PREMERA BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

Payment Policy

cmi_051726

Title	**Modifier 76-Repeat Procedure by the Same Provider**		
Number	**CP.PP.219.v2.9**		
Last Approval Date	03/07/25	**Original Effective Date**	10/01/04

Cross Reference	• *Global Surgery* • *Modifier 58 - Staged or Related Procedure or Service by Same Physician or Other Qualified Healthcare Professional during Postoperative Period* • *Modifier 77-Repeat Procedure by Another Provider* • *Modifier 78 – Unplanned return to the Operating Room for a Related Procedure* • *Modifier 79 – Unrelated Procedure/Service by Same Provider during Postoperative Period* • *Modifier 91 –Repeat Clinical Diagnostic Laboratory Test*
Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.	

Purpose	To define when the Plan recognizes services appended with Modifier 76 that are submitted on a CMS 1500 paper claim or 837P electronic claim form.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.

Policy	The Plan recognizes Modifier 76- *Repeat Procedure by the Same Provider* when appended to a service/procedure to indicate that the **same identical service/procedure** was repeated, subsequent to the original service/procedure, by the **same** physician or other qualified healthcare professional for the same patient, often on the **same** day or at a separate and distinct subsequent session, usually during the global period of the original procedure. If the same identical procedure is repeated by the **same provider** as the original service/procedure **on the same day**, bill both procedures on the same claim and append modifier 76 on the same procedure code on second claim line on the same claim as the original service. The units on the second claim line with modifier 76 should represent the number of repeated services. Billing all of the same services/procedures performed on the same day on the same claim will avoid duplicate claim denials. Documentation in the medical record must indicate the need to repeat the same identical service/procedure as the original reported service/procedure by the same physician or qualified healthcare professional. Modifier 76 is not appropriate to append on surgical codes, per their description, that already indicate **multiple procedures on the same date of service**. Modifier 76 should **not** be appended to the same procedure code already appended with one of the following modifiers: • *Modifier 77-Repeat Procedure by Another Provider* • *Modifier 78- Unplanned return to the Operating Room for a Related Procedure or* • *Modifier 79- Unrelated Procedure/Service by Same Provider during Postoperative Period.* Modifier 76 should not be appended to the same procedure code if that procedure was previously planned or staged to be repeated at a later time. Append modifier 58- *Staged or Related Procedure or Service by Same Physician or Other Qualified Healthcare Professional during Postoperative Period* instead. When the same service/procedure is repeated by a **different physician or qualified healthcare provider**, modifier 77- *Repeat Procedure by Another Provider* must be appended in order to be reimbursed. Modifier 76 should **not** be appended on repeat clinical diagnostic laboratory tests. Repeat clinical diagnostic laboratory tests should be appended with modifier 91- *Repeat Clinical Diagnostic Laboratory Test* when applicable. Modifier 76 is not appropriate for submission with Evaluation and Management (E&M) codes (99202-99499), Pathology/Laboratory codes or Proprietary Lab Analysis codes. If any allowed amount indicated above exceeds the billed charge for the claim line, that line will allow at the billed charge.

Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties and/or termination of the contract. Disciplinary actions will be determined in Plan's sole discretion. Violations of this policy may be grounds for corrective action, up to and including termination of employment.
Exceptions	None
Laws, Regulations & Standards	None
References	• American Medical Association's Current Procedural Terminology (AMA/CPT) codebook • Centers for Medicare and Medicaid Services (CMS), Publication 100-04, Chapter 4, Section 20.6.5

Policy Owner Review	Payment Integrity Oversight Committee	
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department.	
Annual Review Dates	03/07/25; 04/11/24; 05/19/23; 06/06/22; 08/02/21; 08/17/20; 10/11/19; 10/18/18; 12/04/17; 12/12/16; 01/08/16; 01/11/15; 01/12/14; 01/13/13, 01/26/12; 01/27/11; 02/12/10; 03/24/09; 06/16/08; 05/13/07; 04/11/06; 11/06/05; 08/29/05; 10/21/04	
Version History	10/18/18	Annual Review; no changes
	10/11/19	Added the second and third paragraphs in the Policy section to clarify the documentation requirements to support the need for the repeat procedure and to identify scenarios of inappropriate usage of modifier 76
	08/17/20	Clarified the Purpose statement to indicate that the policy pertains to Professional services billed on a CMS-1500 or 837P claim forms
	08/02/21	Clarified in the Policy section that modifier 76 is not valid on Pathology/Laboratory and Proprietary Lab Analysis codes.
	06/06/22	Annual review; no changes
	05/19/23	• Added the third paragraph in the Policy section to indicate that when the same service/procedure is repeated by a "different" provider, modifier 77 must be appended in order to be reimbursed. • Expanded the fifth paragraph to identify examples where Modifier 76 must not be appended when another modifier is also present.
	04/11/24	In the Policy section: • Added the second paragraph to indicate that if the repeated procedure is performed on the same date of service as the original service, both procedures should be billed on the same claim with modifier 76 appended to the second claim line procedure. • Added the sixth paragraph to indicate that modifier 76 is not appropriate to append to a surgical procedure if the procedure was previously planned or staged to be repeated at a later time
	03/07/25	Annual review; no changes

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