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The preoperative consult: A coding quiz

Preop visits present unique coding and documentation challenges. To test your knowledge, take this quiz.

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As family physicians, we're accustomed to seeing patients shortly before they're scheduled for surgery—in the office, the hospital, or other settings. But not all preoperative (preop) visits are created equal in terms of the level of care, the coding, and the documentation required. Test your knowledge:

1 A preop evaluation can be coded as a consultation visit if a request for the evaluation was initiated by:

A. a surgeon.
B. a patient or patient's family member.
C. physician self-referral.
D. all of the above.

2 The best reason to code a preop evaluation as a consultation is:

A. more accurate Current Procedural Terminology Evaluation and Management (CPT E/M) coding.
B. more accurate diagnostic coding per the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) system.
C. reimbursement is (usually) better.
D. all of the above.

3 For outpatient consults for established patients, 2 out of the 3 key components of an encounter must be provided and documented.

A. True. **B.** False.

4 The correct way to report the primary diagnosis for a preop consultation is to use:

A. the ICD-9-CM code for the patient's acute or chronic medical condition that will likely be a concern in the perioperative period (eg, diabetes mellitus, coronary artery disease).
B. the ICD-9-CM code for the acute or chronic condition for which the patient requires surgery (eg, osteoarthritis for an elective joint replacement, or cholelithiasis for a laparoscopic cholecystectomy).
C. V codes V72.81-V72.84 (preop exams).
D. none of the above.

5 A comprehensive level of examination is required for:

A. a level 4 office consultation.
B. a level 3 inpatient consultation.
C. a level 4 established patient office visit.
D. none of the above.

6 Preop consultations conducted in the hospital setting should be coded using inpatient consultation codes.

A. True.
B. False.
C. It depends.

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Author Edward Onusko discusses EHR coding and documentation challenges at www.jfponline.com

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QUESTION 1 When can a preop evaluation be coded as a consultation?

Answer: A When a surgeon requests the consult. Here's why.

A consultation is defined as a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician, or other appropriate source. In order to qualify as a consultation—CPT E/M codes 99241-99245 for outpatients and 99251-99255 for inpatients (**TABLE 1**)—the evaluation must be requested by any of the following:[1]

- a physician
- physician assistant
- nurse practitioner
- chiropractor
- physical therapist
- occupational therapist
- speech-language pathologist
- psychologist
- social worker
- lawyer
- insurance company.

If the consultation is mandated by a third-party payer, use modifier -32 to report it.

If the preop encounter does not meet this requirement, use the customary E/M codes instead.

The physician providing the consult must clearly document the request from the surgeon or other source in the medical record.[1] Our office satisfies this requirement by using a form that is faxed to the surgeon's office at the time the preop visit is scheduled. The surgeon completes and signs the form (sometimes with a little prodding from our office staff) and faxes it back. The signed form is affixed to the patient's chart and available at the time of the consultation visit.

FAST TRACK

If you perform a preop consult at the request of a third-party payer, use modifier –32 to report it.

QUESTION 2 Why should you code a preop evaluation as a consult?

Answer: D There are several reasons to code a preop evaluation performed at the request of a surgeon or other source as a consultation: Doing so offers more accurate E/M coding, more accurate diagnostic coding, and, in most cases, better reimbursement.

The preop evaluation is usually a consultation, sought by a surgeon, regarding the risks to the patient of undergoing the operative procedure and anesthesia, and strategies to provide optimal management of medical problems such as chronic obstructive pulmonary disease (COPD), diabetes mellitus, or asthma in the perioperative period. In general, consultation codes provide significantly better reimbursement than other comparable E/M codes.

For instance, the 2009 Medicare payment for a level 2 outpatient consultation (99242) in the Ohio region is $88.88. In contrast, the fee for a level 2 new patient visit (99202) is $61.71.

Include the 4 Ws: Who, why, what, and where. To bill for a consultation, however, you not only need to provide information about risks and management strategies to the clinician who requests it; you also have to clearly document that you did so. In providing the proper documentation, there are 4 aspects of the consult to consider:

1. Who requested the consult. As noted earlier, our practice requires a signed request from the surgeon for the medical record. (While a note documenting a verbal request would probably sat-

TABLE 1

Consultation codes: The right way to use them

CPT CODE	HISTORY	EXAM	MEDICAL DECISION-MAKING COMPLEXITY	TIME* (MIN)
OUTPATIENT†				
99241	PF	PF	Straightforward	15
99242	EPF	EPF	Straightforward	30
99243	D	D	Low	40
99244	C	C	Moderate	60
99245	C	C	High	80
INPATIENT†				
99251	PF	PF	Straightforward	20
99252	EPF	EPF	Straightforward	40
99253	D	D	Low	55
99254	C	C	Moderate	80
99255	C	C	High	110

CPT, Current Procedural Terminology; C, comprehensive; D, detailed; EPF, expanded problem focused; PF, problem focused.

