ACTION

☒ New Policy
☐ Repealed Policy Date: _____
☐ Superseded Policy Number: _____

The most current version of the reimbursement policies can be found on www.jhhc.com.

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 Johns Hopkins HealthCare (JHHC) 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 must be billed with ICD-10 codes, 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, Johns Hopkins HealthCare (JHHC) may:

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

JHHC reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state or commercial client contracts, or state, federal or CMS contracts and/or requirements.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, JHHC strives to minimize these variations.

JHHC reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on www.jhhc.com.

POLICY:

Johns Hopkins HealthCare LLC allows additional reimbursement for eligible procedures or service of neonates and infants up to a body weight of 4kg reported with modifier 63, and when modifier is valid for the service performed. Ineligible codes, submitted inappropriately with modifier 63 will be denied.

SCOPE:

This payment policy applies to procedures provided to infants with a body weight <4KG at the time of the procedure, reported with modifier 63 on CMS-1500 claim forms or its electronic equivalent.

DEFINITIONS:

Infant – A young baby, from birth to 12 months of age.

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 work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number.

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.

PROVIDER BILLING GUIDELINES:

Infants who weigh less than four kilograms require additional work related to temperature control, obtaining IV access, and procedural complexity to obtain quality health outcomes. Modifier 63 can be appended to procedure codes that do not include “neonate” or “infant” in its description (the reimbursement rate for these codes already accounts for the additional work) for a payment adjustment as a result of this additional work.

Modifier 63 is applicable for procedure codes in the range of 20100-69990 and 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93530, 93531, 93532, 93533, 93561, 93562, 93563, 93564, 93568, 93580, 93582, 93590, 93591, 93592, 93615, and 93616.

Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.

PAYMENT METHODOLOGY

Appropriately billed increased procedures will be paid at 120% of the contracted rate, not to exceed the billed charges. When another modifier that reduces the fee schedule amount is also applicable, Modifier 63 must be reported in the secondary position. Modifier 63's payment adjustment will be applied after the payment reduction indicated by the modifier in the primary position. (Ex: Modifier 1 = 51 and Modifier 2 = 63 will result in reimbursement at 50% of the contracted rate then 120% of the reduced rate).

EXCLUSIONS

This policy does not apply to Priority Partners MCO or AdvantageMD

EXEMPTIONS

N/A

REFERENCES:

American Medical Association. "Appendix A – Modifiers; Modifier 63 Definition." *Current Procedural Terminology* (CPT). Chicago: AMA Press.

American Medical Association. "Appendix F – Summary of CPT Codes Exempt from Modifier 63." *Current Procedural Terminology* (CPT). Chicago: AMA Press.

American College of Cardiology article *"Coding Update: New Flexibility For CPT Modifier - 63"*, March 3, 2020

APPROVALS

Reimbursement Policy Committee Date: 09/23/2020

Review/Revision Dates: 6/16/2020