



Reimbursement Policy

Subject: Modifier 77: Repeat Procedure By Another Physician or Other Qualified Health Care Professional

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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 77 to indicate a procedure or service was repeated by another physician:

- Subsequent to the original procedure or service for professional claims.

	<ul style="list-style-type: none"> • On the same date as the original procedure or service for facility claims. <p>Unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based on the following use of Modifier 77:</p> <ul style="list-style-type: none"> • 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 <p>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 77 with the claim. If a claim is submitted with Modifier 77 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 77 when appropriate may result in denial of the procedure or service.</p> <p>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.</p> <p>Nonreimbursable Amerigroup does not allow reimbursement for use of Modifier 77:</p> <ul style="list-style-type: none"> • With an inappropriate procedure code. • For any procedure repeated more than once. • For the preoperative or postoperative components of a surgical procedure. • When appended to Evaluation and Management codes.
<p>Exemptions</p>	<ul style="list-style-type: none"> • In Florida, the Amerigroup contract with the state requires consistency with the Agency for Health Care Administration (AHCA). AHCA only recognizes Modifier 77 as a valid modifier when billed with radiology codes. Florida claims for nonradiological procedures submitted with Modifier 77 will be denied. • Amerigroup Kansas, Inc., in accordance with the Kansas Medical Assistance Program (KMAP), denies clinical diagnostic laboratory codes when billed with Modifier 77. • This policy is not applicable to Amerigroup Louisiana. • Amerigroup Texas, Inc. and Amerigroup Insurance Company, in

	<p>accordance with the Texas Medical Assistance (Medicaid) Program, allows Modifier 77 for transplant procedures if it is a second transplant of the same organ.</p>
History	<ul style="list-style-type: none"> • Biennial Review approved and effective 11/07/16: Policy language updated; Kansas and Texas exemption added • Effective 04/01/16: Entered Iowa • Effective 03/01/16: Entered South Carolina • Effective 01/01/16: Exited New York FIDA • Effective 12/31/15: Exited Florida Medicare • Review approved 11/09/15: Policy language updated; Washington exemption removed • Biennial review approved 06/09/14: Policy language updated • Washington exemption added, effective 08/27/12 • Biennial review approved 03/26/12: Background section/policy template updated • Review approved 06/20/11 and effective 07/21/11: Policy template updated; 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 nonapplicability to facility claims removed; definition of subsequent added • Review approved 03/23/09 and effective 04/27/09: Claim denial without supporting documentation clarified; radiology claim auto-adjudication clarified; nonreimbursable section added; Background section/policy template updated <ul style="list-style-type: none"> ▪ Initial committee approval and effective date: 05/22/06
References and Research Materials	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> • CMS • State Medicaid • Optum EncoderPro.com for Payers • American Medical Association 2015 Current Procedural Terminology • Professional Edition • American Association of Professional Coders 2016 Procedural Coding Expert Edition
Definitions	<ul style="list-style-type: none"> • Subsequent: the time period after the initial procedure or service is performed and within the global period designated for that procedure or service • Reimbursement Policy Definitions
Related Policies	<ul style="list-style-type: none"> • Assistant at Surgery (Modifiers 80/81/82/AS) • Modifier Usage • Multiple Bilateral Surgery: Professional and Facility

	Reimbursement
Related Materials	<ul style="list-style-type: none">• None