New York | Medicare Advantage

Reimbursement Policy	
Subject: **Modifier 76**	
Policy Number: **G-06018**	Policy Section: **Coding**
Last Approval Date: **08/28/2023**	Effective Date: **11/07/2016**

**** 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 **providers.anthem.com/ny******

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Anthem Medicare Advantage covered the service for the member's 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 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, Anthem Medicare Advantage may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem Medicare Advantage 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.

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Policy

Anthem Medicare Advantage 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:

- 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 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.

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

Anthem Medicare Advantage does not allow reimbursement for use of Modifier 76:

- With an inappropriate procedure code
  - Evaluation and management (E/M) codes
  - Laboratory codes
- For a surgical procedure **repeated** more than once.
- For the preoperative or postoperative components of a surgical procedure.

Related Coding
Standard correct coding applies

Policy History	
08/28/2023	Review approved: updated policy template; removed *Repeat Procedure by the Same Physician* from the policy title; Missouri Medicaid exemption added (not subject to this policy); definition of *subsequent* removed
08/07/2020	Review approved: updated Reference and Material and Related Policies sections
11/07/2016	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2023
- State contract

Definitions
General Reimbursement Policy Definitions

Related Policies and Materials
Duplicate or Subsequent Services on the Same Date of Service
Modifier Usage
Modifier 91
Modifiers 50 and 51: Multiple Bilateral Surgery
Modifiers 80, 81, 82 and AS: Assistant at Surgery