Provider Bulletin

Reimbursement Policy

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These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup* benefit plan. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Proper billing and submission guidelines are required along with the use of industry standard compliant codes on all claim submissions. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, we strive to minimize these variations. For more information on these and other Amerigroup Reimbursement Policies, visit our website providers.amerigroup.com and click on Quick Tools.

Policy update

Modifier 22: Increased procedural service
(Policy 07-020, originally effective 10/04/07)
Amerigroup allows reimbursement for procedure codes appended with Modifier 22 when the procedure or service provided is greater than what is usually required for the listed procedure code. Prepayment reviews are performed to support the use of Modifier 22. If medical review of the documentation submitted with the claim supports Modifier 22, reimbursement is based on **120 percent*** of the fee schedule or contracted/negotiated rate for the procedure appended with Modifier 22. In addition, if the documentation does not support the use of Modifier 22 or there is no documentation submitted with the claim, reimbursement will not exceed 100 percent of the fee schedule or contracted/negotiated rate of the procedure.

Reminder: Modifier 22 is appropriate to use only with surgery, radiology, pathology, laboratory and medicine procedure codes with a global period of 0, 10 or 90 days.

*For market-specific reimbursement information and/or nonreimbursable services, refer to the Modifier 22 Reimbursement Policy at providers.amerigroup.com.

Policy reminders

Split-care surgical modifiers
(Policy 11-005, originally effective 03/16/12)
Reimbursement of **surgical codes** appended with "split-care modifiers," is allowed and based on a percentage of the fee schedule or contracted/negotiated rate for the surgical procedure. The percentage is determined by which modifier is appended to the procedure code. *For your reference, a market specific grid is below.*

Included in the global surgical package are preoperative services, surgical procedures and postoperative services. Total reimbursement for a global surgical package is the same regardless of how the billing is split between the different physicians involved in the member's care.

Claims received with split-care modifiers after a global surgical claim is paid will be denied. Assistant surgeon and/or multiple procedure rules and fee reductions apply when an assistant surgeon is used and/or multiple procedures are performed.

Split-care modifier percentages by market

Market	Modifier 54	Modifier 55	Modifier 56
Georgia	70%	20%	10%
Louisiana	70%	20%	10%
Nevada	70%	30%	10%
New Jersey	70%	20%	10%
New York	80%	Not recognized	Not recognized
Tennessee	70%	20%	10%
Medicare Advantage	70%	20%	Not recognized

Please note that state-specific requirements apply to the policies within this bulletin.
For additional information, refer to the reimbursement policies at ***providers.amerigroup.com,*** *under Quick Tools.*

Your continued feedback is critical to our success. If you have questions, please contact your local Provider Relations representative or call our Provider Services team at 1-800-454-3730 (Medicaid) or 1-866-805-4589 (Medicare).

**In Louisiana, Amerigroup Louisiana, Inc. In Texas, Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members are served by Amerigroup Texas, Inc. In Washington, Amerigroup Washington, Inc.*