JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.023
		Effective Date	02/01/2024
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	Subject **Infants Less Than 4Kg (Modifier -63)**	*Supersedes Date*	11/01/2020
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This document applies to the following Participating Organizations:

EHP US Family Health Plan

Keywords: Infants Less Than 4Kg, Modifier 63, Neonate

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual". The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS guidelines, and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by regulatory mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

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

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JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

The purpose of the -63 modifier is to support additional reimbursement to reflect the increased complexity and physician work commonly associated with procedures for infants up to a present body weight of 4 kg, when billed appropriately. 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.

III. POLICY STATEMENT

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. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to: legislative mandates, provider contracts, and/or the member's benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy. A prior authorization/referral may be required for certain types of care, items and/or services, but it is not a guarantee of payment. Providers are responsible for verifying the individual member's contract for specific plan benefits and to obtain a prior authorization/reauthorization before an item, procedure or service is rendered.

*Providers are responsible for reviewing the **"EXCEPTIONS & EXCLUSIONS" sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES and PAYMENT METHODOLOGY

A. Modifier -63 may 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.
B. Modifier -63 should not be confused with Modifier -22. Modifier -22 is for increased procedural services and can be appended to certain procedure codes when the work required to provide the service is substantially greater than typically required.
   i. Refer to JHHP's Increased Procedure - Modifier 22 policy for additional reimbursement guidance.
C. Appropriately billed increased procedures will be paid at 120% of the contracted rate, not to exceed the billed charges.
D. When another modifier that reduces the fee schedule amount is also applicable, Modifier 63 must be reported in the secondary position.
E. 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).
F. It is expected that the patient's medical records reflect the need for care/services provided. Providers must ensure all necessary records are on file to support services rendered.
G. Providers who bill JHHP for their services are required to follow JHHP's Scope of Practice policy.
H. JHHP will determine if requirements are met for an additional allowance for modifier -63.

I. 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.

V. INAPPROPRIATE USE of MODIFIER –63

1. A. Ineligible codes, modifiers, or codes submitted inappropriately with modifier -63 will be denied.
   B. Modifier 63 should not be appended to any CPT codes listed for (including, but not limited to):
   - Evaluation and Management (E/M) Services
   - Anesthesia services
   - Radiology services
   - Pathology/Laboratory services
   - Durable Medical Equipment, Prosthetics and Orthotics (DMEPOS)
   - Medicine sections (some code exceptions apply).

VI. EXCEPTIONS and EXCLUSIONS

1. This policy **does not** apply to Priority Partners MCO or AdvantageMD.
2. JHHP will process and reimburse claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional, specific information on policy, benefits, and coverage.

VII. CODES, TERMS and DEFINTIONS

Definition of Terms

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

Modifiers

Modifier	Description
22	Increased Procedural Services
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.

VIII. REFERENCES

This policy has been developed through consideration of the following:

- CPT Manual - Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.
- TRICARE Reimbursement Manual

IX. REVISION HISTORY

Date	Review/Revision	Reason for Modification	Approved By:
11/29/2023	Revision	Updated policy language and format.	Reimbursement Policy Committee (RPC)