billed charges.

This policy makes public JHHC's existing policy on the subject matter, and applied prior to the Effective Date of this policy statement.

SCOPE:

This payment policy applies to surgical procedures that required increased services, reported with modifier 22 on CMS-1500 claim forms or its electronic equivalent.

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. These may also be known as *Unusual Procedural Services*. Note: This modifier should not be appended to an E/M service.

PROVIDER BILLING GUIDELINES:

Modifiers 22 applies to surgical procedure codes (10004-69990) for which services performed in the pre-operative or intra-operative period are *significantly* greater than usually required. Modifier 22 cannot be applied if the additional work occurred during post-operative time.

Procedure codes submitted with modifier 22 will be eligible for increased reimbursement if the following criteria are met:

- The procedure code has a global day indicator or 000, 010, or 090 in the current version of the CMS Medicare Physician Fee Schedule
- For all services other than global maternity care, two or more of the following must have occurred:
    - Unusually lengthy procedure due to unforeseen medical complexities or complications
    - Extensive blood loss during the procedure
    - Presence of an excessively large surgical specimen (larger than appeared on imaging or larger than physicians reasonably anticipated when beginning the procedure)

  - Trauma extensive enough to complicate the procedure and not billed as separate procedure codes
  - Other pathologies, tumors, or malformations that directly interfered with the procedure but not billed as separate procedure codes
- For global maternity care, one of the following must have occurred:
  - Cesarean delivery for multiple gestations w/ significant additional physician work
  - Provider bills a delivery only code for a delivery that included repair of a third or fourth degree laceration

Procedure codes submitted with modifier 22 will not be eligible for increased reimbursement in the following circumstances:

- If the additional work was due to the surgeon's choice of approach
- If the additional work is an included component in the primary procedure or in another procedure performed in the same operative session and not separately reimbursable
- If the additional work is due to the use of robotic-assisted devices or computer-assisted navigational devices or other specialized techniques
- If the level of experience and training of the rendering surgeon contributes to increased operative time
- If the additional work is solely for a complication that did not result in a *significant* increase in time or work
- If another code exists which more appropriately defines the services provided
- If the code is an unlisted/non-specific procedure code or a non-surgical procedure code
- If Modifier 63, 66, 80, 81, 82, or AS are billed for the same procedure code

PAYMENT METHODOLOGY

Appropriately billed increased procedures will be paid at 120% of the contracted rate. Modifier 22 can be used on one procedure code per member per date of service.

When another modifier that reduces the fee schedule amount is also applicable, Modifier 22 must be reported in the secondary position. Modifier 22's payment adjustment will be applied after the payment reduction indicated by the modifier in the primary position. (Ex:

Modifier 1 = 51 and Modifier 2 = 22 will result in reimbursement at 50% of the contracted rate then 120% of the reduced rate)

JHHC does not delay reimbursement upon medical documentation review, but medical documentation must be submitted to support the use of the modifier. Documentation should include, but is not limited to, services or length of time provided above and beyond what is typically performed for the procedure code as well as the medical complexities or complications resulting in the additional work. Documentation should be specific as to the baseline time/services required for the procedure and the time/services additionally required resulting in the use of Modifier 22.

EXCLUSIONS

Priority Partners MCO, in accordance with State guidelines, does not provide additional reimbursement for services appended with modifier 22.

EXEMPTIONS

N/A

REFERENCES:

CMS, Medicare Claims Processing Manual, Pub. 100-04, Chap. 12, Sect. 20.4.6 - Payment Due to Unusual Circumstances

TRICARE Reimbursement Manual 6010.61-M, April 1, 2015, Chap 5 Sect 1, 3.2 – Allowable Charges

TRICARE Reimbursement Manual 6010.61-M, April 1, 2015, Chap 3 Sect 1, 2.3.1

Maryland Medical Assistance Program, 2020 Professional Services Provider Manual, page 39

APPROVALS

Reimbursement Policy Committee Date: 7/6/2020

Review/Revision Dates: 6/16/2020