	Reimbursement Policy	
Subject: Modifier 76: Repeat Procedure By the Same Physician		
Effective Date: **11/07/16**	Committee Approval Obtained: **11/07/16**	Section: **Coding**

*****The most current version of the 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.amerigroup.com. Under Quick Tools, select Reimbursement Policies > Medicaid/Medicare. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup 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, Amerigroup may:

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

Amerigroup 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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,

Amerigroup strives to minimize these variations.
Amerigroup 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	Amerigroup 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 or service: 100 percent of the applicable fee schedule or contracted/negotiated rate • For a surgical procedure: 100 percent 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** Amerigroup does not allow reimbursement for use of Modifier 76: • With an inappropriate procedure code: o Evaluation and Management (E&M) codes o Laboratory codes • For any procedure repeated more than once • For the preoperative or postoperative components of a surgical procedure
Exemptions	• Amerigroup Kansas, Inc., in accordance with Kansas Medical Assistance Program (KMAP), denies surgical and clinical diagnostic laboratory codes when billed with Modifier 76. • Amerigroup Texas, Inc. and Amerigroup Insurance Company, in accordance with Texas Medical Assistance (Medicaid) Program, allows Modifier 76 for transplant procedures if it is a second transplant of the same organ. Modifier 76 is used for repeat laboratory non-clinical test.
History	• Biennial review approved and effective 11/07/16: Policy language updated; Kansas and Texas exemption added

	• Effective 01/01/16: Exited New York Medicare • Effective 12/31/15: Exited Florida Medicare • Biennial review approved 10/13/14: Background and policy template updated • Effective 06/01/14: Exited Ohio • Review approved 04/22/13: Background, disclaimer updated • Biennial review approved 03/26/12 and effective 05/05/10: Accountability language updated • Review approved 12/08/09 and effective 05/05/10: Exclusive use of modifier on professional claims for procedures performed on the same date removed; Modifier non-applicability to facility claims removed; Definition of subsequent added • Review approved 03/23/09: Radiology claim auto-adjudication clarified • Review approved 10/20/08: Background section/policy template updated • Review approved 08/15/07: Florida exemption removed • Initial committee approval: 05/22/06 with effective date of 01/01/07
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup State Contracts • Code Editing Guidelines • Optum EncoderPro.com for Payers • American Association of Professional Coders 2016 Procedural Coding Expert Edition • American Medical Association 2015 Current Procedural Terminology 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) • Modifier 91: Repeat Clinical Diagnostic Laboratory Test • Modifier Usage • Multiple Bilateral Surgery: Professional and Facility Reimbursement
Related Materials	• None