*When the physician documents total time and that counseling or care coordination accounted for > 50% of the encounter, time may determine the level of service.

†All 3 components of an encounter are required.

Source: American Medical Association; 2008.[1]

isfy this requirement, a written request would provide much stronger evidence if an audit was done.)

2. Why the consult is being performed. Remember that a consult is initiated as a request for opinion or advice. If you are simply asked to manage a patient's medical problems in the postoperative (postop) period, you should charge for concurrent management, not for a consultation.

What's more, during a patient's hospital stay, you can bill only 1 encounter as a consultation. If, after your initial consult, you are asked to manage the patient's medical problems, code and document subsequent encounters as concurrent management. In documenting this initial inpatient encounter, use the word "consultation." Avoid "referral" or "referred by," which gives the false impression that there has been a transfer of care.

3. What services you provided. Basically, this requirement simply calls for documenting your history, exam, assessment (opinion), and plan (advice). If you provide nonpreop care (such as medication refills or addressing unrelated medical issues) during the consult visit, you can bill separately for these services using modifier -25.

You may be asked to perform a "routine" preop electrocardiogram (EKG), based on a surgical facility's preop protocol. If in your clinical judgment an EKG is indicated as part of the patient's preop evaluation, clearly state that in your consultation note—and attach the ICD-9 code for the indication for the EKG (eg, chest pain) to the EKG procedural charge. If you do not think an EKG is clinically indicated, specify in your consultation note that it was done "per the surgical facility's requirement." You may also wish to complete an Advanced Beneficiary Notice form, to document that you informed the patient of his or her responsibility for payment if the insurer refuses to reimburse you for the EKG.

FAST TRACK

In general, consultation codes provide better reimbursement than other comparable E/M codes.

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TABLE 2

The cardiovascular exam: What's included*

SYSTEM/BODY AREA	ELEMENTS
Constitutional	• Measurement of any 3 of the following 7 vital signs: 1) sitting or standing BP 2) supine BP 3) pulse rate and regularity 4) respiration 5) temperature 6) height 7) weight • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and face	
Eyes	• Inspection of conjunctivae and lids
Ears, nose, mouth, and throat	• Inspection of teeth, gums, and palate • Inspection of oral mucosa with notation of presence of pallor or cyanosis
Neck	• Examination of jugular veins • Examination of thyroid
Respiratory	• Assessment of respiratory effort • Auscultation of lungs
Cardiovascular	• Palpation of heart (eg, location, size, and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4) • Auscultation of heart, including sounds, abnormal sounds, and murmurs • Measurement of BP in 2 or more extremities when indicated Examination of: • Carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay) • Abdominal aorta (eg, size, bruits) • Femoral arteries (eg, pulse amplitude, bruits) • Pedal pulses (eg, pulse amplitude) • Extremities for peripheral edema and/or varicosities
Chest (breasts)	
Gastrointestinal (abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Stool sample for occult blood from patients being considered for thrombolytic or anticoagulant therapy
Genitourinary (abdomen)	
Lymphatic	
Musculoskeletal	• Examination of the back with notation of kyphosis or scoliosis • Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs • Assessment of muscle strength and tone, with notation of any atrophy and abnormal movements
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler's nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissues
Neurological/ psychiatric	Brief assessment of mental status, including • Orientation to time, place, and person • Mood and affect

BP, blood pressure.

*** What you are required to do:**

Level of exam	**Perform and document**
Problem focused:	1-5 elements identified by a bullet
Expanded problem focused:	≥6 elements
Detailed:	≥12 elements
Comprehensive:	Perform all elements, document every element in each shaded box and ≥1 element in each unshaded box.

Source: American Medical Association; 2008.[1]

TABLE 3

The respiratory exam: What's included*

SYSTEM/BODY AREA	ELEMENTS
Constitutional	• Measurement of any 3 of the following 7 vital signs: 1) sitting or standing BP 2) supine BP 3) pulse rate and regularity 4) respiration 5) temperature 6) height 7) weight • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and face	
Eyes	
Ears, nose, mouth, and throat	• Inspection of nasal mucosa, septum, and turbinates • Inspection of teeth and gums • Inspection of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils, and posterior pharynx)
Neck	• Examination of neck • Examination of thyroid • Examination of jugular veins
Respiratory	• Inspection of chest with notation of symmetry and expansion • Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (eg, dullness, flatness, hyperresonance) • Palpation of chest (eg, tactile fremitus) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	• Auscultation of heart, including sounds, abnormal sounds, and murmurs • Examination of peripheral vascular system by observation and palpation
Chest (breasts)	
Gastrointestinal (abdomen)	• Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen
Genitourinary (abdomen)	
Lymphatic	• Palpation of lymph nodes in neck, axillae, groin, and/or other location
Musculoskeletal	• Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Extremities	• Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	• Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)
Neurological/ psychiatric	Brief assessment of mental status, including • Orientation to time, place, and person • Mood and affect

BP, blood pressure.

