

# Socioeconomic tips of the month

## Filing Medicare claims

This month's column focuses on several changes surgeons need to be aware of when filing Medicare claims for their patients. First, a few brief announcements:

- In June 2001, the Health Care Financing Administration (HCFA) became the Centers for Medicare & Medicaid Services (CMS). The name change should not affect the way physicians now submit claims for Medicare services.
- To aid Fellows in keeping track of real changes in coding and Medicare, we are introducing "Around the corner," a calendar of upcoming dates when coding and fee schedule updates are scheduled. We will also note the availability of ACS coding workshops. This new addition to "Tips" appears for the first time in the box at right.

### **Requirements for preoperative services**

In an effort to standardize policies that some Part B carriers have instituted, CMS has established a national policy on preoperative services. All claims for preoperative medical examination and preoperative diagnostic tests must be accompanied by the appropriate ICD-9 V code for preoperative examination. The descriptions of the V codes are as follows:

- V72.81 Preoperative cardiovascular examination
- V72.82 Preoperative respiratory examination
- V72.83 Other specified preoperative examination
- V72.84 Preoperative examination, unspecified

The ICD-9 code that appears in the line item of a preoperative examination or diagnostic test must be the V code for the appropriate preoperative examination.

In addition, the appropriate ICD-9 code for the condition(s) that prompted surgery must be documented on the claim. Other diagnoses and conditions affecting the patient should also be documented on the claim, if appropriate. Claims for preoperative services are still subject to carrier

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### **Around the corner**

#### **October**

- 2002 ICD-9-CM code changes effective October 1. The 90-day implementation period during which Medicare will allow claims to be submitted with the 2001 and the 2002 ICD-9-CM code versions begins.
- Quarterly update to 2001 Medicare fee schedule effective October 1.
- Quarterly update to 2001 *Correct Coding Edits* effective October 1.

#### **November**

- 2002 Medicare fee schedule due for release.
- ACS-sponsored advanced coding workshop for surgeons at the Eastern Pennsylvania chapter meeting on November 1, 2001. Contact Irene Dworakowski at 202/672-1507 or e-mail Idworakowski@facs.org to register.

review for medical necessity.

This policy change became effective January 1, and Part B carriers were instructed to change their edits by June 30. If a claim for preoperative examination during the January-June period was rejected, resubmit the claim with the appropriate V code.

### **Revised remittance advice remarks**

Another step has been taken to fulfill some of the requirements of the administrative simplification provisions of the Health Information Portability and Accessibility Act of 1996 (HIPAA).

An update to the American National Standards Institute Insurance (ANSI X12N) remark codes for provider remittance advice (Standard 835) became effective for Medicare on October 1, 2001. Changes include requirements to: (1) electronically void and correct claim history when adjusting a claim, rather than simply posting differences in payment; (2) to identify the primary payor if denying a claim because Medicare is not primary; and (3) to identify any secondary payor with whom benefits are coordinated.

*continued on page 41*

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dence that deterioration has occurred? Of more concern, if we fail to provide assurances to the public, how can we defend against an attempt to legislate a solution? After all, senior drivers must pass examinations to continue to drive; why should surgeons be exempt from any measurement of declining performance? If we fall back on peer review and outcomes assessment, the criticism is that bad outcomes must occur before a change is recommended, and there are many examples of legal tactics that allow surgeons to continue to operate despite evidence that they should stop.

And what about the medicolegal liabilities of such tests if they were available to plaintiff's attorneys? One solution to that problem is to make the results available only to the surgeon's personal physician, which would mean they would be protected.

If we assume that such information would be of value, how can we accumulate sufficient data to provide a reference database for all ages?

The American College of Surgeons has supported the

concept of a pilot project to collect data during this year's Clinical Congress. A new instrument developed for research on cognitive changes with aging will be available for our use. It is the Cambridge Neuropsychological Test Automated Battery (CANTAB), which is computer-administered and has been normed on over 3,000 patients and controls. It has been found to be particularly sensitive to cognitive changes even when more traditional tests failed to detect them. It uses a touch-screen method that is language-free, making it particularly suitable for potentially noisy environments. We plan to use a screened booth in the scientific exhibit area to avoid visual distractions as well as ear protectors to minimize noise.

Having taken both the MicroCog and CANTAB tests (see photo, p. 40), I can attest to the value of the CANTAB, which takes only 20 minutes to complete, as opposed to the 45 minutes required to complete the MicroCog. The CANTAB test also moves easily from very easy items into more complex

ones that are truly challenging but fun.

This year's Congress attendees are encouraged to stop by the booth in the scientific exhibit area of the Ernest N. Morial Convention Center to see the display and talk with the faculty who will be there to administer the test. All data will be recorded by code, and the name of the volunteers, along with their linked code, will be kept secure and separate from the test data, which will have only a numerical code identifier. Test results will be sent to the participant's personal physician if so desired.

In five years, all participants will be recontacted and encouraged to repeat the test at that time. As "cognitive" surgeons, we will be able to state that we are paying as much attention to the determination of our exit from the profession as to the requirements for admission.

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## SOCIOECONOMIC TIPS, from page 36

The remark codes appear on remittance advice received by physicians. The codes are maintained by CMS, but because HIPAA applies to virtually all U.S. health care payors, expect other payors to begin using the codes as well.

Part B carriers are distributing the remittance advice codes via provider bulletins. Most carriers post their bulletins on their Web sites. If you would like to view the codes on the Washington Publishing Company (WPC) Web site, go to [www.wpc-edi.com](http://www.wpc-edi.com), and select "Guides," "Insurance," "Health

Care Code Lists," and "Remittance Advice Remark Codes" on each successive Web page. 

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This column responds to questions from the Fellows and their staffs, and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics that you would like to see addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or e-mail HealthPolicy Advocacy@facs.org.