HAP CareSource™

NETWORK *Notification*

Notice Date: **March 18, 2026**
To: **HAP CareSource Providers**
From: **HAP CareSource**
Subject: **Modifier 22 and 52 Pricing**

Summary

The purpose of this communication is to notify providers of HAP CareSource's current modifier reimbursement logic to the Michigan Medicaid product.

- **Modifier 22**
  When a provider bills a code with modifier 22, HAP CareSource requires Operative notes for review. If after reviewing, it is determined appropriate, the claim line receives a payment increase of 20%.

- **Modifier 52**
  Pay with a partial reduction of 50% when billed on a facility claim.

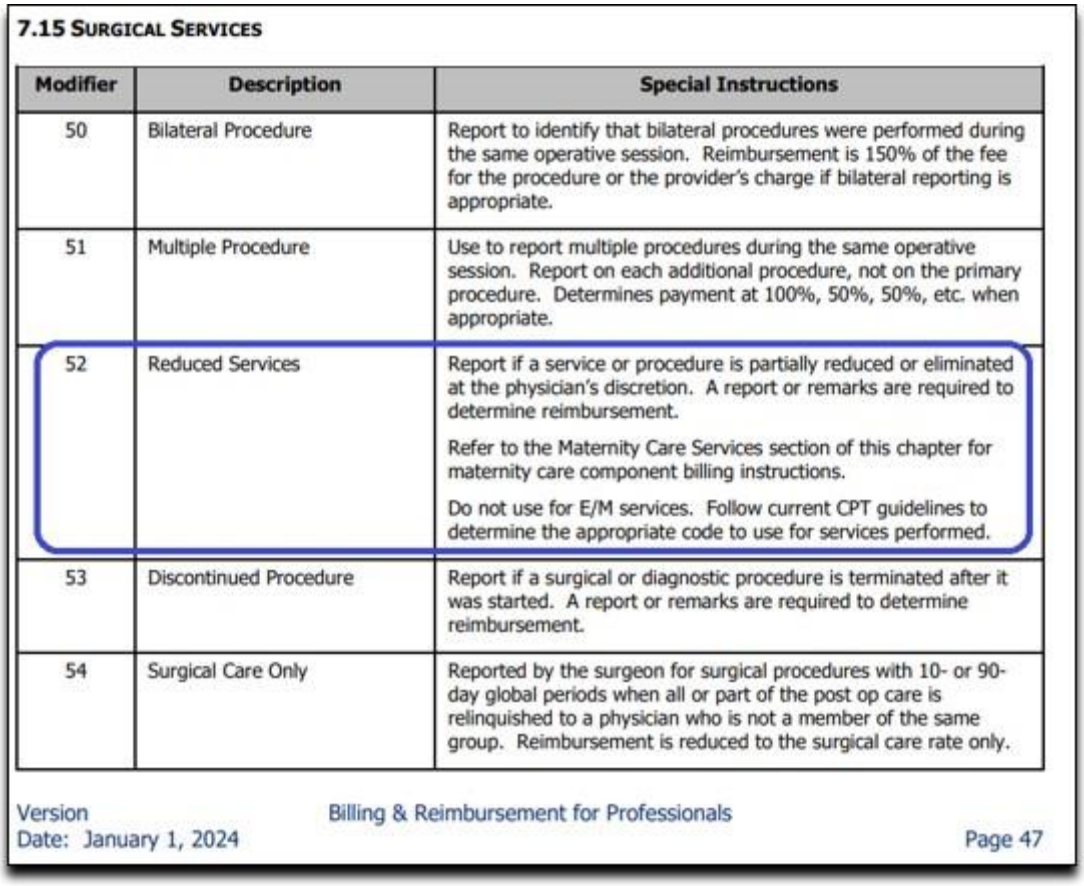
References

MDHHS Medicaid Provider Manual - Chapter: Billing & Reimbursement for Professionals - Section 7- Modifiers

Michigan Medicaid Provider Manual

7.1 GENERAL BILLING GUIDELINES

Modifier	Description	Special Instructions
22	Increased Procedural Services	Providers may report when the work required to provide a service is substantially greater than typically required. Documentation/remarks required.



7.15 SURGICAL SERVICES

Modifier	Description	Special Instructions
50	Bilateral Procedure	Report to identify that bilateral procedures were performed during the same operative session. Reimbursement is 150% of the fee for the procedure or the provider's charge if bilateral reporting is appropriate.
51	Multiple Procedure	Use to report multiple procedures during the same operative session. Report on each additional procedure, not on the primary procedure. Determines payment at 100%, 50%, 50%, etc. when appropriate.
52	Reduced Services	Report if a service or procedure is partially reduced or eliminated at the physician's discretion. A report or remarks are required to determine reimbursement. Refer to the Maternity Care Services section of this chapter for maternity care component billing instructions. Do not use for E/M services. Follow current CPT guidelines to determine the appropriate code to use for services performed.
53	Discontinued Procedure	Report if a surgical or diagnostic procedure is terminated after it was started. A report or remarks are required to determine reimbursement.
54	Surgical Care Only	Reported by the surgeon for surgical procedures with 10- or 90-day global periods when all or part of the post op care is relinquished to a physician who is not a member of the same group. Reimbursement is reduced to the surgical care rate only.

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Impact
Providers should follow MI Medicaid guidelines for submitting allowable services and required documentation to prevent claims denial.

Importance
Claims will be denied if appropriate coding and documentation guidelines are not followed. Providers will be required to rebill with operative notes.

Questions?
If you have questions, please contact HAP CareSource Provider Services at **1-833-230-2102**, Monday through Friday, 8 a.m. to 6 p.m. Eastern Time (ET).

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