BlueCross BlueShield of Arizona
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PRICING GUIDELINES **EFFECTIVE DATE: 2/1/2010**
Changed: Clarified exception codes. **REVISION DATE: 12/1/2017**

MODIFIER 63 – Procedures Performed on Infants Less Than 4 kg

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pricing Guideline must be read in its entirety to determine coverage eligibility, if any.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

Pricing Guidelines are subject to change as new information becomes available.

Description:

Procedures performed on neonates/infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these individuals. This circumstance may be reported by adding modifier 63 to the procedure code.

Modifier 63 should **not** be appended to any procedure code identified in the Evaluation/Management Services, Anesthesia, Radiology, Pathology/Laboratory or Medicine sections of the CPT coding manual.

Certain surgical procedures should **not** be submitted with modifier 63. Refer to Criteria section of this document for a list of the Exception Codes.

Criteria:

- Modifier 63 may be ***eligible for additional reimbursement*** with documentation of **ALL** of the following:

  1. Neonate/infant's present body weight of 4 kg or less
  2. Procedure was not performed specifically to correct a congenital abnormality as those procedure codes reflect an inherent element of complexity in their reimbursement
  3. Services submitted are not listed as exceptions. Refer to list of exceptions codes for modifier 63 in Criteria section of this document.

- With exceptions, reimbursement is at 115% of the fee schedule when the patient is less than one year of age and at 100% of the fee schedule when the patient is greater than one year of age. Refer to list of exception codes for modifier 63 in Criteria section of this document.

MODIFIER 63 (cont.)

Criteria: (cont.)

EXCEPTION CODES FOR MODIFIER 63:
Refer to Appendix F, in the AMA (American Medical Association) CPT Code Reference Manual, for codes that are exempt from the use of modifier 63.

Resources:

1. American Medical Association. Current Procedural Terminology, (CPT®)

2. Health Care Procedure Coding System (HCPCS®)