Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 3 Tips To Cleaning Up 76 & 77 Slipups Before They Cost You Big Bucks

Learn CMS' rule for procedures performed 3 times in 1 day.

Payors may think you made a typo if you leave 76 and 77 off claims for repeat services. Show payors you-ve got coding down cold by applying these modifiers correctly every time.

1. Separate Repeats From Copy-Cats

What they-re for: There are many instances in which modifiers 76 (Repeat procedure by same physician) and 77 (Repeat procedure by another physician) will come in handy to help you differentiate among similar procedures--and get paid for every one.

Example: Physicians often take multiple x-rays that reflect different views of the same anatomic area to get a better idea of the patient's condition. If a patient has chest pain or a possible fracture, the doctor may order several views of those sites. In cases like this, forgetting to append modifiers 76 or 77 to the x-ray code can lose you reimbursement.

Key: Modifiers 76 and 77 tell your payor that you know the CPT code is the same as the one above it (or reported earlier), but it is a repeat, not a duplicate, says **Barbara Cobuzzi, MBA, CPC, CPC-H, CHBME**, president of **CRN Healthcare Solutions** in Tinton Falls, N.J.

2. Back Up 76 Use With Medical Necessity

Hint: Make sure you have an explanation of the medical necessity for repeating the procedure, says Cobuzzi, who presented on modifiers at the Fifth Annual Ingenix Essentials Conference.

Example: A physician performs two chest x-rays on a patient who has come to the emergency department with chest pain. The same radiologist interprets both films. In this case, failing to append modifier 76 to 71020 (Radiologic examination, chest, two views, frontal and lateral) could cost you almost $90.

Also: Payors also typically pay for pre- and post-reduction x-rays if you append 76, Cobuzzi says. For instance, when a patient presents with a broken wrist requiring pre-and post-reduction x-rays, you should report 73100 (Radiologic examination, wrist; two views) and 73100-76.

Guideline: 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. If you repeat a service more than twice, you should indicate this by increasing the number of units in the unit field of the repeat service, says **Suzan Hvizdash, BS, CPC, CPC-EMS, CPC-EDS,** physician educator at the University of Pittsburgh Medical Center, citing the Medicare Part B Reference Manual, Appendix B--Modifiers, at www.highmarkmedicareservices.com/partb/refman/appendix-b.html#3.

Example: Based on your documentation, you know the radiologist performed three medically necessary services meriting 73100. You report one unit of 73100 and two units of 73100-76.

For repeat services, provide additional documentation in the narrative field and include documentation of medical necessity for the repeat service in the patient record, Hvizdash says, again citing the manual.

3. Check Local Rules on 77

You-ll typically use modifier 77 when a second physician from the same specialty and same tax ID number performs the same service on the same day.

-However, occasionally you will receive other instructions from an insurer that will want this used across different specialties, especially in large multi-specialty groups,- says **Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P**, charge capture manager for **University of Washington Physicians**.

Multiple interpretations: Sometimes a second physician needs to interpret a set of films, typically because the second physician has additional training or expertise necessary to make a diagnosis. When this occurs, append modifier 77 to the second interpretation.

Caution: The necessity for this second interpretation is rare.

Example: Highmark Medicare-s Local Coverage Determination (www.highmarkmedicareservices.com/policy/partb/g1/g7f.html), based on the national policy for x-ray interpretation, says: "only on interpretation per test will be paid. Consideration for a second interpretation (which may be identified through the use of modifier 77) may be made if unusual circumstances are documented by the provider. For example, a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or a changed diagnosis resulting from a second interpretation of the results of the procedure."