Repeat Procedure Modifiers 76, 77 and 91

Reimbursement Policy ID: RPC.0119.DEDS

Recent review date: 04/2026

Next review date: 02/2027

AmeriHealth Caritas VIP Care reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas VIP Care may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy describes requirements for billing for repeat procedures modifiers 76, 77 and 91 when performed on the same date of service.

AmeriHealth Caritas VIP Care recognizes modifiers 76,77 and 91 for repeat procedures on the same date of service consistent with CPT/HCPCS terminology.

Exceptions

Repeat Modifiers 76 and 77 should not be used for Evaluation and Management (E/M) services.

Reimbursement Guidelines

Modifiers 76 and 77 indicate that a service or procedure was repeated on the same day or post-operative period, by the same practitioner (modifier 76) or by a different practitioner (modifier 77).

If multiple and/or identical services are provided to the same member, on the same date of service, a repeat modifier would be needed. If clinically appropriate, modifier 76 would be used for repeat procedures performed by the same provider* to indicate that the service was repeated. If the same procedure was performed by a different provider, then use of modifier 77 would indicate that the service was repeated by a different provider.*

Modifier 76 and 77 should be appended to the professional component only see reimbursement policy RPC.0048.DEDS. It may also be appropriate to include anatomical modifiers (RT, LT, etc.) depending on where the procedure was performed.

Examples of appropriate use of modifiers 76 & 77

Modifier 76-repeat by same provider*

A member has two chest x-rays done on the same day one at 10 am the second at 1:30 pm, with each interpretation being made by the same provider*. The second interpretation would be appended with the 76 modifier.

Submit on the same claim as:

10/15/2024 – 71045 -26 – 1 unit
10/15/2024 – 71045 -26-76- 1 unit

Modifier 77-repeat by different provider*

If a member has two EKG's done on the same date of service and the first EKG is performed at 10am is interpreted by provider A with (specialty XX). Then a second EKG is taken at 2pm and is interpreted by a provider B with (specialty YY). The EKG interpretation performed at 2pm would be appended with the 77 modifier.

Submit on separate claims as:

Claim #1 Provider A
10/15/2024 93010-26

Claim # 2 Provider B
10/15/2024 93010-26-77

Multiple Interpretations on the Same X-ray

When a second interpretation by a different provider* is needed for the same film, the second interpretation must be submitted with a 77 modifier. The claim must provide documentation on why a second interpretation is medically reasonable and necessary.

A member is seen in the ED (Emergency Department) and the ED physician orders a single view chest x-ray. The ED physician reviews the x-ray, treats the member for suspected pneumonia, and discharges the member. While in the ED and prior to discharge, the radiology physician's interpretation of the x-ray indicates

the member did not have pneumonia; however, there was a suspicious area of the lung suggesting a tumor that required further testing including chest x-rays.

Submit on the separate claim as:

Claim # 1 ED Physician
71045-26

Claim #2 Radiologist
71045 26-77

Modifier 91 Repeat Laboratory Tests, Same Date
Modifier 91 is used to report any repeat clinical diagnostic laboratory test being billed when a single service (same CPT code) is ordered for the same beneficiary and the specimen is collected more than once in a single day. For example, repeated tests (e.g., blood gases, electrolytes) to track patient response to therapy.

*CMS defines physicians of the same group practice and same specialty as the same physician and requires that they bill as though they were a single physician.

Definitions

Modifier 76 - Repeat Procedure, Same Provider
Modifier 76 is used for a repeat procedure or service by the same provider or other qualified health professional on the same date of service.

Modifier 77 – Repeat Procedure, Different Provider
Modifier 77 is used for a repeat procedure or service by a different provider or other qualified health professional on the same date of service.

Modifier 91 – Repeat Laboratory Tests, Same Date
Modifier 91 is used to report any repeat clinical diagnostic laboratory test being billed when a single service (same CPT code) is ordered for the same beneficiary and the specimen is collected more than once in a single day.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS). https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=53482#:%7E:text=CPT%20Modifier%2076%3A%20'Repeat%20procedure,duplicate%20services%20and%20repeated%20services
V. The National Correct Coding Initiative (NCCI).
VI. Applicable AmeriHealth Caritas VIP Care manual reference
VII. Medicare Fee Schedule(s).
VIII. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c13.pdf
IX. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Attachments

N/A

Associated Policies

RPC.0048.DEDS Professional/Technical components (Modifiers 26, TC)

Policy History

04/2026	Reimbursement Policy Committee Approval
03/2026	Policy name change for the addition of modifier 91
06/2025	Minor updates to formatting and syntax
04/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
04/2024	Revised preamble
08/2023	Removal of policy implemented by AmeriHealth Caritas VIP Care from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section