Codify
BY AAPC

Eli's Rehab Report

3 Tips Help You Choose Among Modifiers -59, -76 and -77

Hint: -76 and -77 signal repeats, while -59 refers to a different procedure

You aspirate a patient's elbow in the morning and again in the afternoon. Your insurer sees two separate claims for 20605 and assumes that you've accidentally submitted a duplicate claim, so you only get paid for one service, right? Not so fast -- if you append modifier -76, you can collect for both procedures.

When your physician wants to describe a medically necessary sequence of events on a claim form, you should know whether the physiatrist's procedures were similar to or exactly the same as other services performed on the same patient on the same day. This way, you can differentiate among modifiers -59 (Distinct procedural service), -76 (Repeat procedure by same physician) and -77 (Repeat procedure by another physician).

Don't Withhold -76 and -77 From Medicare Claims

Although Medicare carriers consider modifiers -76 and -77 "informational only" modifiers, many private payers recognize these modifiers for reimbursement purposes. According to the CMS Web site, Medicare encourages the use of these modifiers "when appropriate." This means that you should still append modifiers -76 and -77 to your Medicare claims to describe procedures that you repeat.

Review local policies: In addition, several Medicare carriers request that practices append modifiers -76 and -77. CIGNA Medicare's policy, for example, states, "When a diagnostic procedure is performed during separate patient encounters (e.g., different times of the day), the second diagnostic procedure should be reported with multiple units on one line item. If the first procedure has already been submitted and paid, the second procedure may be filed with modifier -76 (Repeat procedure by same physician). This modifier requires additional documentation with the claim submission."

The following three tips from coding experts can help you choose the correct modifiers without sacrificing reimbursement.

1. Look for a Distinct Procedural Service

Although modifier -59 describes a distinct procedural service, you should not report it if another modifier describes the service more accurately. Many coding professionals refer to modifier -59 as the "modifier of last resort," so you shouldn't simply append it to every claim that includes more than one code. Look to modifier -59 if your physician's services meet three criteria:

1. The physiatrist performs the procedure on the same day as another service;
2. The two procedures the physiatrist performs are bundled together, according to the **National Correct Coding Initiative** (NCCI) edits (check out http://www.cms.hhs.gov/physicians/cciedits/ for the most recent NCCI restrictions on reporting codes together); and
3. The physiatrist performed the procedures on two distinct locations, during separate sessions or for different diagnoses.

Example: If the physiatrist performs a motor nerve conduction study (NCS) without an F-wave study on the median motor nerve to the abductor pollicis brevis, then performs a motor NCS study with the F-wave on the patient's femoral motor nerve to vastus medialis, report the service with one unit of 95900 (Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study) and one unit of 95903-59 (... motor, with F-wave study).

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2. Watch Out for Repeated Procedures

You should append modifier -76 when the same physiatrist performs a repeated procedure.

Example: A patient presents 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.

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 append modifier -76 to your second claim for 20605 that day.

"I am sure that payers would jump on the opportunity to reduce the second procedure as a multiple procedure, but I would appeal that on the basis that it was a different, medically necessary patient encounter," says **Leslie A. Follebout, CPC**, coding analyst at Peninsula Associates PA in Maryland. "Some individual carriers may request that you append both -76 and -59 to these claims, so check your carrier's guidelines."

Beware: Don't mistakenly use modifier -76 when you should report modifier -59. For instance, if the physiatrist performs joint injections on separate sites, such as the elbow and the knee (even if it is the same CPT code), you shouldn't report it as a repeated procedure, says **Laura Siniscalchi, RHIA, CCS, CCS-P, CPC**, manager of Healthcare & Life Sciences Regulatory Practice at Deloitte & Touche LLP.

Better way: Report a "distinct procedural service," Siniscalchi says, and append modifier -59 to the second listing of 20605.

3. Determine Whether the Physiatrist Repeated a Procedure That Another Physician in the Practice Performed on the Same Day

If one physician in your group performs a procedure in the morning, and another physician in the group performs the exact same procedure later in the day, append modifier -77 to the second line item.

Red flag: Modifiers -76 and -77 are easy to understand and very similar. You should report both for repeat procedures, but assign -76 when the same physiatrist performs the repeat procedure, and assign -77 when another physician completes the repeat procedure.

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