Part B Insider (Multispecialty) Coding Alert

Modifier Quiz: Save Modifier 76 for True Repeat or Risk Overpayment

Modifier 59 might apply even when you use the same code

You could mislabel a modifier 59 procedure as a modifier 76 one and incorrectly get full payment, if you fail to check that the second procedure occurs on the same anatomy as the first.

Modifier 76, per CPT, is a repeat procedure or service by the same physician, says **Therese Burke, BS, CPC,** a coding instructor and consultant with **Medical Office Alternatives** in Chepachet, R.I. You use it to let the payers know that the claim is not a duplicate.

If the physician didn't perform the same procedure twice, you should use modifier 59 (Distinct procedural service) instead of modifier 76 (Repeat procedure by same physician). Modifier 59 identifies "procedures or services that are not normally performed together, but under the circumstances are appropriate." Test yourself with these two scenarios.

1. Is Epistaxis at Same Place?

A physician performs epistaxis twice in the same session. He uses a nitrate stick to cauterize a frontal bleed before taking a film and then post-film cauterizes the same anterior area. Should you use modifier 59 or 76 for the second epistaxis control?

You would use modifier 76 on 30901 (Control nasal hemorrhage, anterior, simple [limited cautery and/or packing] any method), says **Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC,** president of **CRN Healthcare Solutions,** a coding and reimbursement consulting firm in Tinton Falls, N.J. Because the physician did the same procedure twice on the same location, modifier 59 is not appropriate, she says.

"The key word here is SAME," Burke stresses. Modifier 76 is not subject to a payment reduction on your claims.

Tip: Report the epistaxis control on two lines. For instance, if the physician performed and documented a significant, separately identifiable E/M service prior to performing the cauterizations, and reviewing and interpreting the in-office nasal bone x-ray (70160, Radiologic examination, nasal bones, complete, minimum of three views), the claim could contain:

Exception: If the bleed control had occurred at separate sessions, you would then call on modifier 59. For instance, a physician performs simple epistaxis anterior control in the office in the a.m. and then has to cauterize the same site in the emergency room (ER) in the p.m. Because the controls occur at separate sessions, you would use modifier 59 on the second hospital epistaxis control code.

"The key word here is DIFFERENT," Burke points out. Qualifying circumstances include a different session, different procedure, different site, separate incision or lesion.

Reminder: When filing the above encounters, make sure you switch place-of-service (POS) codes and use different forms to accommodate each address. For the initial 30901, you would use POS 11 (Office). Then for the ER 30901-59, use a new claim form with POS 23 (ER -- hospital). Modifier 59 subjects the claim to a payment reduction.

2. Is MD Doing Flap Twice?

On Mohs surgery day 2, a physician makes two pedicle flaps, one on the inside of the nose (mucosa) and one on the outside of a patient's nose to reconstruct the nasal area that was lost during the Mohs surgery. Would you attach modifier 59 or 76 to the second flap code?

Use modifier 59. "The surgeon is doing facial reconstruction on separate sites; he's not doing the same procedure twice," Cobuzzi explains. Therefore, you should append modifier 59 to the second flap creation, 15576 (Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral).

Watch out: You may also need modifier 58 (Staged or related procedure or service by the same physician during the postoperative period) with 15630 (Delay of flap or sectioning of flap [division and inset]; at eyelids, nose, ears or lips) later, if the same physician performs it within 15576's 90-day global period. "Because the sectioning of the pedicle flap falls within the pedicle global period's formation, you need a modifier to tell the insurer that the service is a staged procedure and therefore payable," Cobuzzi explains.

List the payment modifier first, then the unbundling modifier. For the two pedicle flaps, you would enter these items as:

Double Check Insurer's Rules

Although the previous advice follows guidelines from CPT and the AMA's Coding for Modifiers, some carriers create unique rules. "This leaves providers confused as to how to get paid in the situations described above, when they should be rightfully paid for these scenarios," Cobuzzi says.

For example, WPS Health Insurance (Wisconsin's Part B carrier) instructs providers to use modifier 76 only on diagnostic services. The WPS Web site lists one of modifier 76's "inappropriate usages" as "Appending to a surgical procedure code" (http://www.wpsic.com/medicare/part_b/education/modifier_76.pdf). The WPS Web site lists another inappropriate modifier 59 usage as "Exact same procedure code performed twice on the same day." (http://www.wpsic.com/medicare/part_b/education/modifier_59.pdf).