Amerigroup An Anthem Company	**Reimbursement Policy**

Subject: Duplicate or Subsequent Services on the Same Date of Service

Effective Date:	Committee Approval Obtained:	Section:
04/21/20	**04/21/20**	**Administration**

*****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/TX**. 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 of a duplicate or subsequent service provided on the same date of service if billed with an appropriate modifier or with additional units, as applicable within benefit limits, unless otherwise noted by provider, state, federal or CMS contracts and/or requirements.

Reimbursement of a duplicate or subsequent service

Reimbursement of duplicate or subsequent services is based on the correct usage of the below modifiers, which indicate the service was appropriately repeated or additionally billed for the same member:

- Modifier 62: Co-Surgeons
- Modifier 66: Surgical Teams
- Modifier 76: Repeat Procedure by the Same Physician
- Modifier 77: Repeat Procedure by Another Physician
- Modifier 80: Assistant at Surgery Providing Full Assistance to the Primary Surgeon
- Modifier 81: Assistant at Surgery Providing Minimal Assistance to the Primary Surgeon
- Modifier 82: Assistant at Surgery When a Qualified Resident Surgeon is Not Available to Assist the Primary Surgeon
- Modifier AS: Assistant at Surgery Who is a Nonphysician (for example, physician assistant or nurse practitioner)
- Modifier 91: Repeat Clinical Diagnostic Laboratory Test
- Modifier GG: Performance and Payment of a Screening Mammogram and Diagnostic Mammogram on the Same Patient, Same Day
- Modifier GH: Diagnostic Mammogram Converted From Screening Mammogram on Same Day

Amerigroup may deny a duplicate or subsequent service provided on the same date of service, billed on the same or separate claims, unless billed with an appropriate modifier.

Amerigroup will review claims billed with suspected duplicate or subsequent services. Claims will be denied for services determined to be duplicate or subsequent claims without the appropriate modifier(s).

Reimbursement of bundled services

When a service is unbundled from a more complex or comprehensive service and billed individually on the same date of service as the more comprehensive service:

- The claim line for the individual service will be denied through code editing if billed on the same claim.
- The claim will be reviewed if billed on separate claims.

The following modifiers indicate an individual service is distinct and separate from the more comprehensive service:

	• Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service • Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU) **Note**: Refer to specific modifier policies for applicability to individual states.
History	• Biennial review approved and effective 04/21/20; added rendering provider to definition section • Biennial review approved 04/06/18 • Biennial review approved 07/14/16 • Biennial review approved 08/18/14: Background section and policy template updated • Biennial review approved and effective 10/08/12: language updated for clarity; Background section and policy template updated • Biennial review approved 12/06/10: policy reorganized for clarity; Assistant at Surgery modifiers added; processes and benefit limits removed; Assistant at Surgery modifiers and policy reference added; general exemption added; Definitions and Background sections, policy template updated • Review approved 10/20/08: subsequent services clarified, bundled services section added, and Background section/policy template updated • Initial approval and effective date 06/16/06
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts
Definitions	• **Duplicate Services**: o A service is considered a definite duplicate if some or all of the following elements on the claim match: ▪ Member ▪ Date of service ▪ Charge amount ▪ Provider of service/rendering provider ▪ Type of service, based on procedure or revenue codes used o A service is suspected duplicate if the following elements on the claim match: ▪ Member ▪ Procedure code

	▪ Date of service • **Subsequent service**: for purposes of this policy, it is a medically necessary service that is performed or provided for the same member more than once on the same date of service • **General Reimbursement Policy Definitions**
Related Policies	• Assistant at Surgery (Modifiers 80/81/82/AS) • Code and Clinical Editing Guidelines • Distinct Procedural Services (Modifiers 59, XE, XP, XS, XU) • Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service • Modifier 62: Co-Surgeons • Modifier 66: Surgical Teams • Modifier 76: Repeat Procedure by the Same Physician • Modifier 77: Repeat Procedure by Another Physician • Modifier 91: Repeat Clinical Diagnostic Laboratory Test • Modifier Usage
Related Materials	• None