

Internal Medicine Coding Alert

Bill Preoperative Exams as Consults to Optimize Reimbursement

Internists seldom act as consulting physicians or bill the CPT consultation codes. Preoperative clearance examinations are the exceptions to that rule, however. Internists should be billing these examinations as consultations and should be reimbursed for the examinations when they can establish the medical necessity for service with the proper diagnosis code.

Many internists don't realize that they can bill for a consultation; they think consultations can only be billed by specialists, says **Cynthia Thompson, CPC**, senior consultant with Gates, Moore & Co., a healthcare consulting firm in Atlanta. As a result, many internists are losing revenue because the consultations are significantly higher-paying codes than the office visit codes that internists are probably billing instead. A level-three consultation (99243), which requires a detailed history, detailed examination and medical decision-making of low complexity, has a 2001 transitioned non-facility relative value unit (RVU) of 3.09. A level-four established patient office visit (99214), on the other hand, requires a detailed history, detailed examination and medical decision-making of moderate complexity but has a comparable RVU of 2.06.

A preoperative examination is a service needed to evaluate an illness or injury or other related condition that may affect the safety or efficacy of a planned surgery and the use of anesthesia during the surgery. The pre-op examination is often a requirement of the hospital where the surgery is to take place, Thompson says. But being a hospital requirement doesn't mean that the internist will be paid; he or she will get reimbursed only when the examination is medically necessary.

Identify Chronic Illness For Medical Necessity

To qualify as a medically necessary preoperative examination, a chronic illness or condition such as diabetes, hypertension or asthma needs to be evaluated. An underlying illness may pose a risk in surgery or with the use of anesthesia, says **Mary Falbo, MBA, CPC**, president of Millennium Healthcare Consulting Inc., a national healthcare consulting firm in Lansdale, Pa. The internists expertise is needed to evaluate the condition, to prepare the patient for surgery or to tell the surgeon that this patient is in stable condition.

Many otherwise healthy patients are often sent for a preoperative examination, but those examinations will probably not be reimbursed. If a healthy Medicare patient who is scheduled for orthopedic surgery is sent to an internist for a preoperative examination, the internist may not be reimbursed for the examination by Medicare because there are no underlying risk factors involved that support the medical necessity of the preoperative consultation examination, Falbo explains.

Preoperative examinations should not be confused with presurgical evaluations, which are considered part of the global surgical package. Presurgical evaluation means the standard presurgical history and physicals (H&Ps) of the patient won't be separately reimbursed because this is included in the global surgical package, Falbo says.

A preoperative consultation examination requires skills above and beyond those of the surgeons, Falbo continues. An orthopedic surgeon, for example, may not feel comfortable evaluating the patient's diabetes or asthma and may request a consultative opinion from the internist who is active in the patient's medical management of these conditions.

Use Consultation Code to Report Exam

When internists perform preoperative examinations, an office consultation for a new or established patient (99241-99245) should be reported when the examination is performed in an office or outpatient setting. If the

examination is performed in a hospital, an initial inpatient consultation for a new or established patient (99251-99255) should be reported. A consultation code can be billed even if the internist is the primary-care physician of the patient, Falbo says.

Medicare also agrees that a consultation code should be used to report these services. Section 15506 (E) of the Medicare Carriers Manual (MCM) instructs local carriers to pay for the appropriate consultation code for a preoperative consultation for a new or established patient performed by any physician at the request of a surgeon, as long as all of the requirements for billing the consultation codes are met.

If the internist who performs a preoperative examination is later asked by the surgeon to assume postoperative care of the patient, then a subsequent care or established patient office visit code should be reported, not the consultation codes. The MCM states, If subsequent to the completion of a preoperative consultation in the office or hospital, the consultant assumes responsibility for the management of a portion or all of the patients condition(s) during the postoperative period, the consultation codes should not be used. In the hospital setting, the physician who has performed a preoperative consultation and assumes responsibility for the management of a portion or all of the patients condition(s) during the post-operative period should use the appropriate subsequent hospital care codes (not follow-up consultation codes) to bill for the concurrent care he or she is providing. In the office setting, the appropriate established patient visit code should be used during the postoperative period.

Document Consult Requirements

The preoperative examination is a consultation if the surgeon or other specialist is asking the opinion of the internist as to whether the patient can withstand surgery. The previously cited section of the MCM states, A consultation is distinguished from a visit because it is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source (unless it is a patient-generated confirmatory consultation).

The traditional requirements of a consultation still have to be met with a preoperative examination, according to the MCM. This means that there must be a request to do the examination, which is usually from the surgeon, documentation that the services were performed, and a written report from the consulting internist back to the surgeon, Thompson says.

