Internal Medicine Coding Alert

Correct Coding for FOBTs: CPT Indicates Test and Physical Exam Should be Coded Separately

In a previous issue of Internal Medicine Coding Alert, a reader question covered billing for fecal occult blood tests (FOBT), also known as guaiac tests, performed during an office visit. (See ICA February 1999, page 15.)

In that article, **Garnet Dunston, CPC, MPC,** national secretary of the American Academy of Professional Coders and corporate coding specialist with Managed Care Solutions in Phoenix, AZ, advised that the guaiac test is considered part of the overall E/M service if the test is performed in the office during a physical exam.

Only if the patient is instructed to obtain stool samples at home and return them to the office for testing, can the FOBT be coded as 82270 (blood, occult; feces, 1-3 simultaneous determinations), she indicated.

However, **Glenn D. Littenberg, MD,** a practicing gastroenterologist and member of the American Medical Associations (AMA) CPT editorial panel, disagrees with that assessment.

The FOBT 82270 should never be considered bundled into an E/M service, he states. It is always acceptable to bill the 82270 test separately from the E/M service. This applies when done from a fecal specimen obtained by digital rectal exam (DRE), or when done from the take-home test.

Several third-party payers have been known to bundle 82270 in the E/M service for in-office tests, acknowledges Littenberg, but he feels that this is inappropriate coding. According to CPT, this test should be coded separately from the visit.

Understanding FOBT Reporting

The purpose of FOBTs is to determine whether or not the patient has blood in the stool, says Littenberg. The test is used as a preventive screening for colon cancer and other ailments and when patients have gastrointestinal complaints.

When the FOBT is performed in-office, the physician will perform a DRE to obtain a stool sample. The sample is then treated with a solution and examined under a special light to determine whether blood is present in the sample.

In many cases, the stool sample is not obtained in the office, Littenberg adds. In these situations, the patient is given a set of three cards and instructed to take a small portion of a stool and smear on the card. The patient is also instructed to obtain the samples at separate times, usually on separate days.

When the patient has three samples, he or she returns the cards to the office for determination of the results.

According to Dunston, the CPT language 1-3 simultaneous determinations indicates that this code should be used to report only the take-home sampling method and not the in-office method because of the increased work involved.

There is not as much work involved in performing the DRE and testing that sample, she says. Usually, the doctor is just getting the sample, treating it on the glove, and examining it to see if there is blood present.

However, Littenberg says that the one sample, obtained by DRE and tested that day, counts as one determination and meets the code requirement.

The take-home testing does involve more work and resources for the officemaintaining the cards, instructing the patients in their use, and keeping track of when they are given out and turned back in, he says.

In fact, he relates, the CPT panel has previously considered adding a new code for the take-home testing (one that would take into account the increased resources) and leaving the 82270 code for the in-office version. However, the panels ultimate decision was to include both types of testing in the original code.

If a third-party payer is bundling the FOBT into the
E/M code, that decision should be appealed, he states.

Coding for Multiple Determinations

Not only does a test performed in the office count separately from the E/M code, contends Littenberg, but an in-office test and a take-home set of cards can both be billed separately for the same patient.

When an in-office test is done and, subsequently, a set of three cards is given to the patient, who then returns the set of three cards, we bill both separately, using the date the card tests are determined, he explains.

The payment for both tests is the same, he says, adding that the key to billing for these tests is the act of determining the result.

For example, in most cases, the cards are returned together and the determinations are made at the same time, he explains. However, in some cases a patient may bring the cards back separately, i.e., bring one card sample back the next day, one two days later and one three days after that. Theoretically, these three cards could be coded separately because code 82270 indicates 1-3 simultaneous determinations. Each card is one determination if read on a separate date from the other cards.

But, most payers have time limits within which the determinations are considered part of one test, Littenberg says.

Medicare has rules that will deny payment separately if the dates of service (date the cards are determined) are within two weeks of each other, he explains. By the CPT code, though, neither is bundled into the E/M service; and a test from a DRE is not simultaneous with a set of cards done by the patient at some other point of time.

However, Littenberg clarifies, if the patient presents in the office with a complete set of cards and another DRE and test is performed the same day, it is inappropriate to bill two 82270 codes.

Tip: In most cases, coders would bill for the take-home FOBTs on the date the cards are returned. However, some practices choose to bill the FOBT on the date the cards are given. While this is not technically correctthe code is for determination of the results of the testit may be easier for practices to keep track of the charges this way. I dont think they would run into a problem doing that as long as they didnt also code it on the other end, Littenberg says. This means coders must be sure to bill for the testing only one time, either when the cards are given or when they are received back, not both.

Using 82270 vs. G0107

It is important for internal medicine coders to remember that, for Medicare patients, screening FOBTs should be reported using the HCPCS code G0107 (colorectal cancer screening; fecal occult blood test, 1-3 simultaneous determinations).

This G code should be reported for all Medicare patients who undergo this testing as a screening (preventive) service.

Medicare carriers will only pay for FOBTs billed with 82270 if the code is linked with an ICD-9 code that the carrier considers a justifying reason for ordering the test.

Individual carriers usually maintain lists of the ICD-9 codes which, according to their guidelines, justify the medical

necessity of certain diagnostic tests.

Coders should check their carriers list for occult blood, feces to determine whether a particular ICD-9 code is covered, if the test is not a screening service.

Note: As a security measure, many practices have Medicare patients sign a waiver, known as an advance beneficiary notice (ABN), before any diagnostic tests are performed. This waiver indicates that the service may not be covered by Medicare and the patient is responsible for the cost of the test. If the ICD-9 code is on the carriers list, the test is justified and the carrier will pay. If its not, the patient can be billed as long as the waiver was signed before the test was performed.