

		<b>Reimbursement Policy</b>
<b>Subject: Modifier 76: Repeat Procedure by the Same Physician</b>		
Effective Date: <b>10/03/18</b>	Committee Approval Obtained: <b>10/03/18</b>	Section: <b>Coding</b>
<p>***** 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 <a href="https://providers.amerigroup.com/DC">https://providers.amerigroup.com/DC</a>. *****</p>		
<p>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 District of Columbia, Inc. 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 District 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.</p> <p>If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:</p> <ul style="list-style-type: none"> <li>• Reject or deny the claim.</li> <li>• Recover and/or recoup claim payment.</li> </ul> <p>Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, District, federal or CMS contracts and/or requirements.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.</p> <p>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.</p>		
<b>Policy</b>	<p>Amerigroup allows reimbursement for applicable procedure codes appended with Modifier 76 to indicate a procedure or service was repeated by the same physician:</p> <ul style="list-style-type: none"> <li>• Subsequent to the original procedure or service for professional provider claims.</li> <li>• On the same date as the original procedure or service for facility claims.</li> </ul>	

	<p>Unless provider, District, federal or CMS contracts and/or requirements indicate otherwise, reimbursement is based on the following use of Modifier 76:</p> <ul style="list-style-type: none"> <li>• For a nonsurgical procedure or service: 100 percent of the applicable fee schedule or contracted/negotiated rate</li> <li>• For a surgical procedure: 100 percent of the applicable fee schedule or contracted/negotiated rate for the surgical component only <b>limited</b> to a total of two surgical procedures</li> </ul> <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 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.</p> <p>If a <b>repeated</b> 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><b>Nonreimbursable</b> Amerigroup does not allow reimbursement for use of Modifier 76:</p> <ul style="list-style-type: none"> <li>• With an inappropriate procedure code: <ul style="list-style-type: none"> <li>○ Evaluation and management codes</li> <li>○ Laboratory codes</li> </ul> </li> <li>• For any procedure repeated more than once.</li> <li>• For the preoperative or postoperative components of a surgical procedure.</li> </ul>
<b>History</b>	<ul style="list-style-type: none"> <li>• Biennial review approved and effective <b>10/03/18</b></li> <li>• Initial approval <b>07/19/17</b> and effective <b>10/01/17</b></li> </ul>
<b>References and Research Materials</b>	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> <li>• CMS</li> <li>• DC Department of Health Care Finance policies</li> <li>• Amerigroup contract with the DC Department of Health Care Finance</li> <li>• Code Editing Guidelines</li> <li>• Optum EncoderPro.com for Payers</li> </ul>
<b>Definitions</b>	<ul style="list-style-type: none"> <li>• <b>Subsequent:</b> the time period after the initial procedure or service is performed and within the global period designated for that procedure or service</li> <li>• <b>General Reimbursement Policy Definitions</b></li> </ul>
<b>Related Policies</b>	<ul style="list-style-type: none"> <li>• Assistant at Surgery (Modifiers 80/81/82/AS)</li> </ul>

	<ul style="list-style-type: none"><li>• Modifier 91: Repeat Laboratory Test</li><li>• Modifier Usage</li><li>• Multiple and Bilateral Surgery: Professional and Facility Reimbursement</li></ul>
<b>Related Materials</b>	<ul style="list-style-type: none"><li>• None</li></ul>