Eli's Rehab Report

Reader Question: Coding for Preoperative Physicals

Question: How do I code a presurgical physical so we can get paid for the office visit as well as the lab tests performed? We are having trouble getting some insurers to pay when we bill with diagnosis code V72.84.

Ohio Subscriber

Answer: This is an ongoing challenge for coders in practices that provide preoperative physicals. If the preoperative service you are providing is clearance for surgery for another physician (for example, performing a physical before a carpal tunnel release that a hand surgeon will be performing), you should list V72.84 (preoperative examination, unspecified) as the first diagnosis. You should also list a second diagnosis, which represents the medical reason requiring the clearance (i.e., carpal tunnel syndrome, 354.0). Nonetheless, the carrier may not pay for all the labs for all patients unless there is an underlying reason for performing the lab tests, not simply that we order these for all patients having surgery.

You should always have patients sign a waiver (even patients who do not rely on Medicare) to inform them that the cost of these services may be their responsibility. Be prepared to receive denials in those cases where the patient does have a specific underlying condition that requires special testing.

CPT states that the actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of evaluation and management services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the E/M code.