



## Reimbursement Policy

### Subject: Modifier 22: Increased Procedural Service

Effective Date:

**09/14/20**

Committee Approval Obtained:

**09/14/20**

Section:

**Coding**

\*\*\*\*\*The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to <https://providers.amerigroup.com>. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.\*\*\*\*\*

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

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

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

#### Policy

Amerigroup allows reimbursement for procedure codes appended with Modifier 22 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

	<p>Reimbursement is based on 100% of the fee schedule or contracted/negotiated rate when the procedure or service provided is greater than what is usually required for the listed procedure code. The use of Modifier 22 should follow correct coding guidelines for claims submission.</p> <p><b>Note:</b> Modifier 22 is allowed when appropriately used with surgical procedures identified with a global period of 000, 010, 090 or YYY.</p>
<b>Exemptions</b>	<ul style="list-style-type: none"> <li>Medicare Advantage reimburses Modifier 22 at 120% of the fee schedule or contracted/negotiated rate if medical review of the documentation submitted with the claim supports the use of Modifier 22. A prepayment review will be performed to support the use of Modifier 22.</li> </ul>
<b>History</b>	<ul style="list-style-type: none"> <li>Biennial review approved and effective 09/14/20: Definition updated</li> <li>Biennial review approved and effective 10/26/18: Policy language updated</li> <li>Biennial review approved 10/03/16 and effective 11/01/17: Policy language updated; Maryland, Texas and Washington exemptions removed; Medicare Advantage exemption added</li> <li>Biennial review approved 04/28/14: Maryland and Texas exemptions added; Kansas exemption removed</li> <li>Policy approved 08/27/12: Washington and Kansas exemptions added</li> <li>Policy approved 03/12/12 and effective 10/01/12</li> <li>Review approved 09/12/11 and effective 11/10/09: Language clarified for ease of understanding; Background and Definitions sections, policy template updated</li> <li>Review approved 07/13/09 and effective 11/10/09: Denial for no documentation removed; modifier definition updated; Background section updated</li> <li>Initial policy approval 06/06/07 and effective 10/04/07</li> </ul>
<b>References and Research Materials</b>	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> <li>CMS</li> <li>State Medicaid</li> <li>Amerigroup state contracts</li> <li>Optum360: 2020</li> </ul>
<b>Definitions</b>	<ul style="list-style-type: none"> <li><b>Modifier 22: Increased Procedural Services:</b> indicates that the work required to provide a service is substantially greater than typically required</li> <li><b>General Reimbursement Policy Definitions</b></li> </ul>
<b>Related Policies</b>	<ul style="list-style-type: none"> <li>Modifier Usage</li> </ul>

<b>Related Materials</b>	• None
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