



Modifier 22 Fact Sheet

Definition:

- Increased Procedural Service requiring work substantially greater than typically required.

Appropriate Usage:

- Surgeries where services performed are significantly greater than usual.
- Anatomical variants could be an appropriate use of the modifier.
- Assistant at surgery claims where a procedure is significantly greater than usual.
- Procedures having a global surgery indicator of 000, 010, or 090 on the Medicare Physician Fee Schedule Database (MPFSDB).
- Procedures having a global period but not surgical services (i.e. 77761, 77777, 77782).

Inappropriate Usage:

- Additional time alone does not justify the use of this modifier.
- Do not use when there is an existing code to describe the service.
- We may deny the claim when the documentation supports another existing code.
- Do not use to indicate a specialist performed the service.
- Not appropriate for an Evaluation and Management (E/M) service.

Documentation:

- Indicate "additional information available upon request" in field 19 of the 1500 form or loop 2300 NTE for the claim level or loop 2400 NTE segment for the line level in your electronic claim. We will send a development letter asking for the additional information.
- Supply an operative/procedure report along with a short, concise statement describing the way the service was unusual and the increased physician work.
- If we do not receive documentation, the claim will process based on normal Medicare guidelines and fee schedule.
- Carrier Medical Review staff determine the amount of reimbursement based on the information in the documentation.

Unassigned Claim:

- For unassigned claims, an increase in the limiting charge is allowed only when a charge above the fee schedule amount is justified.



Example:

Procedure code 66984 has a 90-day global period on the MPFSBD.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		FROM		MM		DD		YY		TO		MM		DD		YY			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 21.1)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
1. 64421										23. PRIOR AUTHORIZATION NUMBER																			
2.																													
3.																													
4.																													
24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG			D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER			F. \$ CHARGES			G. DAYS OR UNITS			H. EPSDT Family Plan			I. ID. QUAL.			J. RENDERING PROVIDER ID. #		
From To			MM DD YY MM DD YY			CPT/HCPCS MODIFIER																							
12 18 06			21			66984 22			1			1400.00			001						1234567890								
2																													
3																													

Procedure code 77781 does not contain a global period on the MPFSDB.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES																	
										17b. NPI		FROM		MM		DD		YY		TO		MM		DD		YY			
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES																			
										<input type="checkbox"/> YES <input type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 21.1)										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																			
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From To			MM DD YY MM DD YY			CPT/HCPCS MODIFIER																							
12 18 06			21			77781 22			1			1400.00			001						NPI			1234567890					
2																													
3																													

This is an **informational** modifier. Our medical review staff make any payment decisions based on the documentation received.