Reimbursement Policy	
Subject: **Modifier 22**	
Policy Number: **G-07020**	Policy Section: **Coding**
Last Approval Date: **12/27/2022**	Effective Date: **12/27/2022**

**** Visit our provider website for the most current version of our reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://medicareprovider.healthybluemo.com**. ****

Disclaimer

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 Healthy Blue Medicare Advantage 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 participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Healthy Blue Medicare Advantage 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 These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.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, Healthy Blue Medicare Advantage strives to minimize these variations.

Healthy Blue Medicare Advantage 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 our provider website.

Policy

Healthy Blue Medicare Advantage 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 120% of the applicable fee schedule or contracted/negotiated rate for the procedure code when the procedure or service provided is greater than what is usually required for the listed procedure code. Prepayment review will be performed to support the use of Modifier 22. 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.

Related Coding

Standard correct coding applies

History

12/27/2022	Review approved; updated policy title from Modifier 22: Increased Procedural Services to Modifier 22, minor language changes
01/01/2021	Initial policy approval effective

References and Research Materials

This policy has been developed through consideration of the following:
- CMS
- State Medicaid
- State contracts
- Optum EncoderPro 2022

Definitions

Modifier 22	Increased Procedural Services: • Indicates that the work required to provide a service is substantially greater than typically required. Note: This modifier should not be appended to an E/M service.
Reimbursement Policy Definitions	

Related Policies and Materials

Modifier Usage