INCREASED PROCEDURAL SERVICES POLICY

Policy Number: ADMINISTRATIVE 175.17 T0 **Effective Date**: January 1, 2019

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Related Policies

Refer to the Reimbursement Guidelines section of the policy

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

APPLICATION

This reimbursement policy applies to services reported using the UB-04 claim form, the 1500 Health Insurance Claim Form (a/k/a CMS-1500), or their electronic equivalents or their successor forms. This policy applies to all network and non-network providers, including hospitals, ambulatory surgical centers, physicians and other qualified health care professionals, including, but not limited to non-network authorized and percent of charge contract physicians and other qualified health care professionals.

OVERVIEW

The term "increased procedural services" designates a service provided by a physician, hospital, ambulatory surgical center, or other health care professional that is substantially greater than typically required for the procedure or service as defined in the Current Procedural Terminology (CPT®) book. Increased procedural services are reported by appending Modifier 22 to the usual procedure code.

Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician, hospital, ambulatory surgical center or other qualified health care professional work commonly associated with these patients, as defined in the *CPT* book. In these circumstances Modifier 63 may be appended to the usual procedure code, unless directed otherwise in the *CPT* book.

REIMBURSEMENT GUIDELINES

Oxford's standard for additional reimbursement of Modifier 22 (increased procedural services) and/or Modifier 63 (procedures performed on infants less than 4 kg) is 20% of the Allowable Amount for the unmodified procedure, not to exceed the billed charges. Claims submitted with these modifiers must include medical record documentation which supports the use of the modifiers and which will be reviewed by Oxford in accordance with this policy.

Note: When both Modifier 22 and Modifier 63 are appended to the same CPT code, reimbursement will be a total of an additional 20% of the Allowable Amount of the unmodified procedure, not to exceed the billed charges, provided the documentation supports use of either Modifier 22 or Modifier 63.

Refer to the *Obstetrical Policy* for information on the use of Modifier 22 with obstetrical services.

Modifier 22 - Increased Procedural Services

In order to be considered for additional reimbursement when reporting Modifier 22, thorough medical records or reports **and** a separate document containing a concise statement about how the service differed from the usual service or procedure is required. The documents must indicate the substantial additional work performed and the reason for the additional work which may include, but not be limited to, increased intensity or time, technical difficulty of procedure that is not described by a more comprehensive procedure code, severity of the patient's condition, or increased physical and mental effort required.

Additional reimbursement will only be considered for services appended with Modifier 22 that are assigned a global period of 0, 10, 42 or 90 days. Modifier 22 should not be appended to an evaluation and management service. Refer to the *Global Days Policy* for a listing of those codes with a global day period.

Modifier 63 - Procedure Performed on Infants Less Than 4 kg

In order to be considered for additional reimbursement when reporting Modifier 63, thorough medical record(s) or report(s) that support the use of the modifier is required. The document(s) must indicate the substantial additional work performed and the reason for the additional work which may include, but not be limited to, increased intensity or time, technical difficulty of procedure that is not described by a more comprehensive procedure code, severity of the patient's condition, or increased physical and mental effort required.

Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20010-69990 code series. Modifier 63 should not be appended to any CPT code listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.

DEFINITIONS

Allowable Amount: The dollar amount eligible for reimbursement to the physician or health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of Allowable Amounts.

Modifier 22: Increased Procedural Services: 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. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physician and mental effort required).
Note: This modifier should not be appended to an E/M service.

Modifier 63: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding the Modifier 63 to the procedure number.
Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20010-69990 code series. Modifier 63 should not be appended to any CPT code listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.

QUESTIONS AND ANSWERS

1	**Q:**	Do the American Medical Association (AMA), the Centers for Medicare and Medicaid Services (CMS) or other national professional organizations recommend a specific reimbursement amount for use of Modifiers 22 or 63?
	A:	No. Therefore, Oxford has made the determination to reimburse in total an additional 20% of the Allowable Amount of the unmodified procedure, not to exceed the billed charges, provided the documentation supports use of either Modifier 22 or Modifier 63.

2	Q:	Can the concise statement required for Modifier 22 substantiating how a service differs from the usual service performed be included within the operative report?
	A:	No. In alignment with CMS, two separate documents will be required. One required document is either the operative report or medical record. The other required document is a concise statement supporting the substantial additional work and the reason for the additional work.

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [*2018R0061A*]

American Medical Association. Current Procedural Terminology (CPT®) and associated publications and services.

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
01/01/2019	• Updated reimbursement guidelines; modified applicable code range for modifier 63 to reflect annual code edits: ○ Replaced "*20005*-69990" with "*20010*-69990" • Archived previous policy version ADMINISTRATIVE 175.16 T0