Eli's Rehab Report

NCCI 10.2 Bundles Lidocaine Into Hundreds of Codes

If you bill J2001 with your injections, the latest edits will get your attention

If your practice reports **J2001** for lidocaine when you perform injections, expect a flood of denials starting July 1. Although most payers already bundled lidocaine payment into your injection fees, a new National Correct Coding Initiative (NCCI) edit confirms that you should never bill J2001 unless you treat a patient for cardiac arrhythmia.

HCPCS deleted J2000 (Injection, lidocaine HCl, 50 cc) this year and introduced J2001 (Injection, lidocaine HCl for intravenous infusion, 10 mg) in its place. Although most coders accurately took this as a sign that Medicare would no longer allow them to report lidocaine for the small amount of anesthetic that they injected for pain management, some coders simply changed their claim forms and started billing J2001 with every lidocaine injection.

New Bundles Confirm Old Guideline

NCCI's version 8.1 bundled J2000 into several injection codes (such as 20526-20610), which seemed to stop many PM&R practices from billing lidocaine with trigger point injections (20552-20553) and joint injections (20600-20610). At the time, Georgia Medicare's lidocaine policy stated, "The dosage indicated by the code description is specific to the treatment of cardiac arrhythmias and emergencies only. The billing of J2000 is not appropriate for the 1-2 cc usually required for a local anesthetic."

But when HCPCS introduced J2001, the new code breathed new life into the lidocaine debate. NCCI 10.2, effective through Sept. 30, shuts the door on any ambiguity, bundling J2001 into hundreds of codes, including trigger point injections, spine injections, bursa injections, and scores of other codes.

"The injection of a 'caine'while doing a joint injection is for pain control and shouldn't be billed separately," says **Denise Paige, CPC,** president of the American Academy of Professional Coders' (AAPC) Long Beach Chapter.

"There are those who think that this never should have been billed separately in the first place," Paige says, "and after J2000 was deleted, I think that further backs up that theory. I now only bill for the joint injection and the cortisone."

New Therapy Bundles May Allow Modifiers

The NCCI will also bundle the physical therapy reevaluation code 97002 into physical therapeutic procedure codes 97532 and 97533. Because the NCCI already bundles 97002 into almost all of the other therapeutic procedure codes, this edit won't come as a shock to most physical therapists, says **Amy Nasser, PT,** a practicing physical therapist in Kansas City, Mo. "Unless you perform the re-evaluation separately from the therapeutic procedure, most insurers won't pay."

Good news: If you do perform the re-evaluation and the procedure separately, you can append a modifier to separate the services, because the new bundles feature a "1" indicator, which demonstrates that a modifier will separate the services.

No Modifiers Separate New Assistive-Tech Bundle

You cannot, however, separate a new edit that bundles 97750 (Physical performance test or measurement [e.g., musculoskeletal, functional capacity], with written report, each 15 minutes) into the new code 97755 (Assistive technology assessment [e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility], direct one-on-one contact by provider, with written report, each 15 minutes). The code for assistive technology assessment includes payment for the physical performance tests that you would perform

with your assessment, so you cannot report these codes on the same date of service.

Pediatric Critical Care Bundled Into PT, OT Evaluations

NCCI 10.2 also bundles the inpatient pediatric critical care codes 99293 and 99294 into the physical and occupational therapy evaluation and re-evaluation codes 97001-97004. But you can override this mutually exclusive bundling edit if your physiatrist deems both services as separate and distinct. If this circumstance, you should append the appropriate modifier (such as modifier -59, Distinct procedural service).

Note: Visit www.cms.hhs.gov/physicians/cciedits/default.asp for links to documents that explain the edits, including the NCCI Policy Manual for Part B Medicare Carriers, the Medicare Carriers Manual, and an NCCI Question-and-Answer page.