Increased Procedural Services Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Medicare Advantage enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents**. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network 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.

Policy

Overview

The term "increased procedural services" designates a service provided by a physician 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 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

UnitedHealthcare Medicare Advantage'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 UnitedHealthcare Medicare Advantage 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.

Modifier 22 - Increased Procedural Services

In order to be considered for additional reimbursement when reporting Modifier 22, the provider is required to provide a concise statement about how the service differs from the usual; and an operative report. The concise statement may be documented on the operative report, but it must be clearly identified. 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.
Additional reimbursement will only be considered for services appended with Modifier 22 that are assigned a global period of 0, 10, or 90 days. Modifier 22 should not be appended to an evaluation and management service.

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 20005-69990 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.

Codes

Modifier code section	
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, physical and mental effort required). Note: This

	modifier should not be appended to an E/M service.
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 modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20005-69990 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:** 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.

Resources

www.cms.gov

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

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

History

1/4/2019	Annual Anniversary Date and Version Change • Transferred contents of policy to new template • Updated verbiage in Modifier 22 - Increased Procedural Services section • Application section verbiage updated and removed references to other policies • Archived history from 1/1/2017 and older
9/4/2018	Policy Version Change Policy number changed from 2018R0061A to 2018R9015A Added the word 'Professional' to the policy title
3/14/2018	Policy Approval Date Change (new version) Archived history from 1/1/2015 and older
3/8/2017	Policy Approval Date Change (no new version)
12/17/2014	Policy approval

