Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Modifier 77: Repeat Procedure by Another Physician or Other Qualified Healthcare Professional

Effective Date:	Committee Approval Obtained:	Section:
10/03/18	**08/07/20**	**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/GA**. 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 Community Care 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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.

	• 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 77: • For a nonsurgical procedure or 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 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. 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 77: • 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 (E/M) codes.
History	• Biennial review approved 08/07/20: updated References and Related Policies sections • Biennial review approved and effective 11/07/16: policy language updated • Review approved 11/09/15: policy language updated • Biennial review approved 06/09/14: policy language updated • 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 • Initial approval effective 05/22/06
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts • American Medical Association (AMA), 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 Usage • Multiple and Bilateral Surgery (Modifiers 50/51)
Related Materials	• None