Internal Medicine Coding Alert

Use CMS Transmittal To Appeal Denials for Preoperative Clearance Exams

Internists may find it difficult to receive proper reimbursement for a preoperative clearance consultation because carriers have different interpretations of how to code for the service. Denials are common even when the appropriate V codes (V72.81, V72.82, V72.83 and V72.84) are used to support medical necessity.

CMS (formerly HCFA) revised section 15047 of the Medicare Carriers Manual (MCM) to ensure against automatic denials of preoperative exams. According to Medicare transmittal R1707-B3, dated May 31, "Carriers should delete any processing edits that deny claims [for] or identify for manual review ICD codes V72.81 through V72.84." This means, for example, that when a surgeon sends a patient to an internist for preoperative clearance, the appropriate V code rather than the condition that prompted the visit or the condition that warrants surgery may be used to justify the examination.

However, according to the transmittal, "Claims containing these codes are subject to medical-necessity determinations as described in [MCM section] 15047." Medical necessity for such preoperative clearance remains at the discretion of the local Medicare carrier.

Use V Codes as Primary Diagnosis

Internists must use one of the four appropriate pre-op examination ICD-9 CM codes when billing a pre-op consult, in addition to the appropriate CPT code for their service:

1. V72.81 -- pre-op cardiovascular exam
2. V72.82 -- pre-op respiratory exam
3. V72.83 -- other specified pre-op exam
4. V72.84 -- pre-op exam, unspecified.

Medicare carriers will pay for or deny a preoperative clearance based on the medical diagnosis and the careful choice of a secondary diagnosis to indicate the reason for surgery, says **Kathy Pride, CPC,** coding supervisor at Martin Memorial Medical Group in Stuart, Fla.

Still, some doctors feel they will not be paid for the V72.8x codes and therefore look for other (chronic condition) diagnoses to list as primary. But, unless the patient is being seen for a specific problem, the first diagnosis code is the V code. The second diagnosis is the reason for the surgery. The third and fourth diagnosis codes document any complications that may be present.

For instance, a surgeon looks to the internist for preoperative clearance to perform a hip replacement (27130, arthroplasty, acetabular and proximal femoral prosthetic replacement [total hip replacement], with or without autograft or allograft). Typically, for a patient with known heart disease and emphysema, the internist would use V72.81 to indicate that the reason for the visit is a pre-operative cardiovascular exam. And, for documentation, the physician would record the secondary diagnosis, or the reason for surgery, as degenerative hip disease (715.2). The third diagnosis would identify the coronary artery disease (414.9), and the fourth diagnosis would identify emphysema (492.8).

Some Medicare carriers have yet to apply the rules emphasized in the HCFA transmittals indicating that the V72.8x must be used as the primary diagnosis, Pride says. These carriers still require using the reason for surgery as the primary diagnosis. The coder is trapped between doing what is necessary to get paid and doing what he or she believes is right to avoid possible fraud. Pride says the answer lies in the documentation: Thorough documentation is the key to demonstrate medical necessity.

Pride says she still requests prepayment reviews (requests for medical records to be reviewed by Medicare and other payers prior to approving payment) for the preoperative consultation claims she submits -- even after CMS released its 15047 transmittal. But by doing this, she has collected the rightful reimburse-ment for the pre-op services.

"I had eight preoperative consultation claims that the carrier downcoded to office visits," Pride says. "But by submitting a copy of the MCM section 15506 rules, along with the proper documentation on appeal, the carrier changed it back to a consult. We received approximately $100 more for each claim."

Use CPT Consultation Codes for Pre-Op Clearance

Office consultations for a new or established patient (99241-99245) should be reported when the examination is performed in an office or outpatient setting. If the examination is performed in a hospital, an initial inpatient consultation for a new or established patient (99251-99255) should be reported.

According to the MCM, section 15506 (E), the criteria for consultation codes (99241-99275) include:

5. A consultation is provided by a physician whose opinion or advice regarding the E/M of a specific problem is requested by another physician or other appropriate source (unless it is a patient-generated confirmatory consultation).

6. A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.

7. After the consultation, the consultant prepares a written report of his or her findings, which is provided to the referring physician.

8. Sometimes internists hesitate to charge a consult, particularly for established patients. Physicians performing pre-op consults often resort to an established office visit code (99211-99215) -- but if the visit meets the above criteria, the consultation codes should be used.

   According to the 2001 Medicare RBRVS Physician Fee Schedule, a level-three consultation (99243), which requires a detailed history, detailed examination and medical decision-making (MDM) of low complexity, has a transitioned nonfacility relative value unit (RVU) of 3.09. A level-four established patient office visit (99214), on the other hand, requires a detailed history, detailed exam-ination and MDM of moderate complexity, but has a lower RVU of 2.06.

Preoperative Clearance Offers Health-Risk Info

Michael Haynes, MD, internist and compliance director for University Medical Associates in Augusta, Ga., says surgeons require preoperative clearance for patients suspected of a major systemic disease. The internist applies his or her expertise to evaluate the patient's condition, prepares the patient for surgery or tells the surgeon that the patient is in stable condition. The internist must document the examination and submit a written report to the surgeon indicating that the preoperative services were performed. The surgery may create serious additional medical problems for the patient if the pre-op clearance examination is neglected.

For example, if a patient's chronic obstructive pulmonary disease goes unrecognized preoperatively, complications from the surgery may mean the patient must undergo another expensive and dangerous procedure to implant a protracted postoperative ventilator support.

Sometimes the preoperative evaluation may make the surgeon and patient rethink the need for surgery, Haynes says.

For example, a surgeon might consider a percutaneous radiologic procedure -- rather than an incisional approach -- to drain an abscess for a patient on a ventilator at high risk for surgery. Or, a patient with a significant coronary artery disease who is not cleared for surgery might be placed at substantial risk for a perioperative myocardial infarction. In this case, a pre-op clearance would inform the surgeon to protect the patient against that risk by performing a coronary artery bypass graft prior to the elective surgery -- or perhaps to forego the surgery and manage the disease with percutaneous angioplasty.

"I had a case where Medicare denied a preoperative consultation for a pulmonary function test in a high-risk heart patient," Haynes says "It is very short-sighted and not cost-effective to disallow preoperative assessment.

"If the surgeon is not aware of the fact the patient is of high risk and the surgery is performed anyway, the possible complications that may arise afterward most likely will require more medical treatment, which means even more medical expense."

Both Internist and Surgeon Receive Payment

If a patient reports to his or her internist at the request of the surgeon for surgical clearance, Medicare will still reimburse the internist's fee for the pre-op clearance. Although the pre-op clearance is part of the surgeon's global package, if an internist performs the pre-op the procedure is outside the global and reflects an independent billing.

The only hard-and-fast rule is that a surgeon does not bill an E/M for preoperative services the day before a major 90-day global surgery unless it is for the decision for surgery. If this is the case, it is appropriate to append modifier -57 (decision for surgery) to the E/M code.