Codify
BY AAPC

Internal Medicine Coding Alert

Will NCCI 10.2 Reduce Your G0328 Reimbursement?

Why you should stop reporting screening and diagnostic tests together

You can no longer report screening and diagnostic fecal occult blood codes for the same patient and on the same day, thanks to the National Correct Coding Initiative (NCCI), version 10.2, which took effect July 1. But don't expect this edit to hurt your practice's reimbursement.

Modifier -59 Is Not an Option

NCCI bundles fecal occult blood code 82270 (Blood, occult, by peroxidase activity [e.g., guaiac], qualitative; feces, 1-3 simultaneous determinations) with G0328 (Fecal blood screening immunoassay) because G0328 is the "more extensive procedure," according to the edits.

This means that comprehensive code G0328 represents more physician work than component code 82270, so the physician should only receive payment for G0328. And, the edit carries a "0" modifier, which means you can't unbundle the codes.

You also shouldn't report G0328 with 82274 (Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations). NCCI considers these codes "mutually exclusive," which indicates that Medicare won't pay for both on the same day. Also, you can't use a modifier, such as -59 (Distinct procedural service), to unbundle the services.

What the edit means: Essentially, NCCI is saying you can't bill Medicare for a screening and diagnostic blood occult on the same day, which most internal medicine practices don't do anyway.

You have to report either a screening or diagnostic fecal occult blood procedure, not both, says **Kathy Pride, CPC, CCS-P,** a coding consultant for QuadraMed in Port St. Lucie, Fla.

The physician uses diagnostic tests (82270 or 82274) for patients who show signs or symptoms of a disease, or when a physician has previously diagnosed the patient with a disease such as colorectal cancer (153.x, Malignant neoplasm of colon). But physicians generally use screening tests (G0328) for patients with an absence of signs, symptoms or a disease, Pride adds.

Carriers Include Lidocaine With Surgery Codes

In other news, Medicare now bundles lidocaine code J2001 (Injection, lidocaine HCl for intravenous infusion, 10 mg) with more than 1,000 minor surgical procedures, including 12001 (Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities [including hands and feet]; 2.5 cm or less).

The reality: Rarely would an internist use intravenous infusion for most minor surgical procedures, so you shouldn't sweat this edit. Typically, internists use lidocaine as a local anesthesia during surgical procedures, such as a simple repair (12001).

But Medicare and private carriers don't pay for lidocaine when used as a local anesthesia, because they include the drug's payment in the procedure charge, says **Lisa Barnes,** a coder with Fayetteville Diagnostic Clinic, an Arkansas multi-specialty practice that includes internists. And, you should remember that J2001 represents only the infusion, not the local anesthesia, she says.

Most carriers, such as Cahaba GBM, will pay for lidocaine when the patient has a cardiac arrhythmia (427.9, Cardiac dysrhythmia, unspecified) or medical emergency. On the other hand, Empire Medicare Services of New York covers J2001 for intravenous regional anesthesia (or Bier block) "incident-to" a physician's services.