

Reimbursement Policy

Subject: **Modifier 77**

Policy Number: **G-06019**

Policy Section: **Coding**

Last Approval Date: **08/28/2023**

Effective Date: **04/01/2023**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to <https://provider.amerigroup.com/dc-provider/welcome>. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Amerigroup District of Columbia, Inc. covered the service for the enrollee's benefit plan. The determination that a service, procedure, item, etc. is covered under an enrollee'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 enrollee'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 Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional 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.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Amerigroup strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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, district, 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.

Non-reimbursable

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.

Related Coding

Standard correct coding applies

Policy History

08/28/2023	Review approved: updated policy template; removed <i>Repeat Procedure by Another Physician or other Qualified Health Care Professional</i> from the policy title; removed <i>subsequent</i> definition
04/01/2023	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023
- State contract
- State Medicaid

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Duplicate or Subsequent Services on the Same Date of Service

Modifier Usage

Modifiers 50 and 51: Multiple and Bilateral Surgery

Modifiers 80, 81, 82 and AS: Assistant at Surgery

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