LifeWise
Health Plan of Washington

Payment Policy

cmi_051766

Title	**Modifier 63 – Procedure performed on infants less than 4kg**		
Number	**CP.PP.211.v2.6**		
Last Approval Date	03/07/25	**Original Effective Date**	10/01/07
Cross Reference	*Modifier 22 – Increased procedural services*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define when the Plan recognizes surgical services appended with Modifier 63 that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products
Policy	The Plan recognizes Modifier 63- *Procedure performed on infants less than 4kg* appended to a service to indicate that specific invasive surgical procedures were performed on neonates and infants weighing **less than 4 kilograms (kg)** and that those procedures involved a significant increase in complexity and work rendered by the provider. Modifier 22-*Increased procedural services* is not appropriate for use with services rendered to an infant or neonate weighing less than 4kg at the time of service. Modifier 63 and modifier 22 should never be billed together on the same code line. Unless otherwise designated, modifier 63 may only be appended to procedures/services in the code range 20100-69990 and the identified cardiovascular codes from the Medicine section of the CPT Codebook as stated in its Appendix A-Modifiers under the Modifier 63 entry. This modifier should not be appended to any Evaluation and Management (E&M) service or any code(s) in the Anesthesiology, Radiology, Laboratory/Pathology or Medicine sections in the CPT Codebook except for the cardiovascular codes stated in Appendix A-Modifiers under modifier 63. Codes whose description already include the term "neonate" or "infant" should not be appended with modifier 63 as the code value and reimbursement of the code already reflects the additional work involved. Refer to Appendix F of the current CPT codebook, for a listing of codes **exempt** from the use of Modifier 63. Documentation in the patient's medical records should identify the significantly greater effort required for the procedure and the reasons for the additional work. If any allowed amount indicated above exceeds the billed charge for the claim line, that line will allow at the billed charge.

Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	
References	American Medical Association's Current Procedural Terminology (AMA/CPT) codebook: • Appendix A – Modifiers • Appendix F – Summary of CPT Codes Exempt from Modifier 63

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	03/07/25; 04/11/24; 06/06/22; 08/02/21; 08/17/20; 10/11/19; 10/18/18; 11/06/17; 11/08/16; 11/15/15; 11/23/14; 12/15/13; 01/13/13; 01/27/11; 03/04/10; 05/11/09; 07/21/08; 06/09/07; 05/05/06; 11/28/05; 08/29/05; 10/21/04	
Version History	10/18/18	Annual review; no changes
	10/11/19	Added additional qualifiers in the Policy section as to appropriate use of modifier 63, paragraphs 3 and 5
	08/17/20	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms. In the Policy section, called out the code exceptions in the Medicine/Cardiovascular that can also be billed with Modifier 63.
	08/02/21	Revised the first paragraph in Policy section by adding reference to the increased work and complexity of the service rendered by the provider. Added paragraph at the end of the Policy section to indicate that the patient's medical records need to be documented as to the need for the significantly greater effort required for the procedure and the reasons for the additional work.
	06/06/22	Annual review; no changes
	05/19/23	Annual review; no changes
	04/11/24	Annual review; no changes
	03/07/25	Annual review; no changes

This policy was published on March 14, 2025