



Reimbursement Policy

Subject: Modifier 63: Procedure Performed on Infants Less Than 4 kg

Effective Date:
09/14/20

Committee Approval Obtained:
09/14/20

Section:
Coding

*****The most current version of the reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to <https://providers.amerigroup.com/TX>. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy

Amerigroup allows reimbursement for surgery on neonates and infants up to a present body weight of 4 kg when billed with Modifier 63 unless provider, state, federal or CMS contracts and/or requirements indicate otherwise.

	<p>Reimbursement is based on 100% of the applicable fee schedule or contracted/negotiated rate for the procedure code when the modifier is valid for services performed. The neonate weight should be documented clearly in the report for the service.</p> <p>When an assistant surgeon is used and/or multiple procedures are performed on neonates or infants less than 4 kg in the same operative session, assistant surgeon and/or multiple procedure rules and fee reductions apply.</p> <p>Nonreimbursable Amerigroup does not allow reimbursement for Modifier 63 billed in the following circumstances:</p> <ul style="list-style-type: none"> • For facility billing • With evaluation and management codes • With anesthesia codes • With radiology codes • With pathology/laboratory codes • With medicine codes (other than those appropriate for the modifier) • With Modifier 63-exempt codes • In addition to Modifier 22 (Unusual Services) for the same procedure code(s) • With codes denoting invasive procedures that include neonate or infant in the description, since the reimbursement rate for the code already reflects the additional work
<p>History</p>	<ul style="list-style-type: none"> • Biennial review approved and effective date 09/14/20: updated policy language, Exemptions, History, References and Research Materials, and Definitions sections • Biennial review approved and effective 11/16/18 • Biennial review approved 09/15/16 and effective 09/15/17: policy language updated • Review approved 04/14/14 and effective 02/01/15: disclaimer updated • Review approved and effective 11/05/12 • Review approved and effective 06/18/12: policy template updated • Biennial review approved 06/06/11 and effective 08/05/11: Background and Definitions sections updated; policy template updated • Review approved 10/06/08: Background section/policy template updated • Initial approval 05/22/06 and effective 10/01/06

References and Research Materials	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> • CMS • State Medicaid • Amerigroup state contracts • Optum 360 EncoderPro for Payers Professional
Definitions	<ul style="list-style-type: none"> • Modifier 63: 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 healthcare professional work commonly associated with these patients; this circumstance may be reported by adding modifier 63 to the procedure number • General Reimbursement Policy Definitions
Related Policies	<ul style="list-style-type: none"> • Assistant at Surgery (Modifiers 80/81/82/AS) • Modifier Usage • Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Related Materials	<ul style="list-style-type: none"> • None