Wellpoint

Massachusetts | Commercial

Commercial Reimbursement Policy	
Subject: **Modifier 22 – Professional**	
Policy Number: **C-12003**	Policy Section: **Coding**
Last Approval Date: **05/06/2025**	Effective Date: **05/06/2025**

Disclaimer

These reimbursement 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 benefit plan. The determination that a service, procedure, or item 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.

Ensure that you use proper billing and submission guidelines, including 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, we 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive 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

The health plan allows additional reimbursement for procedure codes appended with modifier 22, unless provider, state, or federal contracts and/or requirements indicate otherwise.

Procedure codes reported with Modifier 22 and satisfactory documentation will be eligible for 120% reimbursement of the allowance for the procedure code. The use of Modifier 22 should follow correct coding guidelines for claims submission.

Documentation submitted for use of Modifier 22 must:

- Include the typical circumstances vs. the patient's circumstances.
- Compare the typical time to complete the procedure vs. the actual time the procedure took.
- Clearly state the reason why additional time and/or work was required.

If documentation is missing or insufficient, the procedure code is still eligible for reimbursement at 100% of the allowance for the procedure code.

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

05/06/2025	Review approved and effective: updated Definitions section
07/07/2023	Review approved: removed (Increased Procedural Services) from policy title; removed modifiers from Definition section
08/27/2021	Review approved: policy language updated: • specific reimbursement rate was added to the policy • sentences and documentation requirement language were streamlined • grammatical and formatting changes were made to the Policy History section
07/03/2019	Review approved: administrative changes made to the policy body
06/01/2019	Policy language updated: description section removed, added definition and related coding sections
02/07/2017	Review approved: • Added a disclaimer that the policy applies to Employer Group Retiree Medicare Advantage Programs
02/02/2016	• Examples of appropriate and inappropriate uses of Modifier 22 were added to the policy • Added language requiring documentation to include the time and extra effort required to complete a surgical procedure, time and effort spent on removing adhesions during a procedure, and specific information for obese patients
07/07/2015	Review approved: no changes
07/01/2014	Review approved:

	• Minor grammatical and punctuation updates were made, which did not change the policy positions or criteria ○ Language was added to the policy description section

07/02/2013	Review approved:
	• Minor punctuation and language changes were
	• Policy section updated:
	  ○ Examples of appropriate supporting documentation were added
	  ○ More active language was added

07/10/2012	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- American Academy of Professional Coders
- Optum EncoderPro 2025

Definitions

Modifier 22	An increased procedural service. When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. The modifier may be reported with any code from the surgery, radiology, pathology/laboratory, and medicine sections of the Current Procedural Terminology (CPT) book. However, it should not be reported with evaluation and management services.
General Reimbursement Policy Definitions	

Related Policies and Materials

Modifier Usage - Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving, and we reserve the right to review and update these policies periodically.