Increased Procedural Service (Modifiers 22 and 63)

Reimbursement Policy ID: RPC.0037.2100

Recent review date: 05/2025

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AmeriHealth Caritas Louisiana 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. (Insert plan name) 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.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes conditions for reimbursement of **increased procedural services** by providers contracted with AmeriHealth Caritas Louisiana.

An increased procedural service (e.g., unusual service) occurs when 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. An example of an increased procedural service would be the delivery of twins.

Consistent with CPT/HCPCS terminology, the CMS guidelines on increased procedural services, and Louisiana Department of Health (LDH), AmeriHealth Caritas Louisiana recognizes modifiers 22 and 63.

Exceptions

N/A

Reimbursement Guidelines

AmeriHealth Caritas Louisiana will consider enhanced payment of a claim for an increased procedural service. The rate of enhancement is 125% percent of the allowable (i.e., the lower of billed charges or 125% of the fee on file). 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.
    - LDH explicitly prohibits the use of modifier 22 on procedures codes for Evaluation and Management services (e.g., visits) and laboratory 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 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 not be eligible for 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. Louisiana Department of Health (LDH) Professional Services Provider Manual, fee schedules, and associated resources.

Attachments

N/A

Associated Policies

RPC.0012.2100 Global Surgical Package and Split Surgery

Policy History

06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
03/2025	Annual review • No major changes
07/2024	Reimbursement Policy Committee Approval
07/2024	Annual review-No major changes
04/2024	Revised preamble
09/2023	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas Louisiana from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added
	Precedes Act 319