UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
Policy Number 2023R9015A

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. 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.

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Application

This reimbursement policy applies to all Medicare Advantage products and for 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 network 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 and/or Modifier 63 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

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.

Modifier 22 should not be appended to an evaluation and management service.

Modifier 63

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. 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	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.

Modifier Codes
Code
22
63

Resources
www.cms.gov American Medical Association (AMA) Current Procedural Terminology (CPT®) Centers for Medicare and Medicaid Services: PFS Relative Value Files, Medicare Fee Schedules Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners: Section: 20.4.6, 40.2;10, 40.4

History	
1/1/2023	Policy Version Change
5/6/2022	Policy Version Change Application Section: Updated Reimbursement Guidelines Section: Removed sentence re: global days from Modifier 22 section.
1/1/2022	Policy Version Change Resources Section: Updated sourcing
3/4/2021	Policy Version Change Template Change Q & A Section: Removed Resources Section: Updated resources format and removed hyperlink History Section: Entries prior to 3/4/2019 archived
1/1/2021	Policy Version Change Codes Section: Removed Modifier descriptions History Section: Entries prior to 1/1/2019 archived
12/17/2014	Policy Approval