	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 our 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/IA**.*****		
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 Iowa, Inc. 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 its 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. Reimbursement will be based on 110% of the fee schedule or contracted/negotiated rate of the procedure. The use of Modifier 22 should follow correct coding guidelines for claims submission.	

	Note: Modifier 22 is allowed with surgical procedures identified with a global period of 000, 010, 090 or YYY.
History	• Biennial review approved and effective **09/14/20**: Definition updated • Biennial review approved and effective **10/26/18** • Biennial review approved **10/03/16** and effective **09/15/17**: Policy language updated • Initial policy approval **08/04/15** and effective **04/01/16**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup contract • Optum360: 2020
Definitions	• **Modifier 22: Increased Procedural Services:** indicates that the work required to provide a service is substantially greater than typically required • **General Reimbursement Policy Definitions**
Related Policies	• Modifier Usage
Related Materials	• None