Highmark Blue Cross Blue Shield (Highmark BCBS) partners with Wellpoint companies to administer certain services to Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHPlus), and Essential Plan (EP) members. Please note, this information is specific to the MMC, HARP, CHPlus, and EP programs only.

Reimbursement Policy
Modifier 76

Policy Number: **G-06018**
Policy Section: **Coding**
Last Approval Date: **01/26/2026**
Effective Date: **01/26/2026**

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 **https://providerpublic.mybcbswny.com**.

Policy

The health plan allows reimbursement for applicable procedure codes appended with modifier 76 to indicate a procedure or service was repeated by the same physician:

- Subsequent to the original procedure or service for professional provider 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 76:

- 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 only, 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 76 with the claim. If a claim is submitted with modifier 76 without supporting documentation, the claim will not be eligible for reimbursement. Providers will be asked to submit the required documentation for reconsideration of reimbursement. Failure to use modifier 76 when appropriate may result in the procedure or service not being approved.

Wellpoint Partnership Plan, LLC, an independent company, administers management services for Highmark Blue Cross Blue Shield's Medicaid Managed Care (MMC), Health and Recovery Plan (HARP), Child Health Plus (CHPlus), and Essential Plan (EP) products. Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross Blue Shield Association.
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If a repeated surgical procedure is performed with an assistant surgeon or in conjunction with multiple surgeries, assistant surgeon and/or multiple procedure rules and fee reductions apply.

Nonreimbursable
The health plan does not allow reimbursement for the use of modifier 76:

- With an inappropriate procedure code.
- For any procedure repeated more than once.
- For the preoperative or postoperative components of a surgical procedure.

Related Coding

Standard correct coding applies.

Definitions

- **Modifier 76**: Indicates that a procedure or service was repeated by the same physician or other qualified healthcare professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. Note: This modifier should not be appended to an E/M service.
- **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
- Modifier 91

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

Policy History

- **01/26/2026 -** Review approved and effective: updated Definitions section by adding modifier 76
- **08/28/2023 -** Review approved and effective: updated policy template; *removed Repeat Procedure by the Same Physician* from the policy title; removed *subsequent* definition
- **08/07/2020 -** Review approved: updated background and definition sections
- **10/03/2018 –** Review approved and effective: no changes
- **01/01/2017-** Initial approval and effective

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 a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural 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, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive 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.

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