JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.022
		Effective Date	02/01/2024
		Approval Date	11/29/2023
	Subject **Increased Procedures (Modifier -22)**	*Supersedes Date*	08/01/2020
		Original Date	N/A
		Page	1 of 5

This document applies to the following Participating Organizations:

Advantage MD EHP Priority Partners US Family Health Plan

Keywords: Increased Procedures, Modifier 22, Modifier 63

Table of Contents		Page Number

I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual". The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

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

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

To provide basic reimbursement guidance to both participating and nonparticipating providers submitting claims to JHHP, when surgical procedures that require increased services, are reported with modifier -22. Modifier -22 is to reflect additional work that is not typically part of the procedure, but does not qualify for its own procedure code. Depending on the documentation submitted, JHHP may or may not allow additional reimbursement.

III. POLICY STATEMENT

JHHP recognizes that under unusual circumstances, it may be necessary to indicate that a procedure or service requires substantially more extensive work than usual. JHHP will determine if the requirements are met for an additional allowance, when modifier 22 is reported. Simply appending modifier 22 to the procedure code does not guarantee payment. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy. Providers are responsible for verifying the individual member's contract for specific plan benefits and to obtain prior authorization/reauthorization before an item, procedure or service is rendered.

*Providers are responsible for reviewing the **"EXCEPTIONS & EXCLUSIONS" sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES and PAYMENT METHODOLOGY

A. JHHP aligns with CMS and CPT guidance for the reporting of modifier -22.
B. Services or procedures performed that are significantly greater than usual, may be reported with modifier -22.
C. Modifier -22 can only be used on one procedure code, per member, per date of service.
D. In order to be considered for additional reimbursement, modifier -22 may only be reported with a valid procedure code that has a global period of 0, 10, or 90 days on the Medicare Physician Fee Schedule (MPFS).
E. The appropriate amount of reimbursement for increased procedures will be determined by JHHC, and in accordance with the member's plan benefits; payment not to exceed billed charges.
    i. Reduction for multiple procedures, bundling and other clinical edits will still apply.
F. When another modifier that reduces the allowable amount is also applicable, modifier -22 must be reported in the secondary position.
    i. Payment adjustment for modifier -22 will be applied after the payment reduction indicated by the modifier in the primary position.
G. When procedures are performed together that are basically the same or performed on the same site but are qualified by an increased level of complexity, the less extensive procedure is bundled into the more extensive procedure.
H. An initial approach to a procedure may be followed at the same encounter by a second, usually more invasive approach. There may be separate CPT codes describing each service. The second procedure is usually performed because the initial approach was unsuccessful in accomplishing the medically necessary service. These procedures are considered "sequential procedures." Only the CPT code for one of the services, generally the more invasive service, should be billed.

I. For all services (not including global maternity care), two or more of the following must have occurred:
   i. Unusually lengthy procedure due to unforeseen medical complexities or complications;
   ii. Extensive blood loss during the procedure
   iii. Presence of an excessively large surgical specimen (larger than appeared on imaging or larger than physicians reasonably anticipated when beginning the procedure);
   iv. Trauma extensive enough to complicate the procedure and not billed as separate procedure codes;
   v. Other pathologies, tumors, or malformations that directly interfere with the procedure but not billed as separate procedure codes.

J. For global maternity care, one of the following must have occurred:
   i. Cesarean delivery for multiple gestations w/ significant additional physician work. Modifier -22 may not be added to the code for Cesarean delivery simply because there are multiple babies.
   ii. Provider bills a delivery only code for a delivery that includes repair of a third or fourth degree laceration.

V. INAPPROPRIATE BILLING of MODIFIER –22

1. A. Modifier -22 cannot be reported by a facility, as it is a “physician-only” code.
   B. Procedure codes submitted with modifier -22 will not be eligible for increased reimbursement in the following (but not limited to) circumstances listed below.
      i. If the additional work was due to the surgeon’s choice of approach.
      ii. 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.
      iii. If the provider reports unlisted or non-specific procedural codes.
      iv. If the additional work is due to the use of robotic-assisted devices or computer-assisted navigational devices or other specialized techniques.
      v. If the level of experience and training of the rendering surgeon contributes to increased operative time.
      vi. If the additional work is solely for a complication that did not result in a significant increase in time or work.
      vii. If another code exists which more appropriately defines the services provided.
      viii. If the code is an unlisted/non-specific procedure code or a non-surgical procedure code.
      ix. If Modifier 63, 66, 80, 81, 82, or AS are billed for the same procedure code.
   C. Consistent with CMS, the provider shall not be appended modifier -22 to the following (but not limited to) services:
      i. Evaluation and Management (E/M) services
      ii. Anesthesia services
      iii. Radiology services/procedures
      iv. Pathology services
      v. Laboratory services
      vi. Durable Medical Equipment and Prosthetic and Orthotics (DMEPOS)
   D. Modifier -22 cannot be applied if the additional work occurred during post-operative time.

VI. DOCUMENTATION GUIDANCE

1. A. Documentation should provide our reviewers with a clinical picture of the patient; the procedures/services performed and support the use of modifier -22.
   B. We may deny the claim when the documentation supports another existing code.
   C. Supporting documentation should include (but not limited to) the following:
      i. An operative report;
      ii. A concise statement about how the service differs from the usual;

iii. State when or what time the procedure started and stopped;
iv. Explain why the procedure required substantial additional work;
v. Reason for the additional work
vi. Increased intensity
vii. Technical difficulty of procedure
viii. Severity of patient's condition
ix. Physical and mental effort required
x. Documentation includes a separate paragraph titled “Unusual Procedure”

VII. EXCEPTIONS & EXCLUSIONS

1. A. **PPMCO:** JHHP will process claims in accordance with Maryland Medicaid Administration reimbursement guidance. As such, modifier -22 appended to the claim does not provide additional reimbursement or benefits, as it used for data reporting services and is not reimbursable.
   B. **USFHP**: JHHP will process and reimburse claims appended with Modifier -22 in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional, specific information on policy, benefits, and coverage.

VIII. CODES, TERMS, and DEFINITIONS

Definition of Terms

Terms	Definitions
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. Documentation must support the substantial additional work and the reason for the additional work (e.g., increased intensity, time, technical difficulty of procedure, and severity of patient’s condition, physical and mental effort required).
Scope of Practice	Scope of practice refers to those activities that a person licensed to practice as a health professional is permitted to perform, which is increasingly determined by statutes enacted by state legislatures and by rules adopted by the appropriate licensing entity. Refer to the JHHP Scope of Practice policy for additional information.

Modifiers

Modifier	Description
22	Increased Procedural Services

63	Procedure performed on infants less than 4 kg. Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number.

IX. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- CMS National Physician Fee Schedule Relative Value File
- Medicare Claims Processing Manual Chapter 12
- TRICARE Manuals

X. REVISION HISTORY

Date	Review/Revision	Reason for Modification	Approved By
11/29/2023	Revision	Policy language and references updated	Reimbursement Policy Committee (RPC)