Internal Medicine Coding Alert

ICD-9 Codes Document Medical Necessity for Pre-op Exams

When a Medicare patient with a chronic disease is referred to the internist for a preoperative clearance exam, many offices are unsure of how to code the visit and how to prove that the exam was medically necessary.

There are three key steps:

1. Code the visit as a consultation, making sure the hree R's"" are met (explained below).

2. Document carefully in the patient's chart and in a written report to the surgeon how the chronic disease may affect the patient before during and after surgery.

3. Show medical necessity by using the proper ICD-9 codes to link the patient's chronic disease to the preoperative evaluation.

Note: If the patient is notbeing followed for a chronic illness (e.g. diabetes asthma hypertension) that may influence the decision to proceed with surgery Medicare likely will not pay for the pre-op exam. The pre-op exam must be documented as ""medically necessary"" to be covered.

Code the Visit As a Consultation

A patient will usually have a chronic disease that has prompted the surgeon to ask for the primary care physician's (PCP's) assessment of the patient's ability to withstand surgery. The surgeon will also seek the PCP's recommendation for any changes in medications during the surgery period.

This visit is coded as a consultation using the appropriate office/outpatient consultation code (99241-99245) or if the patient is in the hospital the appropriate initial inpatient consultation code (99251-99255).

To qualify as a consultation the visit must meet the ""three R's "" notes **Barbara Holley CPC CCS-P** coding supervisor at the Stuart Fla.-based Martin Memorial Medical Group which includes more than 50 physicians. The doctor must receive a Request for an opinion the Reason for the request must be documented and a Report must be generated in response to the request. **Jan Rasmussen CPC** president of the Eau Claire Wis.-based Professional Coding Solutions and a member of the AAPC National Advisory Board says some internists are reluctant to use the consultation codes for pre-op exams if they have seen the patient recently for an office visit because of the higher pay structure for the consultation codes. Code 99243 for example has an RVU of 3.2 for a national (unadjusted for region) payment of $115.83 more than double the $50.31 national unadjusted payment for a 99213 (established patient visit) with 1.39 RVUs. However the consultation codes are proper when the surgeon requests advice or an opinion from the internist.

Note: Offices should be careful to have the patient sign an advance beneficiary notice (ABN) before the pre-op exam in case Medicare denies the claim.

Put the Report in Writing

The request from the surgeon to evaluate the patient does not have to be in writing. However the internist must document the evaluation in the patient's chart and send a written report to the surgeon assessing the patient's fitness for surgery. Holley says many doctors find it easy to dictate the report as part of their office notes after seeing the patient. The physician must be careful to document the request from the surgeon note the reason for the request (the patient's chronic illness) and render advice.

For example the physician might dictate ""I have been asked by general surgeon Dr. Smith to render an opinion about Mr. Jones' stability to undergo surgery because of his chronic hypertension and insulin-dependent diabetes."" The physician then gives an opinion about Mr. Jones' fitness for surgery and includes any advice about medications before during and after surgery. Internists should be careful that the letter offers advice and further assistance if needed but does not suggest the internist is assuming care of the patient.

Bruce Rappoport MD CHCC a board-certified internist who works with physicians on compliance documentation coding and quality issues for RCH Healthcare Advisors LLC in Fort Lauderdale Fla. suggests that the internist provide a copy of the report to the surgeon's office and also send one to the hospital where the surgery will be performed.

Use Proper Diagnosis Codes

The key to receiving payment for the pre-op evaluation is to show medical necessity. To accomplish this the internist's office must document the patient's illnesses and select the proper codes for primary and secondary diagnoses. Many offices use the reason for surgery (e.g. broken hip) as the primary diagnosis Holley notes but Medicare has specifically said that the reason for surgery should not be used as the primary diagnosis.

Medicare addressed this issue in Transmittals 1707 and 1719 in 2001. In these transmittals which amended Section 15047 of the Medicare Carriers Manual Medicare stated doctors should use the V72.81-V72.84 series as the primary diagnosis for all pre-op clearance examinations. V72.81 is used for a preoperative cardiovascular examination while V72.82 is used when a pre-op respiratory exam is performed. V72.83 is for other pre-op exam specified and V72.84 is for an unspecified pre-op exam. Holley says the latter two codes are rarely used. For example Rasmussen says V72.83 is used when the patient has a chronic disease that is not respiratory or cardiac e.g. kidney disease. V72.84 is used for a routine pre-op when the patient has no underlying conditions.

Medicare also maintained in Transmittal 1719 that ""additional appropriate ICD-9 codes for the condition(s) that prompted surgery and for conditions that prompted the preoperative medical evaluation (if any) should also be documented on the claim. Other diagnoses and conditions affecting the patient may also be documented if appropriate.""

For example when a patient with chronic hypertension and diabetes has surgery for a broken hip V72.81 is the primary diagnosis. Next use the codes for the patient's chronic conditions as secondary diagnoses: 250.00 (Diabetes mellitus without mention of complication; type II [non-insulin-dependent type [NIDDM type] [adult-onset type] or unspecified type not stated as uncontrolled) and 401.9 (Essential hypertension; unspecified). The reason for surgery can also be listed but it should appear after the primary and secondary diagnosis codes. If the reason was a broken hip for example 820.03 (Fracture of neck of femur transcervical fracture closed; base of neck)could be included as a fourth diagnosis.

Transmittal 1719 also provides that in the absence of a national policy carriers have the discretion to decide whether preoperative evaluation services are ""reasonable and necessary"" and that such a decision will be ""facilitated"" if the ICD-9 codes denoting the reason for the surgery and the reason for the pre-op are included as diagnoses on the claim.

Rasmussen notes that a national policy has not been set on which diagnosis codes are covered for preoperative exams. Ask your local carrier for specific guidelines.

Scenarios Show Importance of Medical Necessity

Patients with chronic illnesses such as diabetes or heart disease especially those who are on medication that must be adjusted prior to surgery will generally meet the criteria for ""medical necessity"" for a pre-op exam.

Rappoport gives the following example: A patient with chronic atrial fibrillation who is on the anticoagulant drug Coumadin is scheduled for surgery. The surgeon requests a pre-op evaluation from the patient's PCP. In his report the internist assesses the patient's fitness for surgery performs a physical and takes a history. He also makes recommendations concerning administration of the patient's medications before during and after surgery. In this case the internist provides specific instructions concerning the anticoagulant such as recommending that the surgeon stop the patient's Coumadin three days prior to surgery and instructs the surgeon on when to begin intravenous heparin. The visit

is coded using the appropriate consultation level with a primary diagnosis of V72.81. Secondary diagnoses that document the medical necessity of the preoperative exam are 427.31 (Cardiac dysrhythmias; atrial fibrillation) and V58.61 (Long-term [current] use of anticoagulants).

Other patients fall into a grayer area. For example a Medicare patient referred for a preoperative examination has a history of asthma but now has no problems and is not on medication. The visit is coded with the appropriate consultation code (e.g. 99243) with V72.82 as the primary diagnosis and 493.90 (Asthma unspecified without mention of status asthmaticus or acute exacerbation or unspecified) as the secondary diagnosis. Because the asthma is not being actively treated however it's questionable whether carriers would consider the pre-op evaluation medically necessary.

Finally Rappoport says an internist would have difficulty documenting medical necessity for a preoperative exam on a healthy athletic patient having minor surgery. If the patient does not have a chronic disease the preoperative evaluation that most hospitals require before surgery is generally performed by the surgeon and bundled into the global surgical package.

"