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Internal Medicine Coding Alert

Update on Billing for Preoperative Clearence Exams

In the November 1998 issue of Internal Medicine Coding Alert, we covered using consult codes to bill for preoperative clearance-for-surgery exams (see pages, 28-30).

Commonly, a patient is sent to the internist by the surgeon requesting that the internist perform a physical and diagnostic tests on the patient to ensure the patient is physically able to undergo a required surgery. Usually, this exam and some diagnostic tests (which often include an ECG and chest x-ray) are required by the hospital before they will allow the surgery.

It is correct for the internist to use consult codes (99241-99245) to bill for these services since the exam is performed at the request of another physician and the internist will report his or her findings and medical opinion back to that doctor.

However, because this exam is a screening examination and not related to a specific medical complaint, reimbursement is often a problem.

The problem with pre-op clearances is that Medicare does not pay for screening exams, notes Barbara J. Cobuzzi, MBA, CPC, president of Cash Flow Solutions, Inc., a physician practice billing company in Lakewood, NJ.

Many other private payers do not cover preventive services, or, if they cover annual preventive physicals, often just cover one per year.

One solution can be to use a diagnosis code relating to a possible complication of surgery for the patient in addition to the ICD-9 V code for a preventive service exam. For example, the patient has diabetes and the surgeon requests that the internist examine the patient and evaluate the possibility of that problem complicating surgery. The internist should bill the consult code for the physical exam (99241-99245) and then use the ICD-9 code for diabetes (e.g., 250.0 diabetes type II [non-insulin dependent type] [NIDDM type] [adult onset]) as the primary diagnosis code. As a secondary diagnosis code, listed second on the claim form, the internist would use a V code indicating that the exam was a preoperative screen (V72.8x).

Although it would be proper coding to just link the consult to the V code for preoperative screening, many payers have edits in their claims software that automatically deny V codes. Several practices have reported success with billing another diagnosis first, with the V code supporting that the exam was a screening.

However, such a strategy may not work if you have a healthy patient.

What if you have a relatively healthy person who needs cataract surgery? asks Cobuzzi.

Coders could use a diagnosis code for cataracts (e.g., 366.30, cataract, complicated NEC), with a secondary diagnosis V code for the screening (V72.83, other specified preoperative examination), but many payers will question a cataract diagnosis with a physical exam performed by an internist, she notes.

Note: As stated in the previous article, some payers may claim that this service is included in the global payment for the surgery. In that case, it would be up to the internist to try to get some reimbursement from the surgeon for his services.

Insurance may pay for the physical exam if you use this strategy, but they often wont pay for the chest
x-ray, she adds.

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Medicare, in particular, has a set list of diagnosis codes that are valid justification of the medical necessity of each diagnostic test or procedure. A cataract diagnosis code is almost certainly not going to be on any carriers list for an ECG. In that situation, Cobuzzi advises sending the patient to the hospital for the required diagnostic tests, usually a chest x-ray and ECG.

The hospital is requiring these tests to allow the surgery, so I would send the patient to the hospital and let them eat the cost, she advises. You are not even going to get paid for your x-ray film, let alone your labor costs. Thats my advice to primary care doctors.

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