Repeat Procedures: Modifiers 76 & 77

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plans supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

Modifiers 76 and 77 are used to indicate that a procedure or service was repeated on the same day for the same patient:

- Modifier 76 is used when the same provider (or providers in the same group and specialty) performs the exact same procedure again on the same day - typically due to a clinical need or a change in the patient's condition.

- Modifier 77 is used when the same procedure is repeated by a different provider or specialty, often for a second opinion or due to a revised clinical interpretation.

These modifiers distinguish legitimate repeat services from billing or claim duplicates. Modifiers 76 and 77 should not be appended to Evaluation and Management (E/M) codes.

In both cases, proper documentation must clearly explain the reason for the repeat service, identify the provider(s) involved, and support the medical necessity of performing the procedure again.

Reimbursement Guidelines

Claims with the same CPT code or HCPCS code for the same patient and same date of service will be reviewed to determine whether modifiers 76 or 77 are properly applied.

- Modifier 76 requires that the provider repeating the service is the same individual or part of the same group or specialty.

- Modifier 77 applies when a different provider performs the repeat service.

Physicians in the same group and specialty are considered the same provider for billing purposes under CMS rules.

Billing Instructions

- When it is the same provider, same patient and same procedure code, submit the first instance of the procedure code without any repeat modifier
- Submit the repeat instance of the procedure code with modifier 76 or 77, depending on the provider relationship.

Examples:

Modifier 76: Same Provider

A physician interprets two chest x-rays on the same day, one at 10:00 AM and another at 1:30 PM.

- First claim: 71045, modifier 26
- Second claim: 71045, modifier 26 and modifier 76

Modifier 77: Different Providers

An EKG is interpreted by two providers in different specialties.

- Dr. A (Specialty XX): 93010, modifier 26
- Dr. B (Specialty YY): 93010, modifier 26, and modifier 77

Emergency Room Scenario

An ER physician reviews a chest x-ray and discharges the patient. A radiologist later performs a second interpretation identifying a suspicious finding.

- ER physician: 71045, modifier 26
- Radiologist: 71045, modifier 26, and modifier 77

Additional Guidance

- If it's unclear who ordered the second procedure, determine the appropriate modifier based on who performed the repeat service.
- Use modifiers 76 or 77 only for distinct, medically necessary repeat procedures, not for billing errors or duplicate claims.
- Failure to apply the correct modifier may lead to claim denial or payment delay.

Supplemental Information

Definitions

Term	Definition
CMS	The Centers for Medicare & Medicaid Services. The Centers for Medicare & Medicaid Services (CMS) is a federal entity under the United States Department of Health and Human Services (HHS). It oversees the Medicare program and collaborates with state governments to manage Medicaid, the Children's Health Insurance Program (CHIP), as well as health insurance portability regulations.
CPT Code	Current Procedural Terminology. Used by physician offices and physicians and clinicians in all settings, outpatient hospital facilities, outpatient dialysis centers, and ambulatory surgery centers. CPT codes are utilized to report the majority of procedures on claims that are submitted.
Evaluation and Management Code (E/M code)	CPT codes that are used to bill for medical services in which a healthcare provider evaluates a patient and makes clinical decisions about their care. These codes apply to settings like office visits, hospital care, and emergency services. The level of code selected depends on factors such as the complexity of the case, time spent, and whether the patient is new or established.
HCPCS code	Healthcare Common Procedure Coding System. Used by physician offices, outpatient hospital facilities, inpatient, outpatient dialysis centers, and ambulatory surgery centers. Medicare mandates that providers (regardless of the type of provider) use alphanumeric HCPCS codes to report various biologicals, drugs, devices, supplies, and certain services.
Modifiers	Two-character codes used to provide additional information about a service or procedure. They are added to the CPT or HCPCS codes to indicate specific details about how a procedure was performed, any special circumstances, or any adjustments that might apply to the standard billing.
Modifier 26	Indicates that the provider is billing only for the professional component of a CPT code or HCPCS code - typically the interpretation or supervision, not the technical component (e.g., equipment, technician, facility. Billing for the technical component is indicated by modifier TC.)
Modifier 76	Modifier 76 indicates that the same physician or qualified healthcare professional repeated a procedure or service on the same day; it should not be used with Evaluation and Management (E/M) services.
Modifier 77	Modifier 77 is used when a procedure or service is repeated on the same day by a different physician or qualified healthcare professional; it should not be applied to Evaluation and Management (E/M) services.

State Exceptions

State	Exception

Documentation History

Type	Date	Action
Initial Creation Date	04/04/2016	New Policy
Revised Date	08/17/2016	Updated links
Revised Date	12/12/2024	Verified Linked and updated the templated
Revised Date	08/07/2025	Updated Template; updated links; revised policy; removed duplicate information.
Revised Date	08/19/2025	Updated Initial Creation Date

References

References This policy was developed using:

- CMS
- State Medicaid Regulatory Guidance
- State Contracts

Reference	Link
CMS	Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 30.6, p.36 Medicare Claims Processing Manual, Chapter 13 - Radiology Services and Other Diagnostic Procedures Article - Billing and Coding: Repeat or Duplicate Services on the Same Day (A53482) (CMS.gov) Article - Billing and Coding: Radiology Services: Multiple, Identical Services on Same Day (A53488) (cms.gov) Medicare Claims Processing Manual, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), Sections 20.6.5 and 20.6.6

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.*