An internal medicine practice should create a standardized form with the results of the history, examination and medical decision-making on it. It can be faxed back to the surgeon and may substitute for the written report in this situation, Falbo adds. A copy of this form should be kept in the patients medical record. This form then becomes the progress note for the consultative encounter.

All three of the key components of an evaluation and management (E/M) service the history, examination and medical decision-making must be considered when determining the level of consultation to bill. The history and examination must be related to the patients chronic conditions, which means that the internist will tend to do a focused history and exam instead of a comprehensive one, Falbo says.

Medical decision-making will follow the same guidelines as all E/M services, but it must be relevant to clearing the patient for surgery, Falbo continues. The internist may tell the patient to stop taking his or her medication until after the surgery is over, for example, or may put them on an alternative medication.

Do Not Use V Code as a Primary Diagnosis

Both Falbo and Thompson agree that reporting the correct diagnosis codes with a consultation code is critical to getting reimbursed for a preoperative examination. Many internists make the mistake of reporting one of the following preoperative V codes as the primary diagnosis code for the consultation:

- V72.81 preoperative cardiovascular examination
- V72.82 preoperative respiratory examination
- V72.83 other specified preoperative examination

V72.84 preoperative examination, unspecified

Primary Diagnosis Should be Underlying Condition

Instead of using a V code as the primary diagnosis, internists should use a diagnosis code that reflects the underlying chronic condition of the patient. The key to getting reimbursed for a preoperative examination is establishing the medical necessity of the examination, and that means you need to report the underlying factors first, Falbo says. If a V code such as V72.83 is the primary diagnosis code on a claim, the payer may interpret that to be a screening procedure and deny payment. If the patient has diabetes, for example, the primary diagnosis code should reflect that condition, such as 250.70 (diabetes with peripheral circulatory disorders).

Thompson agrees that the diagnosis codes for any chronic conditions should be reported first. If the patient has a chronic condition, that gets reported first, she says. Only in the absence of a chronic condition should you report a V code.

It is also important to match the diagnosis code to the underlying condition and not the reason for the surgery. As an example, Falbo cites a patient with hypertension who is having cataract surgery. The internist needs to use a hypertension diagnosis code, such as 401.1 (essential hypertension, benign), not a cataract diagnosis code, to report the examination. A payer may question why an internist is reporting a cataract diagnosis code and deny reimbursement, Falbo says.

Use V Codes as Secondary Diagnosis

While the V code should not be reported as the primary diagnosis code on the claim for a preoperative examination, it should be reported as a secondary diagnosis code to explain to the payer why an internist is billing a consultation.

You need the V code to explain to the payer why the consultation is being done because internists don't usually bill consultations, Thompson says. Also, the internist may have seen the same patient previously for the same problem, but that visit falls outside of the timeframe that the hospital requires for a preoperative examination. So the use of the V code as a secondary diagnosis helps the internist avoid accusations of overuse from the payer.

Code V72.81 should be used to report a patient who has a cardiovascular condition that needs to be evaluated prior to surgery, but the cardiovascular condition is not the reason for the surgery, Thompson says. Likewise, V72.82 is used to report a patient who has a respiratory condition that needs to be evaluated prior to surgery, but the respiratory condition is not the reason for the surgery.

Code V72.83 should be used to report all other chronic conditions not covered by V72.81 or V72.82, such as diabetes and hypertension, Thompson says. Again, these chronic conditions should not be the reason for the surgery.

Code V72.84 should be used when the patient does not have any chronic conditions that would put him or her at risk during surgery, and is otherwise healthy, Thompson says. In these situations, the preoperative examination is a requirement of the hospital, but is not medically necessary. Internists should expect that claims with this diagnosis code on them will be denied by Medicare and many other payers.

Note: Internists need to check with their local payers regarding the use of V codes for preoperative examinations because some payers accept those codes as a primary diagnosis for both the consultation and any other services or procedures performed during the visit. Also, some payers, such as First Coast Service Options (the Part B carrier for Florida), list V72.84 as a covered diagnosis code for preoperative services.

Waiver, Modifier -25 May Be Necessary

In situations in which the patient does not have any chronic or underlying conditions to establish the medical necessity of the preoperative examination, the internist may have the patient sign a form that acknowledges his or her financial responsibility to pay for the service if it is denied by the payer. Because there are no chronic conditions to report, Thompson suggests that the appropriate diagnosis code to report would be V72.84 in this situation.

When laboratory tests and other procedures are performed in addition to the preoperative examination, modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) should be attached to the consultation code depending on the type of service that was performed and the payers requirements. Internists may not need to attach modifier -25 to the consultation code, Thompson says. If the service is bundled with the consultation code in the Correct Coding Initiative, the internist should attach the modifier to the E/M code. It is important for the internist to follow the payers policy, and its probably a good idea to check your payers requirements for these examinations, especially if the internist does a large number of them.