	Reimbursement Policy	
Subject: Modifier 22: Increased Procedural Service		
Effective Date: **09/14/20**	Committee Approval Obtained: **09/14/20**	Section: **Coding**

***** The most current version of our 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.healthybluela.com**.*****

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 Healthy Blue Dual Advantage (HMO D-SNP) member's 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 Dual Advantage may:

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

Healthy Blue Dual 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 These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.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 set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue Dual Advantage strives to minimize these variations.

Healthy Blue Dual 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 the website.

Policy	Healthy Blue Dual Advantage allows reimbursement for procedure codes appended with Modifier 22 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Healthy Blue Dual Advantage performs prepayment review 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 120% of the fee schedule or

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	contracted/negotiated rate. 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.
History	• Biennial review approved and effective **09/14/20**: Definition updated • Initial policy approval effective **01/01/20**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contract • Healthy Blue contract(s) • Optum360: 2020
Definitions	• **Modifier 22: Increased Procedural Services:** indicates that the work required to provide a service is substantially greater than typically required • **General Reimbursement Policy Definitions.**
Related Policies	• Modifier Usage
Related Materials	• None