Clover

Clover Health Increased Procedural Services Reimbursement Policy

Policy # RP-039

Policy Title	Increased Procedural Services Reimbursement Policy
Policy Department	Payment Strategy Operations
Effective Date	4/1/2022
Revision Date(s)	
Next Review Date	

Disclaimer:

Clover Health applies CMS criteria and guidelines, National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Clover Policies, and MCG for determining medical necessity. Clover Policies are intended to provide a standard guideline but are not used to preempt providers' judgment in rendering services. Providers are expected to provide care based on best practices and use their medical judgment for appropriate care.

Description:

Clover Health has developed this policy to define reimbursement when circumstances during a procedure require substantially greater work effort than would normally be required. This policy applies to all contracted and non-contracted Clover providers.

Definitions:

- Increased Procedural Services
  - Services provided by a physician or other healthcare professional that are substantially greater than typically required for the procedure or service as defined in the Current Procedure Terminology (CPT) book. Increased Procedural Services should be submitted with a modifier 22 appended to them.

Policy:

Clover Health's standard reimbursement for procedures that require increased procedural services is an additional 20% of the allowable amount, not to exceed the billed charges.
A detailed description is required for review. Additional records may be requested. Inclusion of a statement or note with the submission of services is not sufficient documentation of the need for additional work.

Reasons for additional work:

- Increased intensity
- Increased time
- Technical difficulty of procedure
- Severity of the patient's condition
- Physical and mental effort that was required

Do not append modifier 22:

- To Evaluation and Management (E/M) codes 99202-99499).
- Procedure codes that do not have a global period of 0, 10, or 90 days
- If the additional work performed has a specific code.

Claim Codes (if applicable)	• Modifier 22 ○ 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 (ie, 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.

References
Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners: Section: 20.4.6, 40.2;10, 40.4
American Medical Association (AMA) Current Procedural Terminology (CPT®)