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 the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://providers.anthem.com/ny**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem Medicare Advantage covered the service for the member's 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 Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem 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.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem Medicare Advantage strives to minimize delays in policy

implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem 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

Policy History	
12/27/2022	Review approved: updated policy title from Modifier 22: Increased Procedural Services to Modifier 22; minor language changes
09/14/2020	Review approved and effective 09/14/2020: Definition updated
10/26/2018	Review approved and effective 10/26/2018: Prepayment review language added
10/03/2016	Review approved 10/03/2016 and effective 11/01/2017: Policy language update
01/01/2015	Initial approval and 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.
General Reimbursement Policy Definitions	

Related Policies and Materials
Modifier Usage