Reimbursement Policy

Subject: **Modifier 63**	
Policy Number: **G-06015**	Policy Section: **Coding**
Last Approval Date: **09/06/2024**	Effective Date: **11/04/2022**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.amerigroup.com/GA**.****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Amerigroup Community Care covered the service for the member's 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 Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional 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.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Amerigroup strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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.

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.

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.

Nonreimbursable

Amerigroup does not allow reimbursement for modifier 63 billed in the following circumstances:

- For facility billing
- With Evaluation and Management (E/M) 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

Related Coding
Standard correct coding applies

Policy History	
09/06/2024	Review approved: no changes
11/04/2022	Review approved and effective: updated minor language; updated title to only include modifier 63; updated definition for modifier 63
08/28/2020	Review approved and effective: updated policy language, Background, References and Research Materials, and Definitions sections
11/16/2018	Review approved and effective: updated policy language
09/15/2016	Review approved and effective: updated policy language; updated policy template

04/14/2014	Review approved 04/14/2014 and effective 02/01/2015: updated disclaimer
11/05/2012	Review approved and effective: no changes
06/18/2012	Review approved and effective: updated policy template
06/06/2011	Review approved 06/06/2011 and effective 08/05/2011: updated policy language; updated Background and Definitions sections; updated policy template; updated accountability language
10/06/2008	Review approved: updated Background section; updated policy template
05/22/2006	Initial approval 05/22/2006 and effective 10/01/2006

References and Research Materials
This policy has been developed through consideration of the following: • CMS • Optum EncoderPro 2024 • State contract • State Medicaid

Definitions	
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 and Materials
Modifier 22
Modifiers 50 and 51: Multiple and Bilateral Surgery
Modifiers 80, 81, 82, and AS: Assistant at Surgery
Modifier Usage