Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: 6 Quick Tips Help You Differentiate Repeat Procedure Modifiers

Use modifiers 59, 76 and 77, and 91 without jeopardizing your pay.

When you consider reporting modifiers 59 (Distinct procedural service), 76 (Repeat procedure by same physician) and 77 (Repeat procedure by another physician), you should know if the physician's procedures were similar to or exactly the same as other services performed on the same patient on the same day.

Case in point: A medical practice submitted the following question to Codify: "Our otolaryngologist treated a patient for a severe nosebleed. Later the same afternoon, that patient came back with another nosebleed, which a different physician treated. Which modifier should we append to show that we did the same procedure twice?"

Solution: Keep your repeat procedure modifiers in check. Here are some tips that will help you append the correct modifiers without sacrificing any payments.

1. Separate Practices Means No Modifier Is Necessary

Using the nosebleed example above, keep in mind that no modifiers will be needed if the two physicians work for different practices and under different tax ID numbers.

For instance, if an urgent care center dealt with the nosebleed in the morning and your physician treated a separate nosebleed in the afternoon, your physician should not append any modifiers to her services.

2. Considering 59? Look for Distinct Procedural Service

Reporting modifier 59 (Distinct procedural service) indicates that the physician completed a distinct procedural service, and may be a good option for coding this service in certain circumstances.

Before you report modifier 59, you should know:

- If the physician performed the procedure on the same day as another service;
- If the two procedures the physician performed on that day are normally reported together (check out http://www.cms.hhs.gov/physicians/cciedits/ for the most recent NCCI restrictions on reporting codes together); and
- If the physician performed the procedure on two distinct locations or two or more different lesions.

In the example of the nosebleed, modifier 59 might be the right modifier depending on the documentation. For instance, if the first physician performs an anterior nasal hemorrhage control, you'll submit 30903 (Control nasal hemorrhage, anterior, complex [extensive cautery and/or packing] any method) for the procedure.

Then if another physician in the same practice performs a posterior nasal hemorrhage control later that day, he will report 30905 (Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial). Because the Correct Coding Initiative (CCI) bundles 30903 and 30905 together, you'll append modifier 59 to 30903 to show the insurer that the nosebleeds were treated during separate sessions, and you'll use 784.7 (Epistaxis) as the diagnosis code for both services.

3. Modifier 77 Applies for Exact Same Procedure

If the morning and afternoon physicians work for the same practice and perform the exact same procedure, modifier 77

(Repeat procedure or services by another physician or other qualified health care professional) applies to the service.

If both physicians in the nosebleed example perform anterior nasal hemorrhage packing, you'll report 30903 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 use of modifier 77. For instance, the policy for Independence Blue Cross/Blue Shield states, "The reason for the repeat of the procedure or service by another physician should be provided in the narrative field of the claim line to support the medical necessity of the repeated services. Medical records, notes, or other supporting documentation should **not** be appended to the claim unless specifically required and/or requested by the Company."

4. 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 the same physician or other qualified health professional).

As with modifier 77, payers maintain specific rules for reporting modifier 76. The policy for insurer AmeriHealth, for example, includes the following requirements:

- The procedure or service that is repeated is performed either on the same date of service or within 24 hours of the initial procedure or service.
- The events precipitating the repeat of the same procedure or service by the same provider are as follows: A change occurs in the physical status or diagnosis of the patient, or subsequent to the initial procedure or service, a different procedure or service is performed that necessitates the repetition of the initial procedure or service for diagnostic or confirmatory purposes.
- Supporting medical necessity documentation is maintained in the medical record describing the circumstances precipitating the repetition of the procedure or service.

5. 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.

6. Avoid 'Repeat' Modifiers When Re-Reading Test Results

One instance where physicians have been found to have misused repeat modifiers is when re-reading test results that another physician already interpreted. For instance, suppose a patient presents to the emergency department (ED) in the morning after falling in a parking lot and the ED performs an x-ray. The patient then presents to your practice later in the day because she is still complaining of pain.

Even if the physician reviews the x-rays that the ED performed, your practice cannot bill an interpretation for those x-rays, since another doctor (at the ED) already interpreted the films and wrote a report.

The physician's additional review of the x-rays should be factored into the E/M work for the day and should not be billed separately

The only exception to this rule is in the rare instances when the physician finds something on the x-ray that the first physician did not include in the report, such as a fracture. In this case, the physician should bill using the applicable x-ray CPT code with modifiers 26 (Professional component) and 77 appended.

Billing this way is supported by Medicare guidelines. For instance, the policy for Medicare carrier TrailBlazer states, "Medicare can be billed separately for an x-ray interpretation when there is a significantly different interpretation than the one that was initially provided."
(www.trailblazerhealth.com/Publications/Training%20Manual/DiagnosticRadiology.pdf)