	Reimbursement Policy

Subject: Modifier 76: Repeat Procedure by the Same Physician

Effective Date: **10/03/18**	Committee Approval Obtained: **08/07/20**	Section: **Coding**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.healthybluela.com**.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Healthy Blue if the service is covered by a member's Healthy Louisiana 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 should be billed with 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, Healthy Blue may:

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

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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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

Healthy Blue reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Healthy Blue allows reimbursement for applicable procedure codes appended with Modifier 76 to indicate a procedure or service was repeated by the same physician: • Subsequent to the original procedure or service for professional provider claims. • On the same date as the original procedure or service for facility claims.

	Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based on the following use of Modifier 76: • For a nonsurgical procedure of service: 100% of the applicable fee schedule or contracted/negotiated rate • For a surgical procedure: 100% of the applicable fee schedule or contracted/negotiated rate for the surgical component only **limited** to a total of two surgical procedures Professional services, other than radiology, will be subject to clinical review for consideration of reimbursement. Providers must submit supporting documentation for the use of Modifier 76 with the claim. If a claim is submitted with Modifier 76 without supporting documentation, the claim will be denied. Providers will be asked to submit the required documentation for reconsideration of reimbursement. Failure to use Modifier 76 when appropriate may result in denial of the procedure or service. If a **repeated** surgical procedure is performed with an assistant surgeon or in conjunction with multiple surgeries, assistant surgeon and/or multiple procedure rules and fee reductions apply. **Nonreimbursable** Healthy Blue does not allow reimbursement for use of Modifier 76: • With an inappropriate procedure code: o Evaluation and management codes o Laboratory codes • For any procedure repeated more than once. For the preoperative or postoperative components of a surgical procedure.
History	• Biennial review approved **08/07/20**: Updated Reference and Material and Related Policies sections • Biennial review approved and effective **10/03/18** • Policy template updated effective **09/01/17** • Biennial review approved and effective **11/07/16**: Policy language updated • Biennial review approved **10/13/14**: Policy template updated • Review approved **04/22/13**: Policy template updated • Biennial review approved **03/26/12** and effective **05/05/10**: Policy template updated • Review approved **12/08/09** and effective **05/05/10**: Policy template updated • Review approved **03/23/09**: Policy template updated • Review approved **10/20/08**: Policy template updated • Initial approval **05/22/06** and effective **01/01/07**

References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • State contracts • American Medical Association, CPT 2020, Professional Edition
Definitions	• **Subsequent:** the time period after the initial procedure or service is performed and within the global period designated for that procedure or service • **General Reimbursement Policy Definitions**
Related Policies	• Assistant at Surgery (Modifiers 80/81/82/AS) • Duplicate or Subsequent Services on the Same Date of Service • Modifier 91: Repeat Clinical Diagnostic Laboratory Test • Modifier Usage • Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Related Materials	• None