

## Modifier -63

**Policy** REIMB-033

**Origination Date:** 04/26/2021

**Reviewed/Revised Date:** 05/24/2023

**Next Review Date:** 05/24/2024

**Current Effective Date:** 05/24/2023

### Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. **This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.**

### Description:

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. When this circumstance occurs it may be appropriate to add modifier -63 to the procedure number.

### Policy Statement and Criteria

#### 1. Commercial Plans

**U of U Health Plans reimburses modifier -63 at a premium of the fee schedule or other allowed amount when the procedure(s):**

- A. Is performed on a neonate or infant weighing 4kg or less; AND
- B. Is an invasive procedure; AND
- C. Associated with one of the following CPT codes

i. 92920	vii. 92990	xiii. 93530
ii. 92928	viii. 92997	xiv. 93531
iii. 92953	ix. 92998	xv. 93532
iv. 92960	x. 93312-93318	xvi. 93533
v. 92986	xi. 93452	xvii. 93561
vi. 92987	xii. 93505	xviii. 93562

xix. 93563	xxii. 93580	xxv. 93592
xx. 93567	xxiii. 93582	xxvi. 93615
xxi. 93568	xxiv. 93590	xxvii. 93616

**OR**

Procedures/services listed in the **20100-69990** CPT code series.

**U of U Health Plans does NOT allow reimbursement for modifier -63 in the following circumstances:**

- A. For facility billing;
- B. With evaluation and management codes;
- C. With anesthesia codes;
- D. With radiology codes;
- E. With pathology/laboratory codes;
- F. With medicine codes (other than those appropriate for the modifier);
- G. With Modifier 63-exempt codes;
- H. In addition to Modifier 22 (Unusual Services) for the same procedure code(s);
- I. 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.

**2. Medicaid Plans**

Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at: <https://medicaid.utah.gov/utah-medicaid-official-publications/> or the [Utah Medicaid code Look-Up tool](#)

CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.

**Applicable Coding**

**Modifiers:**

**63** Procedure Performed on Infants less than 4 kg

**CPT Codes**

**20100-69990** CPT Surgical Coding Sections

**92920** Percutaneous transluminal coronary angioplasty; single major coronary artery or branch

- 92928** Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch
- 92953** Temporary transcutaneous pacing
- 92960** Cardioversion, elective, electrical conversion of arrhythmia; external
- 92986** Percutaneous balloon valvuloplasty; aortic valve
- 92987** Percutaneous balloon valvuloplasty; mitral valve
- 92990** Percutaneous balloon valvuloplasty; pulmonary valve
- 92997** Percutaneous transluminal pulmonary artery balloon angioplasty; single vessel
- 92998** Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)
- 93312-93318** Transesophageal echocardiography
- 93452** Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
- 93505** Endomyocardial biopsy
- 93530** Right heart catheterization, for congenital cardiac anomalies
- 93531** Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies
- 93532** Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies
- 93533** Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies
- 93561** Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)
- 93562** Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output
- 93563** Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)
- 93564** Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (e.g., aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (e.g., internal mammary), whether native or used for bypass to one or

more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)

- 93568** Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)
- 93580** Percutaneous transcatheter closure of congenital interatrial communication (i.e., Fontan fenestration, atrial septal defect) with implant
- 93582** Percutaneous transcatheter closure of patent ductus arteriosus
- 93590** Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve
- 93591** Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve
- 93592** Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)
- 93615** Esophageal recording of atrial electrogram with or without ventricular electrogram(s);
- 93616** Esophageal recording of atrial electrogram with or without ventricular electrogram(s); with pacing

### References:

1. American Medical Association (AMA). AMA CPT Professional Edition 2022.
2. Centers for Medicare and Medicaid Services (CMS). Available at: <https://www.cms.gov/>
3. Optum360 EcoderPro.com for Payers Professional. (2022).

### Disclaimer:

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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