Codify
BY AAPC

Internal Medicine Coding Alert

Reader Question: Give V Codes Priority When Coding Pre-Ops

Question: What is the correct sequencing for the diagnoses associated with a preoperative exam?

Montana Subscriber

Answer: When you submit claims for preoperative medical examinations and preoperative diagnostic tests, you should list the appropriate V code (V72.81-V72.84, preoperative examinations), with the reason for the surgery as the secondary code, according to the Medicare Carriers Manual.

Example: An ophthalmologist requests a preoperative clearance from your physician for a hypertensive 70-year-old man who will have cataract surgery. Your physician performs an E/M service and orders an electrocardiogram (ECG) and a blood draw for various lab tests.

You should report V72.83 (Other specified preoperative examination) for the consultation (99241-99245, Office consultation for a new or established patient), V72.81 (Preoperative cardiovascular examination) for the ECG (93000, Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report), and V72.83 for the blood draw (G0001, Routine venipuncture for collection of specimen[s]).

Use the reason for the surgery - the cataract, such as 366.13 (Anterior subcapsular polar senile cataract) - as the secondary diagnosis. You should also assign a diagnosis for the patient's hypertension (for instance, 401.1, Essential hypertension; benign).

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