Payment Policy CPP_51

Modifiers -76, -77, -78, -79
Repeat, Unplanned, & Unrelated
Procedures

BlueCross BlueShield of Vermont
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Last Review: October 16, 2025
Next Review: October 16, 2027
Effective Date: January 01, 2026

Description

Provide a payment policy statement and guidelines that address the claims processing and payment for eligible services submitted with procedure codes appended with the following modifiers: -**76** [Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional], -**77** [Repeat Procedure by Another Physician or Other Qualified Health Care Professional], -**78** [Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period], -**79** [Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period] professional and outpatient facility claims.

Policy & Guidelines

According to the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS), a modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. It may also provide more information about a service such as it was performed more than once, unusual events occurred, or it was performed by more than one provider and/or in more than one location.

Policy Statement

Effective dates of service on or after January 1, 2026, Blue Cross and Blue Shield of Vermont (Blue Cross VT) may process payment for eligible services reported with procedure codes appended with modifiers -76, -77, -78 and -79 to the extent they follow the guidelines set forth in this payment policy.

Eligible

Blue Cross VT may consider it appropriate to use modifiers -76, -77, -78 and -79, when thoroughly documented and in accordance with AMA CPT® guidelines and the Centers for

Medicare and Medicaid Services (CMS) methodology and guidelines Refer to Addendum A. For additional information in the Provider Handbook located at: https://www.bluecrossvt.org/documents/provider-handbook

Not Eligible

The following claim scenarios when appended with modifiers -76, -77, -78 and -79 are considered not compensable and will be denied provider liability:

- Procedures appended with modifier -76 (repeat procedure/same physician) when the same procedure code has not been billed by the same provider identification (ID) on the same date of service, or within the post- operative period of the billed procedure.

- Procedures appended with modifier -77 (Repeat procedure/different physician) when the same procedure code has not been billed by a different provider ID on the same date of service or within the post- operative period of the billed procedure.

- Procedures appended with modifier -77 (Repeat procedure/different physician) when the same procedure code has been billed by the same Provider ID on the same date of service or within the post -operative period of the original procedure billed.

- Procedures lacking modifier -77 (Repeat procedure/different physician) when the same procedure has been billed by a different provider ID on the same date of service.

- Procedures appended with modifier -78 when the same or different 0, 10 or 90 day-procedure code has not been billed on the same day for a 0-day post-operative period, on the same day or in the previous 10-days for a procedure code with a 10-day post-operative period, or on the same day or in the previous 90 days for a procedure code with a 90-day post-operative period.

- Procedures appended with modifier -79 when the same or different 0, 10 or 90 day procedure code has not been billed on the same day for a procedure code with a 0-day post-operative period, on the same day or in the previous 10 days for a procedure code with a 10-day post-operative period, on the same day or in the previous 90 days for a procedure code with a 90-day post-operative period.

Provider Billing Guidelines and Documentation

Consistent with CMS payment rules, Blue Cross VT recognizes claims including modifier -76 for repeated procedures are compensable when medically necessary. For example, if multiple electrocardiograms (ECGs) are performed for the same patient on the same date of service by the same provider and such ECGs are medically necessary, as supported by the patient's medical record, a claim with modifier -76 would be payable if the multiple additional ECGs are

medically necessary. Note that the services must be identical when modifier -76 is used.

Consistent with CMS payment rules, Blue Cross VT recognizes claims using modifiers -76 and -77 are compensable when medically necessary. Documentation shall support the medical necessity for repeating a procedure on the same day or during the surgical global period.

Modifiers -76 or -77 should be appropriately reported with procedure codes accordingly (by the same or a different provider, respectively).

When reporting codes with more than one modifier, it is vital to sequence the modifiers: First, enter the functional modifier (pricing and or payment modifier) next, enter the informational modifier (or statistical modifier), which clarifies aspects of the procedure or service rendered. If multiple informational modifiers are reported those can be reported in any order, after the primary functional modifier has been entered.

Per the provider handbook the modifier sequencing have certain requirements or have specific payment rules:

1. Modifiers that are not listed as informational must be billed in the first position of the modifier field to process correctly.

2. If a modifier has an impact on pricing, the service line it is reported on must be billed at the full charge,* without any reductions. Our claims processing system uses the billed charge as part of the calculation for payment. If a reduction has already been made, it will further reduce the allowance for the service.

*We define “full charge” as the amount that would be billed if you were performing the complete service.

For coding and documentation of procedures reporting modifiers -76, -77, -78 and -79 refer to AMA CPT® guidelines, and CMS guidelines pertaining to Global Surgical Package.

Benefit Determination Guidance

Payment for services is determined by the member’s benefits. It is important to verify the member’s benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member’s benefit.

Eligible services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information, please contact FEP customer service or refer to the FEP Service Benefit

Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (Blue Cross VT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment, it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

N/A

Related Policies

CPP_32 Claims Editing Payment Policy

Process to Submit Questions Related to Coding Denial(s)

Provider Handbook/Modifiers

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
3) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
4) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

References

American Medical Association. (2025). *CPT®: Current Procedural Terminology (Professional*).

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.

CMS.GOV. Retreived from: https://www.cms.gov/files/document/r11287cp.pdf#:~:text=In%20addition%20to%20the%20CPT%20code%2C%20physicians,the%20postoperative%20period%20of%20the%20initial%20procedure.CMS Global Surgery. Retrieved from: https://www.cms.gov/files/document/mln907166-global-surgery-booklet.pdf

Policy Implementation/Update Information

This policy was originally implemented on 10/16/2025

Date of Change	Effective Date	Overview of Change
October 16, 2025	January 01, 2026	New policy.

Approved by **Update Approved: 10/16/2025**

Tom Weigel, MD

Tom Weigel, MD, Chief Medical Officer

Addendum A

Modifier Payment Table

Modifier	
-76 Modifier	▪ **[Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional]**
-77 Modifier	▪ **[Repeat Procedure by Another Physician or Other Qualified Health Care Professional]**
-78 Modifier	▪ **[Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period]**
-79 Modifier	▪ **[Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period]**

Blue Cross VT may pay for reduced services appropriately appended with modifier -78 the allowed amount will be the lesser of (a.) 80% of the fee schedule or contracted amount for the unmodified service (same CPT®/HCPCS code without the modifier) or (b.) the provider's allowed charges.

Blue Cross VT recognizes modifiers -76, -77 &-79 as informational.