moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM062
Policy Title:	Modifier 63 - Procedure Performed on Infants Less Than 4 kg		
Section:	Modifiers	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☐ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☒ Moda Health Plan ☒ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☐ All Types ☒ Commercial Group ☒ Commercial Individual ☒ Commercial Marketplace/Exchange ☒ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☒ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	10/23/2018	Initially Published:	12/12/2018
Last Updated:	10/9/2024	Last Reviewed:	10/9/2024

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

Last Update Effective Date for Texas:	10/9/2024

Reimbursement Guidelines

A. Definition and Documentation.

1. Submitting modifier 63 on an appropriate CPT code indicates:
   a. The infant's weight is under four kilograms at the time the service is rendered.
   b. This low weight resulted in increased work or complexity of work.
2. The patient's medical record documentation must indicate:
   a. The significantly greater effort required.
   b. The reason for the additional work, which may include, but not be limited to:
      i. Increased intensity or time.
      ii. Technical difficulty of procedure that is not described by a more comprehensive procedure code.
      iii. Severity of the patient's condition.
      iv. Increased physical and mental effort.
3. Medical records may be requested at Moda Health's discretion for review to support the additional payment.

B. Impact to reimbursement.

1. Moda Health allows additional reimbursement for an eligible procedure or service reported with modifier 63 appended.

2. When the procedure is eligible for modifier 63, reimbursement will be 120% of the normal allowance (contracted fee or maximum plan allowable).
3. Moda Health denies codes which are not eligible for modifier 63 when inappropriately submitted with modifier 63.

C. Claims and codes eligible for modifier 63 additional reimbursement.

1. Professional claims.
2. Procedure codes listed in the 20005-69990 code series. (AMA[1])
3. Procedure codes not listed in section D (below).

D. Claims and codes not eligible for modifier 63 or additional reimbursement.

1. Facility claims.
2. Moda Health does not allow additional reimbursement for modifier 63 when the contracted fee allowance is based on a percentage of billed charges.
3. Procedure codes listed in "Summary of CPT Codes Exempt from Modifier 63," Appendix F of the CPT book for the date of service on the claim. These codes are additionally identified with the parenthetical instruction "(Do not report modifier 63 in conjunction with….)." (AMA[2])
4. Procedure codes that include "neonate" or "infant" in the code description. The reimbursement rate for the code already reflects the additional work associated with the age and size of the neonate or infant.
5. Procedure codes outside of the 20005-69990 code series. (AMA[1])
    a. Evaluation and Management Services.
    b. Anesthesia services.
    c. Integumentary services.
    d. Radiology services.
    e. Pathology/Laboratory services.
    f. Medicine services.
    g. Category III code services.
    h. HCPCS codes.
6. Modifier 63 and modifier 22 may not be reported on the same code.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
AMA	American Medical Association
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")

Acronym or Abbreviation	Definition
HIPAA	Health Insurance Portability and Accountability Act
MPFSDB	(National) Medicare Physician Fee Schedule Database (aka RVU file)
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka "CCI")
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	Relative Value Unit
UB	Uniform Bill

Definition of Terms

Term	Definition
Homeostasis	A property of cells, tissues, and organisms that allows the maintenance and regulation of the stability and constancy needed to function properly. Homeostasis is a healthy state that is maintained by the constant adjustment of biochemical and physiological pathways. An example of homeostasis is the maintenance of a constant blood pressure in the human body through a series of fine adjustments in the normal range of function of the hormonal, neuromuscular, and cardiovascular systems. These adjustments allow the maintenance of blood pressure needed for body function despite environmental changes and changes in a person's activity level and position. Other homeostatic mechanisms, for example, permit the maintenance of body temperature within a narrow range. [3]
Infant	A baby younger than one year old; from birth up to (but not including) their first birthday.
Neonate	A newborn baby, specifically a baby in the first 4 weeks after birth. After a month, a baby is no longer considered a neonate. [3]

Modifier Definitions:

Modifier	Modifier Description & Definition
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 or other qualified health care professional 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 20005-69990 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.
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 (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.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"**Note:** Unless otherwise designated, this modifier [modifier 63] may only be appended to procedures/services listed in the 20005-69990 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." [1]

Cross References

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.

B. "Modifier 22 – Increased Procedural Services." Moda Health Reimbursement Policy Manual, RPM007.

C. "Medical Records Documentation Standards." Moda Health Reimbursement Policy Manual, RPM039.

References & Resources

1. American Medical Association. "Appendix A – Modifiers; Modifier 63 Definition." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
2. American Medical Association. "Appendix F – Summary of CPT Codes Exempt from Modifier 63." *Current Procedural Terminology (CPT)*. Chicago: AMA Press.
3. Medical Definitions of Homeostasis, Infant, and Neonate. Medicinenet.com. November 19, 2018. https://www.medicinenet.com/medterms-medical-dictionary/article.htm .
4. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 20.4.4, 20.4.6.

Background Information

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 health care professional work commonly associated with these patients. The increased complexity may be related to temperature control, obtaining IV access, and/or other difficulties maintaining homeostasis.

Modifiers

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider

- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

RVUs and Fee Allowances

The RBRVU and fee allowance for services represent the average work effort and practice expenses required to provide a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. (CMS[4]) For any given procedure code, there could typically be a range of work effort or practice expense required to provide the service. Thus, the payment for a service should be increased only under very unusual circumstances based upon review of medical records and other documentation. [4]

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
10/9/2024	Updated Cross References. Formatting Updates. No policy changes.
10/11/2023	Formatting Updates. No policy changes.
8/10/2022	Formatting Updates. No policy changes.
12/12/2018	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
10/23/2018	Original Effective Date (with or without formal documentation). Policy based on AMA & CMS guidelines for modifier 63.