Eli's Rehab Report

Reader Question: Append -59 for Two Fluoros

Question: Our physician performed fluoroscopy for a transforaminal lumbar epidural steroid injection, and later used fluoroscopy again with a sacroiliac (SI) joint injection. Our office manager said that we should append modifier -76 to the second fluoroscopy code. Is this advice accurate?

Florida Subscriber

Answer: Depending on your payer, you may be able to report the second fluoroscopy session, but you should append modifier -59 (Distinct procedural service), not modifier -76 (Repeat procedure by same physician), to the fluoroscopy code.

According to the May 2001 CPT Assistant, Modifier -76 is intended to describe a reoperation, rather than performing the same procedure at multiple sites. Because you administered separate types of injections, carriers would not consider the second procedure a reoperation.

Some insurers will deny a second fluoroscopy session, so you should ask your carrier whether it maintains specific guidelines for this service. If your payer does not maintain a fluoroscopy only once per day rule, your claim should read as follows:

64483 Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level

76005 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction.

Link the above CPT codes to the ICD-9 code that necessitated the epidural injection. Then report the remaining two codes as follows:

27096 Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid

76005-59.

Remember to link these two CPT codes to the diagnosis code that necessitated the SI injection.