CareSource

REIMBURSEMENT POLICY STATEMENT
Wisconsin Marketplace

Policy Name & Number	Date Effective
Modifier 22-WI MP-PY-1825	09/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding, and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject
Modifier 22

B. Background
Reimbursement modifiers are 2-character codes used by physicians and other qualified health care professionals to indicate that a service or procedure has been altered due to a specific circumstance. Although CareSource accepts the use of modifiers, use does not guarantee reimbursement. Some modifiers increase or decrease the reimbursement rate, while others do not affect the reimbursement rate. CareSource may verify the use of any modifier through prepayment and post-payment audit. Using a modifier inappropriately can result in the denial of a claim or an incorrect reimbursement for a product or service. All information regarding the use of these modifiers must be made available upon CareSource's request.

Modifier 22 is appropriate to use when increased procedural services means the physician/other qualified health care professional performed work that is substantially greater than typically required for the procedure, as defined by American Medical Association (AMA) Current Procedural Terminology (CPT) guidelines.

C. Definitions
- **Current Procedural Terminology (CPT)** – Codes that are issued, updated, and maintained by the AMA that provide a standard language for coding and billing medical services and procedures.
- **Healthcare Common Procedure Coding System (HCPCS)** – Codes that are issued, updated, and maintained by the AMA that provide a standard language for coding and billing of products, supplies, and services not included in the CPT codes.
- **Modifier** – A 2-character code used along with a CPT or HCPCS code to provide additional information about the service or procedure rendered.

D. Policy
I. Modifier 22 may be reported when the service is significantly greater than usual. It applies only to procedures with a 0-, 10-, or 90-day global period.

II. CareSource may consider additional reimbursement when modifier 22 is supported by documentation, the service is significantly more complex than the reported CPT/HCPCS code description, and no other code more accurately describes the additional work.

III. CareSource reviews the submitted documentation to determine whether modifier 22 is supported:
   A. If documentation supports modifier 22, CareSource pays the contracted allowed amount for the billed code, plus an additional percentage.
   B. If documentation does not support modifier 22, CareSource pays the contracted allowed amount for the billed code, and no additional payment is made.

IV. Do not append modifier 22 to evaluation and management, unlisted Procedure, or add-on codes.

V. Providers are responsible for submitting accurate documentation and using the most appropriate CPT/HCPCS codes for the services provided. Coding should follow recognized guidelines, including but not limited to:
   A. National Correct Coding Initiative (NCCI) edits
   B. American Medical Association (AMA) guidelines
   C. American Hospital Association (AHA) billing rules
   D. Current Procedural Terminology (CPT)
   E. Healthcare Common Procedure Coding System (HCPCS)
   F. ICD-10 CM and PCS
   G. National Drug Codes (NDC)
   H. Diagnosis Related Group (DRG) guidelines
   I. NCCI table edits

E. Conditions of Coverage

I. Reimbursement policies are designed to assist providers when submitting claims to CareSource and are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify a member's eligibility.

II. Reimbursement is dependent on, but not limited to, submitting approved CPT or HCPCS codes along with appropriate modifiers, if applicable.

III. Providers must follow proper billing, industry standards, and state compliant codes on all claim submissions. The use of modifiers must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, CareSource policies apply to both participating and nonparticipating providers and facilities.

IV. In the event of a conflict between this policy and a provider's contract with CareSource, the provider's contract will be the governing document.

F. Related Policies/Rules

Modifiers

G. Review/Revision History

	DATE	ACTION
Date Issued	06/17/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	09/01/2026	
Date Archived		

H. References

1. *2026 AMA CPT Professional*. American Medical Association; 2025.
2. *2026 HCPCS Level II Expert*. AAPC; 2025.
3. *2026 ICD-10-CM Official Coding Guidelines for Coding and Reporting*. AAPC; 2025.
4. *General Correct Coding Policies for National Correct Coding Initiative Policy Manual for Medicare Services*. US Centers for Medicare and Medicaid Services; 2025. Accessed June 01, 2026. www.cms.gov