UnitedHealthcare Community Plan

Reimbursement Policy
CMS 1500
Policy Number 2022R0061B

Increased Procedural Services Policy, Professional

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 reimbursement policies may 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. 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's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare 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 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, 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 due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations. UnitedHealthcare 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.

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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'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 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 that support the use of the modifier are 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

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 records or reports that support the use of the modifier are 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

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	Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.

State Exceptions	
Nebraska	Per the State of NE, Chiro Fee Schedule claims billed with the 22 modifier should only be reimbursed at the rate published on the NE Medicaid Chiro fee schedule and not increased to 120%.

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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 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.

Resources
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	
7/1/2022	Policy Version Change Reimbursement Guidelines: Updated Modifier 22 Section History Section: Entries prior to 4/24/2020 archived
1/14/2022	Policy Date and Version Change State Exceptions section: Created section and added Nebraska History Section: Entries prior to 1/14/2020 archived
7/1/2021	Policy Version Change Reimbursement Guidelines: Updated Modifier 22 Document Requirements
1/1/2021	Policy Version Change Definitions sections: Updated Allowable Amount History Section: Entries prior to 9/30/2018 archived
1/1/2001	Policy implemented by UnitedHealthcare
Prior to 1995	Policy approved by the Payment Policy Oversight Committee

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