Optometry Coding & Billing Alert

Reader Questions: Modifier 76 Can Help You Avoid Repeat Denials

Question: How should I report a service that the optometrist performs more than once in a day? I-m concerned that the payer will think I-m just making a billing mistake by listing the same code twice on one CMS-1500 form.

Georgia Subscriber

Answer: You-re right to be concerned that payers might consider a repeat code to be a typographical error on your claim. That's why you-ll need to append modifier 76 (Repeat procedure by same physician) to let the payer know that the OD really did perform the service more than once in the same day.

Keep track: CMS says that when repeating a service is medically necessary, you should report the first service as usual and report the repeat service on the next line, appending 76.

For example, Pennsylvania's Medicare carrier says if you repeat a service more than once, you should indicate this by increasing the number of units in the unit field of the repeat service, according to the Medicare Part B Reference Manual, Appendix B -- Modifiers, which you can find online at http://www.highmarkmedicareservices.com/partb/refman/appendix-b.html#3.

Caution: Be sure the medical record shows that the physician had medical necessity for performing the service more than once.

Alternative: If you have a payer that's not paying appropriately with modifier 76, you can use modifier 59 (Distinct procedural service) to show that the service took place during a separate session. However, keep in mind that modifier 59 should be your "modifier of last resort," experts say.

Many private payers and even some Medicare carriers pay on modifier 76 only for radiology repeat procedures.

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