

## Internal Medicine Coding Alert

### Get Paid for 'Clearance for Surgery' Exams by Using Consultation Codes

It's a common situation in internal medicine, a specialist, such as a cardiologist, is scheduling a surgery and requests an exam to ensure that the patient is in good enough physical condition to undergo the procedure.

How to code for these examinations, which typically involve a medical history, physical, and screening tests, is a problem for many internists.

How do you code for clearance for surgery when there is no underlying disease [that we are treating], yet the surgeon needs the clearance, writes **Yehuda Handelsman, MD**, a practicing internist in Tarzana, CA. Handelsman's query echoes a number of questions IMCA has received from its readers.

The main answer lies in proper use of the consultation codes 99243-99245, says **James Stephenson, CPC**, reimbursement specialist in internal medicine at the Cleveland Clinic Foundation, in Cleveland, OH.

Stephenson's clinic has an entire department of internists who do nothing but clear patients for surgery, he says. And, they use the consultation codes. It's probably the only situation in internal medicine in which these codes are used.

The physician should choose the consultation code that corresponds to the level of service given, notes Stephenson. The office consultation codes are 99241-99245. But 99243-99245 are the codes that would most likely be used in these situations, he notes.

Then, the physician would need to document the referring specialist's request for clearance, and provide a written report to the specialist detailing his recommendations.

#### Linking Correct Diagnosis Code

The important thing to remember is to link this consultation code with the right diagnosis code.

Even though there may not be a presenting problem for the internist, he or she should not record the diagnosis as a V70.0 (routine general medical examination at a health care facility) or use another of the V70 codes, Stephenson notes.

You should use the diagnosis code for whatever you were asked to evaluate the patient for, he says.

Frequently, internists are asked to clear patients for surgery because they have hypertension or diabetes. You would use the diagnosis code for HBP (401, essential hypertension), or the code for the diabetes (250.0, diabetes type II [non-insulin dependent type] [NIDDM type] [adult-onset type] or unspecified type, not stated as uncontrolled) as the primary diagnosis, he explains.

There are ICD-9 codes for preoperative screening, but they are V codes, Stephenson says. While it is correct to use these codes, many payers automatically reject them.

The solution is to use the problem the internist is asked to evaluate as the primary diagnosis, then list the preoperative screening code for example, V72.81 (preoperative cardiovascular examination).

Actually, this is the most specific way to code the diagnosis and it should get the claim paid, Stephenson says.

The patient is seen for the problem indicated by the primary diagnosis, and the secondary diagnosis indicates the preoperative screening, he continues.

That has sort of stopped all questions [by payers], in our case, Stephenson adds.

### **Accurately Code Screening Procedures**

This linking strategy also holds true for procedures ordered to clear patients for surgery.

For example, in most cases, a patient undergoing general anesthesia would be required to have a screening ECG, says **Priscilla Brown**, coding supervisor for Medical Associates of West Florida.

Brown's practice received a payment denial for a preoperative ECG (93000) for a patient undergoing major surgery, she says.

They used 799.9 (other unknown, unspecified cause) and V72.84 (preoperative examination, unspecified). In addition to using as specific a primary diagnosis as possible, Stephenson says he would generally avoid the V72.84 because it is not specific enough, he says.

If there is nothing else to use, the code is there, but V72.81 is more specific. I would use that, he adds.

### **Part of Global**

Many practices still see denials even though they code correctly, Stephenson notes.

We always get some claims back that say it (the exam) is part of the global (fee for the surgery), he says.

Because his department is part of a large institution, they have gone back to the other specialists and negotiated to get a portion of the global fee for the surgery from them, he says.

Im not sure how well that would work for other practices, but we have been able to do that here, he notes.

Its not particularly fair to the [surgical] specialists because the clearance work is really not supposed to be part of the global service for the surgery and it should be paid separately, Stephenson contends. But, you have to try to get your internists paid in some way.

In addition, some payers are denying consultation codes for internists who clear patients for surgery that they also see as primary care providers. The payers contention: you cant perform a consultation on your own patient.

That rationale is totally incorrect, Stephenson contends, because the specialist is justified in seeking to ensure that his patient is fit to withstand surgery and is asking the internist for his or her expert opinion, a consultation.

In that situation, the diagnosis coding should clear up the problem, or the payer policy should be appealed.

### **Consultation Codes Used for Clearance for Surgery**

**99243** - Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

**99244** - Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

**99245** - Office consultation for a new or established patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patients and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

### Preoperative ICD-9 Codes

**V72.81** Preoperative cardiovascular examination

**V72.82** Preoperative respiratory examination

**V72.83** Other specified preoperative examination

**V72.84** Preoperative examination, unspecified