	Reimbursement Policy
Subject: Modifier 76: Repeat Procedure by the Same Physician	

Effective Date: **11/07/16**	Committee Approval Obtained: **08/07/20**	Section: **Coding**

*****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 **https://providers.amerigroup.com/IA**.*****

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 Iowa, 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 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 acce pted 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 its 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: 100% of the applicable fee schedule or contracted/negotiated rate.
	
	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.
	
	Nonreimbursable
	Amerigroup does not allow reimbursement for use of Modifier 76:
	• With an inappropriate procedure code:
	  ○ When appended to evaluation and management codes
	  ○ When appended to surgical codes
	  ○ When appended to laboratory codes
	• For any procedure **repeated** more than once
	• For the preoperative or postoperative components of a surgical procedure

History	• Biennial review approved **08/07/20**: Updated Reference and Material and Related Policies sections • Biennial review approved **10/03/18**: Policy language updated • Biennial review approved and effective **11/07/16**: Policy language updated • Initial committee approval **08/04/15** and effective **04/01/16**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup contract • American Medical Association, 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 91: Repeat Clinical Diagnostic Laboratory Test • Modifier Usage

	• Multiple and Bilateral Surgery: Professional and Facility Reimbursement
Related Materials	• None