Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Blue Cross Blue Shield of Michigan Reimbursement Policy

These documents are not used to determine benefits or reimbursement. Please reference the appropriate certificate or contract for benefit information.

Enterprise:	Blue Cross Blue Shield of Michigan
Department	Medical Affairs
Effective Date:	02/20/2003
Next Review Date	1st Quarter 2025

Topic: Modifier 22 Criteria for Unique Complex Care

Background:

Modifier 22 is a code when appended to an established procedure code serves as a declaration that an extraordinary amount of work effort was expended by the physician. The standard reimbursement for a procedure already takes into account that a particular procedure has some variation in its difficulty, complexity, and duration. However, when the procedure is unusually difficult, additional compensation may be justified. For more commonly encountered issues, BCBSM has developed established written criteria and a fixed 35% additional payment amount. For these more common situations, BCBSM offers automated adjudication and processing to reduce administrative expense and provider burden. For evaluation of unusual cases, payment determination follows detailed review of appended clinical documentation.

Reimbursement Policy Statement:

BCBSM payment review will be conducted by a professional with training sufficient to understand the procedure and the complexities that make it exceptional and justify higher payment. This is not a medical necessity determination, but rather a pricing determination, so “same specialty” review is not necessary.

Criteria

The following represents criteria to be used by reviewers to determine eligibility for the 35 percent additional payment:

Audit

Post payment review (audit) of cases modifier -22 claims will be conducted periodically to verify compliance with criteria. Physician level review of occasionally complex cases reported with modifier 22, is also an available option.

Scope:

This policy applies to all underwritten and ASC, self funded contracts.

BCBSM Policy History

Policy Effective Date	BCBSM Signature/Review Date	Comments
02/20/2003	02/20/2003	Established as BCBSM Only Policy
02/20/2003	04/01/2005	Appended Addendum
02/20/2003	06/08/2006	Appended Addendum
02/20/2003	09/06/2006	Appended Addendum
02/20/2003	05/25/07	Appended Addendum
02/20/2003	12/16/2008	Appended Addendum
02/20/2003	03/01/2009	Appended Addendum
02/20/2003	03/01/2010	Appended Addendum
02/20/2003	09/01/2010	Appended Addendum
02/20/2003	07/31/2015	Annual review – no revisions
02/20/2003	6/21/2017	Annual review – minor editing changes, codes verified and updated
02/20/2003	4/18/2018	Annual review – no revisions
02/20/2003	3/19/2019	Annual review – no revisions
02/20/2003	3/12/2020	Annual review – no revisions
02/20/2003	3/11/2021	Annual review , CPT code ranges updated based on deleted codes, minor edits
02/20/2003	3/10/2022	Annual review , no revisions
02/20/2003	3/09/2023	Annual review , no revisions
02/20/2003	3/14/2024	Annual review , no revisions

Appendix A

The following criteria will simplify the process of adjudicating claims for very complex care. These services include surgical procedures or "certain" medical procedures that are interventional, diagnostic or therapeutic in nature; which are performed within an operative or radiology suite, or a cardiac catheterization or electrophysiological lab. They are provided to address circumstances that increase case complexity, and/or risk to the patient. Our standard pricing mechanism, based on service codes, must necessarily reflect an average distribution of degrees of time, effort, and skill. The establishment of these criteria will assist in the recognition of those services which truly fall outside of the standard distribution curves reflected in the average payment for the services.

The current experience is burdensome, requiring the submission and review of medical records, and consistency in determination has been difficult to achieve across reviewers, especially considering the diverse circumstances that underlie such requests.

As a start, BCSM approves of the following criteria for appropriate use of the -22 modifier, which would be priced for payment at a level 35% above that of the standard approved fee for the procedure. The -22 modifier will be limited to surgical procedures, and should not be used for evaluation and management services where there is already a tiered payment level reflecting degrees of time and complexity.

-22 Modifier Conditions

The following criteria are appropriate for application of the -22 modifier. Each leads to a significant increase in complexity or risk.

