Reimbursement Policy	
Subject: **Modifier 63**	
Policy Number: **G-06015**	Policy Section: Coding
Last Approval Date: **11/04/2022**	Effective Date: **09/14/2020**

**** 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 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 Community Care 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.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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 These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.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 our provider 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 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

11/04/2022	Review approved; minor language updates; changed title to only include Modifier 63; updated Modifier 63 definition
09/14/2020	Review approved and effective date: updated policy language, Exemptions, History, References and Research Materials, and Definitions Sections
11/16/2018	Review approved and effective: Georgia exemption removed
09/15/2016	Review approved and effective 09/15/2017: policy language updated; Georgia exemption updated
04/14/2014	Review approved and effective 02/01/2015: disclaimer updated
11/05/2012	Review approved and effective 11/05/2012

06/18/2012	Review approved and effective: policy template updated
06/06/2011	Review approved and effective 08/05/2011: background and definitions sections updated; policy template updated; Georgia exemption added; accountability language updated
10/06/2008	Review approved: background section/policy template updated
05/22/2006	Initial approval and effective 10/01/2006

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Association, CPT 2020, Professional Edition
- CMS
- State Contracts
- State Medicaid
- Optum EncoderPro 2022 for Payers Professional

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

Assistant at Surgery (Modifiers 80/81/82/AS)
Modifier 22: Increased Procedural Service
Modifier Usage
Multiple and Bilateral Surgery