# Part B Insider (Multispecialty) Coding Alert

## How to Use Modifiers 76 and 77 to Your Advantage

If you're one of the practices that the RACs identified as improperly billing duplicate services, the problem could be that you simply don't understand how to use the repeat procedure modifiers to your advantage. And if you haven't been targeted by RACs, the following can help ensure that you don't make this mistake.

**Modifier 77 Applies for Exact Same Procedure:** If two physicians work for the same practice and perform the exact same procedure on the same date, modifier 77 (Repeat procedure or services by another physician or other qualified health care professional) applies to the service.

For instance, suppose your physician treats a patient for a severe nosebleed. Later the same afternoon, that patient returns with another nosebleed, which a different physician treats. In this case, if both physicians perform anterior nasal hemorrhage packing, you'll report 30903 (Control nasal hemorrhage) for the morning physician and 30903-77 for the afternoon physician, provided that the second physician is in the same practice as the physician who controlled the nosebleed initially.

**Keep payer preferences in mind:** Each payer maintains its own policies for the use of modifier 77. For instance, the policy for WPS Medicare states that this modifier is appropriately used "when billing for multiple services on a single day and the service cannot be quantity billed," but should not be used on E/M codes or bundled procedures.

**Look to Modifier 76 When the Same Physician Does Both Procedures:** In our nosebleed example, the patient was treated by two separate physicians on the same date. If, however, the same doctor saw the patient during both encounters, you would instead choose modifier 76 (Repeat procedure or service by same physician or other qualified health care professional).

**Consider Modifier 91 for Repeat Labs.** One major exception to the use of modifiers 76 and 77 is when you perform repeat laboratory tests. In these situations, you should append modifier 91 (Repeat clinical diagnostic laboratory test) instead.

**For example:** A 73 year-old diabetic patient presents to your practice with weakness and tremors. You perform a glucose test, which reveals hypoglycemia with a value of 40. You administer glucose gel to the patient and retest him 15 minutes later, at which point his glucose is normal and he returns home.

In this case, you should report the appropriate lab test code (such as 82947, Glucose; quantitative, blood [except reagent strip]), followed by a second line item of 82947 with modifier 91 appended.

Keep in mind that CPT® does not allow you to report modifier 91 when billing for tests that must be repeated due to testing problems with specimens or equipment. In addition, you cannot use it for codes that by definition require serial measurements, such as those glucose tolerance tests performed over a three-hour period that require multiple tests.