LifeWise Health Plan of Washington	**Payment Policy**

cmi_051727

Title	**Modifier 77-Repeat Procedure by Another Provider**		
Number	**CP.PP.247.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 76-Repeat Procedure by the Same 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 77 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 77-*Repeat Procedure by Another Provider* when appended to a service to indicate that the **same identical procedure**/**service** performed previously by **another physician** or other qualified healthcare professional had to, subsequent to the original procedure, be repeated by a **different 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. Documentation in the medical record must indicate the need to repeat the same identical procedure or service as the original reported procedure or service, but by a different physician or qualified healthcare professional. Modifier 77 should **not** be appended to the same procedure code already appended with one of the following modifiers: • *Modifier 76-Repeat Procedure by the Same 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 77 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. Modifier 77 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 77 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	03/07/24; 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 paragraph to indicate that the reason for a repeat procedure should be documented
	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	Annual review; no changes
	06/06/22	Annual review; no changes
	05/19/23	• Added additional Policy references cited in the Policy section. • Added the third and fourth paragraphs in the Policy section to identify when modifier 77 is not appropriate to use.
	04/11/24	In the Policy section, added the fourth paragraph to indicate that modifier 77 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