- Criteria applies to surgical procedure codes (15000 – 69990) and technical surgical assistance performed by MD/DO providers done within the operative suite that meet the attached criteria
- Applies to certain medical procedures (92920 – 92998, 93503 – 93660) done within the operative, endovascular and/or radiology suites as well as a cardiac catheterization and electrophysiological lab
- Services that meet the criteria should contain supportive documentation within the medical records, however, submission of the medical records will not be required
- Services meeting the criteria and reported with modifier 22 will be paid at 35% above the BCBSM maximum allowance, up to but not exceeding the charge. All applicable member co-pay and deductibles will be applied
- Claims will be subject to the multiple procedure (ClaimCheck) rules
- Eligible services are subject to all benefit and medical policy rules
- Services that do not meet the criteria but are felt to have some attendant complexity etc,

may be submitted with modifier 22 and supportive documentation to BCBSM for routing through the established individual consideration (IC) process
- Post radiation treatment patients, where the procedure is within the previous or current field of irradiation
- Unusual body habitus (i.e. morbid obesity, contractures) where the body habitus contributes significantly to the technical difficulty and complexity of the surgical procedure or provision of anesthesia. Exception- not to be used as a Modifier 22 criteria for bariatric surgeries. (Revised December 16, 2008 and September 1, 2010)
- Surgical procedures done within the operative suite for patients with coagulopathy, including warfarin (but not anti-platelet treatment), and major hemoglobinopathies, including Thalassemia Major and Sickle Cell Anemia.
- Patient was referred by a provider in the same specialty (in recognition of the special skills and experience of the specialist) outside of the practice plan of the referred physician
- Surgical procedures done on current renal dialysis patient, either hemodialysis or peritoneal dialysis, except for procedures that are only performed on such patients (e.g. vascular access in dialysis patient, renal transplant surgery)
- ECMO (extracorporeal membrane oxygenation) patients, with the exception of procedures normally employing this modality
- Revision surgery if the CPT code does not already include a revision
- Extremely prolonged duration of surgery (>2 times the usual time) will be considered appropriate, once we have established the usual time for the procedures

Addendum 4/1/05

- BCBSM now considers a BMI of 35 to define morbid obesity when imposing a severity index on patient with this condition requiring surgical and other interventional procedures
- Renal failure patients who have dialysis access operations or kidney transplants will not be considered appropriate candidates for the 22 modifier
- Renal failure will not be considered as a co-morbidity when it is the primary reason that the procedure is being performed
- The modifier is not to be used with ancillary providers (e.g. nurse practitioner)
- Exception to above**:** CRNAs are eligible for payment of Modifier 22.
- Specialties not recognized as a specialty by BCBSM (e.g. pediatric surgery, vascular surgery), receiving a referral from general surgery would be considered a referral from the same specialty as pediatric or vascular surgery if the surgical procedure was a procedure recognized to be within the training and domain of general surgery

Appended June 8, 2006

1. All of the dermatologic CPT codes listed below will be added to the body of CPT codes currently APPROVED FOR Modifier 22 use without initial BCBSM physician review.

2. Cases requiring dermatological/surgical intervention referred from community dermatologic providers outside of the academic medical center multi-disciplinary clinic specialists for the surgical management of skin cancers are appropriate for Modifier 22 use within this program.
3. The procedures listed below, in addition to surgical procedures done for patients with a coagulopathy, including warfarin management (but not including antiplatelet treatment), and major hemoglobinpathies including Thallassemia Major and Sickle Cell Anemia are considered eligible for Modifier 22 fee adjustment when performed in an adequately equipped procedure room as deemed appropriate by the provider of care.

NEW DERMATOLOGIC CODES FOR ADDITION:

11602	12032	12053	13133
11603	12034	12054	13151
11604	12035	12055	13152
11606	12036	12056	13153
11622	12037	12057	14000
11623	12041	13100	14001
11624	12042	13101	14020
11626	12044	13102	14021
11642	12045	13120	14040
11643	12046	13121	14041
11644	12047	13122	14060
11646	12051	13131	14061
12031	12052	13132	14300*

* 14300 deleted 1/1/2010, use 14301-14302

These additions to the joint pilot will become effective July 1, 2006.

