Increased Procedural Service (Modifiers 22 and 63)

Reimbursement Policy ID: RPC.0037.0900

Recent review date: 07/2024

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AmeriHealth Caritas New Hampshire reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas New Hampshire may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy describes conditions for reimbursement of **increased procedural services** in claims processing by AmeriHealth Caritas New Hampshire.

An **increased procedural service** occurs when the a provider's work required on a particular case is significantly greater than what is typically required for the procedure or service, due to the patient being a small infant (under 4 kilograms) or due to another highly unusual circumstance (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).

Consistent with CPT/HCPCS terminology and the CMS guidelines on increased procedural services, AmeriHealth Caritas New Hampshire recognizes modifiers 22 and 63.

Exceptions

N/A

Reimbursement Guidelines

AmeriHealth Caritas New Hampshire will consider enhanced payment of a claim for an increased procedural service. The rate of enhancement is 110% of the allowable (i.e., an additional 10% of the allowable). The appropriate procedure code must be on the applicable New Hampshire Medicaid fee schedule. All other appropriate payment rules (e.g., multiple procedure payment reductions) are still applicable.

For accurate reimbursement of an increased procedural service:

(1) A clean claim must be submitted with either modifier 22 or 63 appended to the appropriate procedure code. Appending both modifiers 22 and 63 to the same procedure code will not increase the prospect nor the percentage of enhanced payment under consideration.

- Modifier 22 can be appended to CPT/HCPCS procedure codes with a CMS Professional Fee Schedule (PFS) global period indicator of “000,” “010,” or “090” only, for increased procedural service due to unusual circumstances. Procedure codes with a PFS global period indicator of “MMM,” “XXX,” or “ZZZ” will not be considered for enhanced payment, even with modifier 22 appended. These include Evaluation and Management (E/M) services.
- Modifier 63 can be appended for increased procedural service due to the patient being an infant under four kilograms for the following CPT procedure codes only:
    - 20100-69990
    - 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93563, 93564, 93568, 93569, 93573, 93574, 93575, 93580, 93581, 93582, 93590, 93591, 93592, 93593, 93594, 93595, 93596, 93597, 93598, 93615, 93616

It is inappropriate to append modifier 22 or 63 to unbundle payment for a service that is considered part of the global surgical package or another medical practice standard. This includes routine lysis of adhesions from the same region of a surgical procedure.

(2) Clinical documentation of the increased procedural service must be submitted along with the claim. The documentation must clearly explain both the unusual circumstance and the significantly greater work performed by the provider. The following examples are insufficient explanation of an increased procedural service:

- “Surgery took an extra [amount of time]” or “surgery was longer than average.”
- “Surgery was difficult” or “surgery was harder than average.”
- “Patient is morbidly obese” or “visual field was distorted.”
- “Provider is a [type of specialist].”

Claims submitted with modifier 22 or 63 that do not meet the requirements for an increased procedural service will be processed without enhanced payment.

Refer to CPT/HCPCS manuals for complete descriptions of procedure codes and modifiers, National Correct Coding Initiative (NCCI) manuals for correct coding policies, PFS files for global surgery indicators, and state billing resources for fee schedules and guidelines.

Definitions

Modifier 22-Increased Procedural Service
Modifier 22 is used to identify a service that requires significantly greater effort, such as increased intensity, time, technical difficulty of procedure, severity of the patient's condition, and physical and mental effort required, than is usually needed for that procedure.

Modifier 63-Procedure Performed on Infants less than 4 kg
Modifier 63 is used to reflect the increased complexity and physician work commonly associated with procedures for infants up to a present body weight of 4 kilograms**.**

Edit Sources

I. Current Procedural Terminology (CPT).
II. Healthcare Common Procedure Coding System (HCPCS), and associated publications and services.
III. Centers for Medicare and Medicaid Services (CMS) Physician Fee Schedule and associated resources.
IV. Centers for Medicare and Medicaid Services (CMS) Claims Processing Manual, Chapter 12, Section 20.4.6 - Payment Due to Unusual Circumstances.
V. New Hampshire Medicaid fee schedules and other billing resources.

Attachments

N/A

Associated Policies

RPC.0012.0900 Global Surgical Package

Policy History

07/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
07/2023	Reimbursement Policy Committee Approval
06/2023	Policy Implemented by AmeriHealth Caritas New Hampshire
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added