UnitedHealthcare Community Plan

Reimbursement Policy
CMS 1500
Policy Number 2021R0061B.LA

Increased Procedural Services Policy, Professional for Louisiana

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

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 Community Plan reimbursement policies uses 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. 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 reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan 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 Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication. **CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.*

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid Product.

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 Community Plan'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 Community Plan 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, 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. In accordance with Louisiana Medicaid guidelines, when documentation supports, reimbursement for modifier 22 is 125% of the fee on file or billed charges, whichever is lower.

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. CPT codes 59400-59699 can be billed with modifier 22 to signify multiple gestation deliveries, no supporting documentation required. 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 20100-69990 code series and 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93530, 93531, 93532, 93533, 93561, 93562, 93563, 93564, 93568, 93580, 93582, 93590, 93591, 93592, 93615, 93616 from the Medicine/Cardiovascular section. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections (other than those identified above from the Medicine/Cardiovascular section).

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.

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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, UnitedHealthcare Community Plan 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.

Resources

Individual state Medicaid regulations, manuals & fee schedules

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

History

3/2/2021	Removed reference to state exception for Louisiana Definitions Section: Verbiage updated to remove Modifier definitions
2/15/2021	Removed all reference to state exceptions
2/21/2020	Policy Version Change Reimbursement Section: Updated Modifier 63 guidelines Definitions Section: Updated Modifier 63 History Section: Entries prior to 1/1/2018 archived
5/1/2019	Policy Version Change Title section: Removed Annual Approval information & moved policy # to the header
2/1/2019	Annual Anniversary Date and Version Change Title section: Removed Annual Approval information & moved policy # to the header Application Section: Removed pathway to policies for other lines of business
1/1/2019	Annual Policy Version Update
9/30/2018	Policy Version Change Policy Verbiage Change: Removed reference to other UnitedHealthcare policies under Reimbursement Guidelines.
8/31/2018	Added the word "Professional" to the policy title (no new version)

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4/5/2018	State Exceptions Section: Exception added for Arizona
3/14/2018	Policy Approval Date Change Annual Policy Version Change History Section: Entries prior to 1/1/2016 archived

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