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Part B Insider (Multispecialty) Coding Alert

DIAGNOSIS CODING: When Can V Codes Stand Alone?

How long after you remove a tumor can it serve as the primary diagnosis for follow-up visits? Days or years?

Coders disagree over whether they should code for the original diagnosis that caused the surgery, or just the aftercare codes that represent the follow-up visits. **Jennifer Schmutz** with Salt Lake City-based **Neurosurgical Associates** argues that the aftercare codes alone should be sufficient.

But **Jennifer Darling**, owner of **BBC Medical Management Services** in Frisco, Texas, and lead biller for the Dallas-based **Center for Oncology Research & Treatment**, insists that coders must often include the original diagnosis that caused the surgery as well as the new V codes.

Under Medicare, you can bill some V codes as the primary diagnosis, but you should know Medicare's rules for your specialty, Darling insists. And some drugs may not be covered with some diagnoses, so it's important to consult your carrier's local medical review policies to see how they address V codes. You should also know which procedures have 10-day global periods and which have 90-day periods.

In the case of a patient who had a brain tumor removed, Darling would continue to code for a brain tumor even after the surgery. If the patient's main reason for seeing the doctor concerns the now-absent tumor, it should remain the primary diagnosis for follow-up visits.

Some diagnoses have mandated or suggested time limits for how long you can continue to code them while a patient remains disease-free, Darling says. For example, you can code breast cancer as the primary diagnosis for five years for patients who are in remission and show no signs of cancer. Those patients may be following up with their oncologists because they remain on Tamoxifen.

After five cancer-free years, you could give these patients a "personal history of" code to show the cancer lurking in their past.

There are two other ways to handle the situation, Darling says. One is to send the patient back to his or her primary-care physician for routine follow-up visits and ask the PCP to forward documentation back to the specialist to follow it as well. The specialist can write a discharge note or summary of the patient's care and request that the PCP follow up.

The other alternative is to have the patient sign an advance beneficiary notice agreeing to cover the costs of the follow-up care if Medicare decides to deny the claims.

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