Addendum: September 6, 2006; Revised May 25, 2007

Effective October 23, 2005 the anesthesia CPT codes 00100 – 01999 will be included for Modifier 22 consideration when the patient undergoing surgery and anesthesia possesses an unusual body habitus (i.e. morbid obesity, contractures due to cerebral palsy or other neuron-motor condition, etc) where the body habitus contributes to the difficulty and complexity of the procedure or provision of anesthesia. For the purposes of this policy, morbid obesity is defined as a body mass index (BMI) of 35 or more, consistent with BCBSM Medical Policy.

New Language Regarding Modifier 63: Procedures Performed on Infants less than 4 kg

Effective November 11, 2005

Surgical procedures and anesthesia for infants with body weights less than 4 kg are eligible for Modifier 22 consideration and additional payment.

1. **Anesthesiologists:** Use Modifier 22 in lieu of Modifier 63 or the Physical Status Modifiers that reflect levels of risk.
2. **Surgeons:** Use Modifier 63 for patients who qualify when the CPT procedure code submitted does not reflect the risk characteristics of the patient or the level of complexity of the procedure. These cases will be handled manually in the current Modifier 22 process.

The CPT Manual (Appendix F) contains a list of codes exempt from Modifier 63.

Addendum: December 16, 2008

- Effective January 1, 2009, atrial fibrillation (CPT codes 93653- 93757) that involve 75 or more ablations will be included for Modifier 22 consideration and additional 35% reimbursement. Cases where 74 or less ablations are performed will not meet the criteria under the Modifier 22 Program unless other Modifier 22 Program criteria is met (i.e. outside referral, BMI > 35%, etc.). All other CPT codes reported in addition to code 93651 will be paid at standard fee schedule rates, unless other Modifier 22 Program criteria are met.
- Clarification for CPT codes 17311-17315 for Mohs Micrographic Surgery effective 1/1/2009. Mohs will be included for Modifier 22 consideration and reimbursement when there is a referral from a Mohs specialist outside of the practice plan of the referred physician or other Modifier 22 Program criteria is met.

Addendum: March 1, 2009

- Clarification for CPT code 21249 reconstruction of mandible or maxilla, endosteal implant (e.g. blade, cylinder); complete will be included for Modifier-22 consideration and reimbursement when the documentation including imaging demonstrates that the patient has had significant ablative surgery to the maxilla or mandible, including basal bone with the loss of 5 or more teeth and the plan of treatment requires autogenous bone grafting and three or more endosseous fixtures to support the reconstruction of the anatomical defect.

Addendum: March 1, 2010

- Clarification for CPT code 19364 effective March 1, 2010. Autologous Breast Reconstruction using DIEP, Deep Inferior Epigastric Artery Perforator flap (or muscle sparing TRAM flap) will be included as applicable for Modifier 22 consideration and reimbursement under this code. Additional payment based on Modifier 22 accurately reflects the sophisticated and labor intensive nature of the DIEP process.

Addendum: September 1, 2010

- Effective September 1, 2010, the Morbid Obesity policy is revised and defined as**:**

    a) Body mass index (BMI) of 35 or higher for adult patients (age 20 or older)
    b) BMI at the 97th percentile or higher (based on CDC growth charts) for pediatric patients ages 2-19.
    c) Weight at the 97th percentile or higher (based on CDC growth charts) for pediatric patients under 2 years of age.

- Effective September 1, 2010, the reimbursement policy is established to allow the use of modifier 22 for High Risk OB/GYN Patients based on the following conditions**:**

    a) Diabetes
    b) Deep Venous Thrombosis Antepartum
    c) Elderly Primagravida Complicating Pregnancy
    d) Elderly Multigravida Complicating Pregnancy
    e) Incompetent Cervix Complicating Pregnancy

The CPT codes listed below are payable with Modifier 22 when billed with diagnosis codes: 648.0X, 654.5X, 659.5X, 659.6X, and 671.3X.

ICD10 codes effective 10/1/2015:
024.319, 024.32, 024.911, 024.912, 024.913, 024.92, 024.93
034.30, 034.31, 034.32, 034.33
009.519, 009.511, 009.512, 009.513
009.529, 009.521, 009.522, 009.523
022.30, 022.31, 022.32, 022.3

59425	59409	59514	59618
59426	59410	59610	59620
59400	59510	59612	