Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Modifier 22: Increased Procedural Service		
Effective Date: **11/01/17**	Committee Approval Obtained: **10/13/16**	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. Under Quick Tools, select Reimbursement Policies > Medicaid/Medicare. 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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. Reimbursement is based on 100 percent 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. **Note:** Modifier 22 is appropriately used with surgical procedures identified with a global period of 000, 010, 090 or YYY.

Exemptions	• A prepayment review will be performed to support the use of Modifier 22. If medical review of the documentation submitted with the claim supports the use of Modifier 22, reimbursement is based on the following:
	  ○ Medicare Advantage:
	  ▪ 120 percent of the fee schedule or contracted/negotiated rate
	• Amerigroup Kansas Inc., in accordance with The Kansas Department of Health and Environment (KDHE), allows reimbursement of Modifier 22 for anesthesia procedure codes and surgery codes with a global period of 000, 010, 090 or YYY.

History	• Effective 02/01/18: Policy template updated • Effective 11/01/17: Louisiana exemption removed • Biennial review approved 10/03/16 and effective 11/01/17: Policy language updated; Florida, Maryland, Texas and Washington exemptions removed; Kansas, Louisiana and Nevada exemption updated; Medicare Advantage exemption added • Effective 12/31/15: Exited Florida Medicare • Effective 12/31/14: Exited Maryland Medicare • Update due to regulatory directive (committee approval not required in accordance with Reimbursement Policy Program Guidelines): Kansas exemption added, effective 06/12/14 • Biennial review approved 04/28/14: Florida, Maryland and Texas exemptions added; Kansas exemption removed • Policy approved 08/27/12: Washington and Kansas exemptions added • Policy approved 03/12/12 and effective 10/01/12: Louisiana exemption added • Review approved 09/12/11 and effective 11/10/09: Language clarified for ease of understanding; Background and Definitions sections, policy template updated • Review approved 07/13/09 and effective 11/10/09: Denial for no documentation removed; modifier definition updated; Background section updated • Initial committee approval 06/06/07 with effective date of 10/04/07

References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts • American Medical Association: Coding with Modifiers, fifth edition • Optum Learning: Understanding Modifiers, 2014 edition
Definitions	• **Modifier 22:** indicates that the work required to provide a service is substantially greater than typically required • **Reimbursement Policy Definitions**
Related Policies	• Modifier Usage
Related Materials	• None