Anthem Blue Cross and Blue Shield | Serving Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect

Reimbursement Policy	
Subject: **Modifier 77**	
Policy Number: **G-06019**	Policy Section: **Coding**
Last Approval Date: **08/28/2023**	Effective Date: **10/03/2018**

**** 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/in**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect member's Anthem 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 may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, and Hoosier Care Connect through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.
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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem 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

Anthem 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, state, 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 **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 procedures rules and fee reductions apply.

Non-reimbursable

Anthem 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 Repeat Procedure by Another Physician or other Qualified Health Care Professional from the policy title; removed *subsequent* definition
08/07/2020	Review approved: updated References and Research Materials and Related Policies and Materials sections
10/03/2018	Review approved and effective
11/07/2016	Review approved and effective: policy language updated
02/01/2015	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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