Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Suffering From Repeated Denials On Your Repeat Procedures Claims? Here's Help

Fine-tune your use of modifier -76 and -77 with these expert tips and examples

Don't be fooled: Repeat procedure modifiers may seem self-explanatory, but you could be overlooking some key requirements for payment.

Physicians choose to repeat procedures on patients for various reasons. When this happens, appending modifier -76 (Repeat procedure by same physician) or modifier -77 (Repeat procedure by another physician) is essential to tell the carrier your "billing is not a duplicate claim of the originally performed service, but rather an additional claim for payment of the repeated procedure," says **Maggie Mac, CMM, CPC, CMSCS**, consulting manager with **Pershing, Yoakley & Associates** in Clearwater, FL.

Difference: Differentiating between the two modifiers is the easy part. You should apply modifier -76 when the same physician repeats a procedure "on the same day or during a post-operative period," Mac says. You should apply modifier -77 when a different physician repeats the procedure, says **Lisa Center, CPC**, quality coordinator with **Freeman Health System** in Joplin, MO.

The hard part is making sure you have the proper documentation, place of service and billing procedures necessary to secure reimbursement. Avoid denials and hang-ups with these three repeat procedure tips from the experts:

1. Check for adequate documentation before coding a repeat procedure. Carriers may require documentation to explain why the physician needed to repeat the procedure, so the physician must document medical necessity, Mac says. "CMS does not require documentation with the original [claim] submission, but may request it prior to payment," she adds.

Even though you don't need the documentation up front, you should never submit a claim unless you have proper documentation to back you up in case the carrier asks.

2. Verify an acceptable place of service before coding a repeat procedure. CMS may stipulate that the physician must perform the repeat procedure in the operating room (OR) or another place "specifically equipped for procedures," Mac says. CMS defines an OR as "the hospital OR, ambulatory surgery center (ASC) OR, cardiac catheterization suite, laser suite or endoscopy suite," she explains.

A minor treatment room cannot constitute an OR. Also, the place of service cannot be the patient's hospital room unless the physician is unable to move the patient for medical reasons, Mac says.

Exception: CMS does allow payment for repeat procedures such as x-rays, EKGs and angiograms that physicians do not perform in an OR setting, Mac says.

3. Use Block 19 of the **CMS-1500 claim** form to tell carriers the whole story. By appending modifier -76 or -77 you've already told the carrier you're not double billing the same claim, but instead reporting a separate and additional service. To help clarify the situation even further, however, you should explain the reason for the repeat procedure (such as comparative purposes, follow-up treatment or intervention, repeat at different intervals, etc...) in Block 19 of the 1500 form, Mac recommends.

3 Examples Show You The Way

Example #1: A patient presents to a pulmonologist suffering from respiratory distress (for instance, 786.09 - Symptoms involving respiratory system and other chest symptoms; dyspnea and respiratory abnormalities; other) and requires two chest x-rays in the office during the course of the same day.

-76: If the same physician reads both x-rays, you would report 71010 (Radiologic examination, chest; single view, frontal) and 71010-76.

-77: However, if two different physicians order and read the two chest x-rays during the same day, you would report 71010 and 71010-77 to indicate that a different physician ordered the second procedure.

Note on reimbursement: Both modifier -76 and -77 have an RVU of "1" - so appending this modifier to a code will not affect your reimbursement. For example, in the scenario above you could expect full payment for each 71010 code you report.

Example #2: A patient presents to a physiatrist's office for a joint aspiration to the elbow in the morning. That afternoon, the patient returns with substantial swelling to the area, so the physician performs another joint aspiration.

-76: Because both services are described by code 20605 (Arthrocentesis, aspiration and/or injection; intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]), you should report 20605 and then append modifier -76 to your second claim for 20605 that day.

Watch out: Don't mistakenly use modifier -76 when you should report modifier -59 (Distinct procedural service). For example, suppose the physiatrist in the scenario above performs joint aspirations on separate sites, such as the elbow and wrist. You shouldn't report this as a repeat procedure, even if the same CPT code describes both services. In this case, you should report 20605 for one aspiration and 20605-59 for the other.

Example #3: A surgeon completes a diagnostic catheterization (e.g., 93510 - Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous) on a patient. Later the same day the patient's condition changes and a different surgeon decides to perform the same diagnostic catheterization again.

-77: You should report 93510 for the first procedure and 93510-77 for the second procedure to indicate another physician completed the repeat procedure.