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), and Child Health Plus (CHPlus) members. Please note, this information is specific to the MMC, HARP, and CHPlus programs only.

Reimbursement Policy	
Subject: **Duplicate or Subsequent Services on the Same Date of Service**	
Policy Number: **G-06032**	Policy Section: **Administration**
Last Approval Date: **05/22/2024**	Effective Date: **04/11/2022**

**** 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 **providerpublic.mybcbswny.com**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Highmark BCBS covered the service for the member's 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, Highmark BCBS 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or

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requirements. Highmark BCBS 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

Highmark BCBS allows reimbursement of a duplicate or subsequent service provided on the same date of service if billed with an appropriate modifier, unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement of a Duplicate or Subsequent Service

Reimbursement of duplicate or subsequent services is based on the correct usage of the modifiers located in the *Related Coding* section. These modifiers indicate the service was appropriately repeated or additionally billed for the same member.

Highmark BCBS will review claims billed with suspected duplicate or subsequent services. Claims will be denied for services determined to be duplicate or subsequent without the appropriate modifier(s) when billed on the same or separate claim.

Reimbursement of Bundled Services

When a service is unbundled from a more complex or comprehensive service and billed individually on the same date of service:

- The claim line for the individual service will be denied through code editing if billed on the same claim.
- The claim will be reviewed if billed on separate claims.

The modifiers that indicate an individual service is distinct and separate from the more comprehensive service are identified in the *Related Coding* section below.

Note**:** Refer to specific modifier policies for applicability.

Related Coding		
Modifier	**Description**	**Comment**
25	Significant, separately identifiable Evaluation and Management service by the same physician on the same day of the procedure or other service	See Reimbursement of Bundled Services section
59	Distinct Procedural Service	See Reimbursement of Bundled Services section
62	Co-surgeons	
66	Surgical teams	
76	Repeat procedure by the same physician	
77	Repeat procedure by another physician	
80	Assistant at surgery providing full assistance to the primary surgeon	

81	Assistant at surgery providing minimal assistance to the primary surgeon	
82	Assistant at surgery, when a qualified resident surgeon is not available to assist the primary surgeon	
91	Repeat clinical diagnostic laboratory test	
AS	Assistant at surgery who is a nonphysician (e.g. physician assistant, nurse practitioner)	
GG	Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day	
GH	Diagnostic mammogram converted from screening mammogram on same day	
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter	See Reimbursement of Bundled Services section
XP	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission	See Reimbursement of Bundled Services section
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure	See Reimbursement of Bundled Services section
XU	Unusual nonoverlapping service, the use of a service that is distinct because it does not overlap usual components of the main service	See Reimbursement of Bundled Services section

Policy History	
05/22/2024	Review approved: no changes
04/11/2022	Review approved: updated template; moved modifiers to Related Coding section; minor language changes
04/21/2020	Review approved; Added rendering provider to definition section
04/06/2018	Review approved
07/14/2016	Initial approval 07/14/2016 and effective 01/01/2017

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract
- State Medicaid

Definitions	
Duplicate Services	A service is considered a definite duplicate if some or all of the following elements on the claim match: • Member • Date of service • Charge amount • Provider of service/ Rendering provider. • Type of service, based on procedure or revenue codes used A service is suspected duplicate if the following elements on the claim match: • Member • Procedure code • Date of service
Subsequent service	For purposes of this policy, it is a medically necessary service that is performed or provided for the same member more than once on the same date of service
General Reimbursement Policy Definitions	

Related Policies and Materials
Code and Clinical Editing Guidelines
Modifier Usage
Modifiers 25 and 57: Evaluation and Management with Global Procedures
Modifiers 59, XE, XP, XS, XU: Distinct Procedural Services
Modifier 62
Modifier 66
Modifier 76
Modifier 77
Modifiers 80, 81, 82, and AS: Assistant at Surgery
Modifier 91

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