*** What you are required to do:**

Level of exam	Perform and document
Problem focused:	1-5 elements identified by a bullet
Expanded problem focused:	≥6 elements
Detailed:	≥12 elements
Comprehensive:	Perform all elements, document every element in each shaded box and ≥1 element in each unshaded box.

Source: American Medical Association; 2008.[1]

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4. Where you sent the results of your evaluation. It is also necessary to document that you completed the loop by sending your report to the surgeon who requested the consultation. Often, I complete a handwritten consult on a history and physical (H&P) form at the request of the surgeon. I document in my note that a copy of the H&P form was faxed to the surgeon, another copy was put into the patient's medical record in my office, and the original was given to the patient to give to the surgeon on the scheduled day of the procedure. (Electronic health records would accomplish the same thing without paper, of course.)

QUESTION 3 True or false: Outpatient consults for established patients require 2 components of an encounter.

Answer: B False. Unlike other outpatient E/M codes, the consultation codes require that all 3 components of an encounter—history, examination, and medical decision making—be provided and documented for the appropriate level of service for both new and established patients (**TABLE 1**).

All 3 must be included in an inpatient consultation as well.

QUESTION 4 What's the primary diagnosis code for a preop consult?

Answer: C V codes for preop exams (V72.81-V72.84) should be used as the primary diagnosis. In general, V codes are used "on occasions when circumstances other than a disease or an injury justify an encounter with the health care delivery system or influence the patient's current condition."[2] The 4 allowable V codes for preoperative visits are:

- V72.81 (preop cardiovascular exam)
- V72.82 (preop respiratory exam)
- V72.83 (other specified preop exam)
- V72.84 (unspecified preop exam)

The acute or chronic medical condition for which the patient requires surgery should be listed as the secondary ICD-9-CM code.[3] Additional codes may be used for the patient's other acute or chronic medical conditions.

FAST TRACK

If you are simply asked to manage a patient's medical problems in the postop period, charge for concurrent management—not a consultation.

QUESTION 5 When is a comprehensive exam required?

Answer: A A level 4 (99244) office consult requires a comprehensive exam level; a level 3 (99253) inpatient consult does not.

The 1997 E/M guidelines[4] specify that a level 4 office consult in which a general multisystem examination is conducted requires a comprehensive level—with documentation of 2 exam points from each of 9 systems (for a total of 18 points) and performance of all exam points in those 9 systems. The level 3 inpatient consult

and level 4 established patient office visit codes require only a detailed exam, which entails documentation of 12 or more of the allowable exam points. Although the 1995 E/M guidelines can be used as a source to ensure that all the requirements are met, the 1997 guidelines are much more specific about the documentation needed for each exam level.

When to conduct a single-system exam. While family physicians frequently use the requirements of the general multisystem exam to determine their level of coding, the CPT rules allow the option of performing certain single-organ system exams. Because the cardiovascular system is the most common concern with a preop consult, it is often easier, and more appropriate, to document the elements of the cardiovascular system exam (**TABLE 2**) than the general multisystem exam.

In this instance, the V code (V72.81, preop cardiovascular exam) would be used for diagnosis. For patients with COPD or other respiratory problems, it would be appropriate to document the elements of the respiratory system exam (V72.82) instead (**TABLE 3**).

QUESTION 6 Should inpatient codes be used for preop consults in a hospital?

Answer: C It depends. While you'll typically use inpatient codes, there are exceptions. Patients who are in the hospital but assigned to observation status, in the outpatient surgery area, or in the emergency department and not subsequently admitted, are considered outpatients. Thus, encounters with patients under such circumstances should be billed using outpatient codes.

What's your score?

Give yourself 1 point for each question you answered correctly. If you scored 5 or better, you're a coding genius. Please come to my office and help me run my practice!

If you scored 4 or lower, take the opportunity to learn more about coding. Go to http://www.cms.hhs.gov/MLNEdWebGuide, a Centers for Medicare and Medicaid Services site featuring downloadable publications, interactive tutorials, and other coding tools (click on "Documentation Guidelines for E&M Services"). The American Medical Association Web site is also a valuable source of E/M coding. At www.ama-assn.org/ama/pub/category/3113.html, you'll find CPT/RVU Search, a free search engine you can use to learn more about the relative value unit system and review reimbursement rates for your geographic region. ■

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Disclosure

The author reported no potential conflict of interest relevant to this article.

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FAST TRACK

For a preop consultation, use V codes (V72.81-V72.84) for the primary diagnosis.