Summit COMMUNITY CARE

Arkansas | Medicaid

Reimbursement Policy
Modifier 77

Policy Number: **G-06019**
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://provider.summitcommunitycare.com**.

Policy

The health plan allows reimbursement for applicable procedure codes appended with modifier 77 to indicate a procedure or service was repeated by another physician:

- Subsequent to the original procedure or service for professional 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 77:

- 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 77 with the claim. If a claim is submitted with modifier 77 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 77 when appropriate may result in the procedure or service not being approved.

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

We do not allow reimbursement for the use of modifier 77:

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

- When appended to evaluation and management (E/M) codes.

Related Coding
Standard correct coding applies.

Definitions
- **Modifier 77:** Indicates that a basic procedure or service was repeated by another physician or other qualified healthcare professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 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

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 77
- **08/28/2023 -** Review approved and effective: updated policy template; removed *Repeat Procedure by Another Physician or other Qualified Health Care Professional* from the policy title; removed *subsequent* definition
- **08/07/2020 -** Review approved: updated References and Research Materials and Related Policies and Materials sections
- **03/01/2019 -** 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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