BlueCross BlueShield of Arizona
An Independent Licensee of the Blue Cross and Blue Shield Association

PRICING GUIDELINES

EFFECTIVE DATE: 02/01/11
REVISION DATE: 12/08//11

MODIFIER 22 –INCREASED PROCEDURAL SERVICES (Surgical and Maternity Care)

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pricing Guideline must be read in its entirety to determine coverage eligibility, if any.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

Pricing Guidelines are subject to change as new information becomes available.

Description:

"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 (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service."[1]

Criteria:

Surgical Services:

- An additional reimbursement of 15% beyond the applicable BCBSAZ allowed amount will automatically be calculated when modifier 22 is submitted on a professional surgery (surgeon and assistant surgeon) claim to indicate a degree of complexity or difficulty.

- Additional reimbursement of 10% beyond that which the claims payment system has applied ***may be eligible*** on a professional surgery claim (surgeon and assistant surgeon) with documentation to indicate a **significant** degree of complexity or difficulty. **Clinical documentation supporting the degree of complexity will be reviewed by the medical director(s) and/or clinical advisor(s).**

- Additional reimbursement beyond the applicable BCBSAZ allowed amount is ***not eligible*** if the clinical documentation fails to document a degree of complexity or difficulty greater than that usually required.

MODIFIER 22 – INCREASED PROCEDURAL SERVICES (Surgical and Maternity Care) (cont.)

Criteria: (cont.)

Maternity Services:

- An additional reimbursement of 15% beyond the applicable BCBSAZ allowed amount will automatically be calculated when modifier 22 is submitted on a maternity care or delivery claim to indicate a degree of complexity or difficulty. Examples of conditions appropriate for this reimbursement included, *but are not limited to*:

    1. Diabetes that may contribute toward an increase risk to the pregnancy or delivery
    2. History of genetic abnormalities that may contribute toward an increased risk to the mother (e.g., blood dyscrasias, cardiopulmonary abnormalities)
    3. Hypertension
    4. Placenta previa
    5. Pre-eclampsia
    6. Twin gestation
    7. Vaginal delivery following previous cesarean section
    8. Vaginal delivery of breech presentation

- An additional reimbursement of 50% beyond the applicable BCBSAZ allowed amount will automatically be calculated when modifier 22 is submitted on a delivery claim with **ANY** of the following diagnoses in the first position:

    1. Abruptio placenta
    2. Diabetes complicating pregnancy and delivery
    3. Eclampsia, severe pre-clampsia
    4. Multiple gestation greater than twins
    5. Premature rupture of the membranes
    6. Preterm labor (labor prior to 37 weeks gestation with documented cervical changes of dilation and/or effacement)

MODIFIER 22 – INCREASED PROCEDURAL SERVICES (Surgical and Maternity Care) (cont.)

Coding:

CPT: Modifier 22 attached to the procedure code

Resources:

1. American Medical Association. CPT®. Appendix A-Modifiers.