Anthem Blue Cross and Blue Shield Healthcare Solutions | Medicaid Managed Care

Reimbursement Policy	
Subject: **Modifier 22**	
Policy Number: **G-07020**	Policy Section: **Coding**
Last Approval Date: **09/06/2024**	Effective Date: **09/06/2024**

**** 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://providers.anthem.com/nv. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement for Anthem members. 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 also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

Please follow proper billing and submission guidelines including the use of 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 may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem 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 allows reimbursement for procedure codes appended with modifier 22 unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

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Reimbursement is based on 125% 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	
09/06/2024	Review approved and effective: updated Definitions section
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: definition updated
10/26/2018	Review approved and effective
02/01/2018	Policy template updated effective
10/03/2016	Review approved 10/03/2016 and effective 11/01/2017: policy language updated
04/28/2014	Review approved
03/12/2012	Policy approved 03/12/2012 and effective 10/01/2012
09/12/2011	Review approved 09/12/2011 and effective 11/10/2009: language clarified for ease of understanding; Background and Definitions sections; Policy template updated
07/13/2009	Review approved 07/13/2009 and effective 11/10/2009: denial for no documentation removed; Modifier definition updated; Background section updated
02/01/2009	Initial approval and effective

References and Research Materials
This policy has been developed through consideration of the following: • CMS • Optum EncoderPro 2024 • State contract • State Medicaid

Definitions	
Modifier 22	Indicates increased procedural services. This modifier shall not be reported unless the service(s) performed is (are) substantially more extensive than the usual service(s) included in the procedure described by the HCPCS/CPT code reported. Note: Modifier 22 should not be appended to an E/M service.
General Reimbursement Policy Definitions	

Related Policies and Materials
Modifier Usage