Internal Medicine Coding Alert

Reader Question: Secondary Diagnosis Code

Question: In reference to the article Understand Coding for Preoperative Clearance Exams on page 13 of the February 2000 Internal Medicine Coding Alert, you recommend that the reason for the surgery can be reported as a secondary diagnosis code after the V72.8x code. The question is, what line does the secondary diagnosis go on? Only one diagnosis can be linked to any given procedure.

Florida Subscriber

Answer: In the February article, we clarified the appropriate coding of preoperative clearance examinations. The first diagnosis code reported should be the chief reason the patient was being seen by that physician (namely, preoperative clearance cardiovascular examination [V72.81], preoperative clearance respiratory examination [V72.82], other specified preoperative examination [V72.83] or unspecified preoperative examination [V72.84]), says **Catherine Brink, CMM, CPC,** president of Healthcare Resource Management Inc., a practice management consulting firm in Spring Lake, N.J.

The second diagnosis code reported should be the chief medical reason the preoperative clearance is being sought (i.e., congestive heart failure, insulin-dependent diabetes mellitus, chronic obstructive pulmonary disease, etc.). If no medical condition is found by the internist performing the examination, then a second diagnosis code can be assigned based on the reason for the surgery (i.e., gallbladder surgery).

Most payers will not recognize V codes as primary diagnoses that substantiate medical necessity. Therefore, the medical condition for which the preoperative consultation is being performed may be listed as the first diagnosis code, with the V72.8x code listed as the secondary diagnosis.

The readers question asked, What line does the secondary diagnosis go on? The question also indicated that, only one diagnosis code can be linked to any given procedure. Actually, the HCFA 1500 form allows for four diagnosis codes to be reported. Any one of those diagnoses, or all four, or two or three of the four, can be linked to any one CPT code reported on the 1500 form.

According to HCFA, in column 24E, titled Diagnosis Code, when multiple services are performed you should enter the primary reference number for each service, either a 1, 2, 3 or 4 (depending on the CPT code that the diagnosis is linked to and whether it is the first, second, third, or fourth code listed). This means that if you performed an E/M service that is coded as 99204, you could enter four diagnoses codes in Box 21, and reference all four codes in Box 24E by writing, A1, 2, 3, 4.