Summary

This policy describes reimbursement for procedural codes submitted with modifier 22 (Increased Procedural Services) or modifier 63 (Procedure Performed on Infants less than 4 kg).

Policy Statement

Increased procedural services designates a service provided by a physician or other qualified health care professional that is substantially greater than typically required. The use of modifier 22 indicates that a procedure was complicated, complex, difficult, or took significantly more time than usually required by the provider to complete the procedure.

Modifier 22 should only be appended to procedure codes with a global period of 0, 10, 42 or 90 days. Note: See the Global Days Policy.

In order to be considered for increased reimbursement, documentation from the patient's record that will support the significantly greater effort performed must be submitted with the claim. Medica requires submission of relevant documentation including an operative report and other statements that clearly outline how the service differs from the usual service performed. Consideration of an additional 20% of the allowable amount for the unmodified procedure will be determined based on review of this supporting documentation.

Modifier 63 indicates procedures performed on neonates and infants up to a present body weight of 4 kg. The intended use of this modifier is to represent a significant increase in physician work and complexity related to invasive surgery on neonates and infants. Appendix F in the Current Procedural Terminology (CPT®), published by the AMA, includes a summary of codes exempt from Modifier 63.

The reimbursement for codes submitted with 63, if supported by documentation, is an additional 20% of the allowable amount for the unmodified procedure. In order to qualify for additional reimbursement, procedures/services appended with modifier 63 require a copy of the medical records.

Definitions

**Modifier 22** – Increased Procedural Services. When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.
**Modifier 63** – Procedure performed on infants less than 4 kg. Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20000-69990 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.

**Resources**

- Centers for Medicare and Medicaid Services (CMS)
- Healthcare Common Procedure Coding System (HCPCS)

**Effective Date**

01/01/2001

**Revision Updates**

- 06/08/2017  Annual policy review
- 07/07/2016  Annual policy review
- 07/23/2015  Annual policy review; policy statement updated

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