Reimbursement Policy
Commercial

Effective Date.....07/18/2023
Annual Review Date 07/18/2025
Reimbursement Policy Number M22

Modifier 22 Increased Procedural Services

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Related Policy Resources

R03 – Multiple Births
R04 – Robotic Assisted Surgery

INSTRUCTIONS FOR USE
*Reimbursement policies are intended to supplement certain **standard** benefit plans. Please note, the terms of an individual's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which a reimbursement policy is based. For example, an individual's benefit plan document may contain specific language which contradicts the guidance outlined in a reimbursement policy. In the event of a conflict, an individual's benefit plan document **always supersedes** the information in a reimbursement policy. Reimbursement terms in agreements with participating health care providers may also supersede the information in a reimbursement policy. Proprietary information of Cigna.*

Overview

On occasion, a procedure may require a substantially greater amount of work and effort from the provider than typically provided.

Modifier 22 is used to indicate that the procedure or service performed by the provider involved significantly increased effort and work than what is typically provided. Documentation should indicate the details of and reason for the increased services.

This policy applies to all claims submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 and their electronic equivalents for Commercial lines of business.

Reimbursement Policy

Cigna may provide additional reimbursement of procedure codes appended with modifier 22, up to a maximum of 120% of the appropriate fee schedule or maximum allowed fee. Documentation must support the substantially increased work, time, and complexity required of the physician compared to what is normally provided for the procedure. The increased complexity of the service should not be represented by other more appropriate codes.

General Background

Modifier 22 identifies substantial additional work that is occasionally encountered with a procedure that is not described by another code. Modifier 22 can be used on all procedure codes with a Medicare global period of zero, ten, or ninety days when the work required to provide a service is substantially greater than typically required.

According to the American Medical Association (AMA), modifier 22 is appropriate in reporting substantially greater work than what is typically required to provide a service, such as the following:

- Trauma extensive enough to complicate the particular procedure and cannot be billed with additional procedure codes
- Significant scarring requiring extra time and work
- Extra work resulting from morbid obesity
- Increased time resulting from extra work by the physician

Additional factors considered for additional reimbursement include:

- Increased anesthesia time
- Excessive bleeding and other co-morbidities
- Multiple births delivered by cesarean section, if the cesarean requires substantially increased time and complexity compared to what is typically required

In summary, modifier 22 should be appended in limited circumstances. Claims with modifier 22 may be individually reviewed by Cigna when submitted with appropriate documentation (such as operative reports and office notes). Review the following information prior to submitting documentation:

- Documentation must reflect the substantially increased intensity, time, technical difficulty of the procedure, severity of the patient's condition, physical and mental effort required. Co-morbidities should be noted as well as any surgical complications
- Do not use modifier 22 to indicate surgery performed on an emergency basis or in the middle of the night
- Do not use modifier 22 in combination with an E/M service

References

1. American Medical Association. Current Procedural Terminology (CPT®) ©2025 Professional Edition

2. American Medical Association. Coding with Modifiers: A Guide to Correct CPT® and HCPCS Level II Modifier Usage. Sixth Edition ©2020

3. Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners, 20.4.6 Payment Due to Unusual Circumstances (Modifiers "-22" and "-52"). Accessed January 8, 2025 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104C12.pdf

4. Optum 360° Understanding Modifiers 2022 (West Valley City, UT: Optum 360, LLC, ©2021)

Policy History/Update

Date	Change/Update
01/10/2025	Template updated.
07/18/2023	Annual review completed. Policy template updated. R04 Robotic Assisted Surgery added to related policies section. Overview revised for clarity and added applicable line of business and claim form. Reimbursement Policy and General Background sections updated for clarity. Reference section updated.
08/19/2021	Removed the Coding/Billing Information header. Reorganized the General Background section.
02/25/2021	Added modifier 22 definition and statement, "Do not use modifier 22 in combination with an E/M service." Updated template and reference section.
08/17/2018	Template update and reference section.
07/29/2016	Template updated.
12/31/2013	Updated template to include new logo.
08/06/2009	Effective date for former Great-West Healthcare.
05/06/2009	Updated format; Notification for former Great-West Healthcare.
04/20/2009	Effective date for Cigna changing reimbursement up to 120%.
01/14/2009	Update format to integrated document; change reimbursement to up to120%.
04/04/2008	Updated modifier title changed by AMA.
06/12/2007	Policy effective for Cigna.
05/21/2007	Policy notification for Cigna.