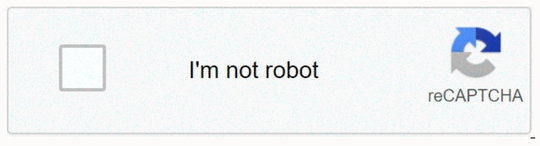

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Pre op medical clearance icd 10

You are using an out of date browser. It may not display this or other websites correctly.You should upgrade or use an alternative browser. Thread starter Collette_J Start date Mar 16, 2018 I work for a Family Practice physician who often does preoperative clearances for local surgeons. I need a little bit of guidance on coding for for a recent visit. What ICD-10 code should I use if the surgeon requested that he do a preprocedural EKG (Z01.810), a preprocedural chest x-ray (Z01.811) and preprocedural labwork (Z01.812)? Can I use all three or should or should I use the "OTHER preprocedural exam" (Z01.818)? Many of his patients have multiple chronic issues. I have not seen this situation discussed previously. Any help is appreciated. You must log in or register to reply here. 2016 2017 2018 2019 2020 2021 Billable/Specific Code POA Exempt Z01.818 is a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes. The 2021 edition of ICD-10-CM Z01.818 became effective on October 1, 2020. This is the American ICD-10-CM version of Z01.818 - other international versions of ICD-10 Z01.818 may differ. Applicable ToEncounter for preprocedural examination NOSEncounter for examinations prior to antineoplastic chemotherapy The following code(s) above Z01.818 contain annotation back-referencesAnnotation Back-ReferencesIn this context, annotation back-references refer to codes that contain:Applicable To annotations, orCode Also annotations, orCode First annotations, orExcludes1 annotations, orExcludes2 annotations, orIncludes annotations, orNote annotations, orUse Additional annotations that may be applicable to Z01.818: Z00-Z99 2021 ICD-10-CM Range Z00-Z99Factors influencing health status and contact with health servicesNoteZ codes represent reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed. Categories Z00-Z99 are provided for occasions when circumstances other than a disease, injury or external cause classifiable to categories A00-Y89 are recorded as 'diagnoses' or 'problems'. This can arise in two main ways:(a) When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem which is in itself not a disease or injury.(b) When some circumstance or problem is present which influences the person's health status but is not in itself a current illness or injury. Factors influencing health status and contact with health servicesZ00-Z13 2021 ICD-10-CM Range Z00-Z13Persons encountering health services for examinationsNoteNonspecific abnormal findings disclosed at the time of these examinations are classified to categories R70-R94.Type 1 Excludesexaminations related to pregnancy and reproduction (Z30-Z36, Z39.-) Persons encountering health services for examinationsZ01 ICD-10-CM Diagnosis Code Z012016 2017 2018 2019 2020 2021 Non-Billable/Non-Specific Code Includesroutine examination of specific systemNoteCodes from category Z01 represent the reason for the encounter. A separate procedure code is required to identify any examinations or procedures performedType 1 Excludesencounter for examination for administrative purposes (Z02.-)encounter for examination for suspected conditions, proven not to exist (Z03.-)encounter for laboratory and radiologic examinations as a component of general medical examinations (Z00.0-)encounter for laboratory, radiologic and imaging examinations for sign(s) and symptom(s) - code to the sign(s) or symptom(s)Type 2 Excludesscreening examinations (Z11-Z13) Encounter for other special examination without complaint, suspected or reported diagnosisZ01.81 ICD-10-CM Diagnosis Code Z01.812016 2017 2018 2019 2020 2021 Non-Billable/Non-Specific Code Applicable ToEncounter for preoperative examinationsEncounter for radiological and imaging examinations as part of preprocedural examination Encounter for preprocedural examinations Approximate Synonyms Central venous access evaluation Central venous access evaluation and exam done Conscious sedation medical clearance exam Conscious sedation medical clearance examination done Preoperative exam Preoperative examination done Present On AdmissionPOA Help"Present On Admission" is defined as present at the time the order for inpatient admission occurs — conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered POA. Z01.818 is considered exempt from POA reporting. ICD-10-CM Z01.818 is grouped within Diagnostic Related Group(s) (MS-DRG v38.0): 951 Other factors influencing health status Convert Z01.818 to ICD-9-CM Code History 2016 (effective 10/1/2015): New code (first year of non-draft ICD-10-CM) 2017 (effective 10/1/2016): No change 2018 (effective 10/1/2017): No change 2019 (effective 10/1/2018): No change 2020 (effective 10/1/2019): No change 2021 (effective 10/1/2020): No change Diagnosis Index entries containing back-references to Z01.818: Examination (for) (following) (general) (of) (routine) Z00.00ICD-10-CM Diagnosis Code Z00.002016 2017 2018 2019 2020 2021 Billable/Specific Code Adult Dx (15-124 years) POA Exempt Applicable ToEncounter for adult health check-up NOS medical (adult) (for) (of) Z00.00ICD-10-CM Diagnosis Code Z00.002016 2017 2018 2019 2020 2021 Billable/Specific Code Adult Dx (15-124 years) POA Exempt Applicable ToEncounter for adult health check-up NOS pre-procedural pre-procedural (pre-operative) pre-chemotherapy Z01.818 (antineoplastic) prior to chemotherapy Z01.818 (antineoplastic) ICD-10-CM Codes Adjacent To Z01.818 Z01.4 Encounter for gynecological examination Z01.41 Encounter for routine gynecological examination Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings Z01.42 Encounter for cervical smear to confirm findings of recent normal smear following initial abnormal smear Z01.8 Encounter for other specified special examinations Z01.81 Encounter for preprocedural examinations Z01.810 Encounter for preprocedural cardiovascular examination Z01.811 Encounter for preprocedural respiratory examination Z01.812 Encounter for preprocedural laboratory examination Z01.818 Encounter for other preprocedural examination Z01.82 Encounter for allergy testing Z01.83 Encounter for blood typing Z01.84 Encounter for antibody response examination Z01.89 Encounter for other specified special examinations Z02 Encounter for administrative examination Z02.0 Encounter for examination for admission to educational institution Z02.1 Encounter for pre-employment examination Z02.2 Encounter for examination for admission to residential institution Z02.3 Encounter for examination for recruitment to armed forces Z02.4 Encounter for examination for driving license Reimbursement claims with a date of service on or after October 1, 2015 require the use of ICD-10-CM codes. July 15, 2016 Steve Adams, MCS, COC, CPC, CPMA, CPC-I, PCS, FCS, COA The Issue This article will outline the three things we need to see in your documentation when billing a preoperative medical evaluation: 1. Reference to the request for a preoperative medical evaluation 2. The specific medical condition you were asked to address during the preoperative evaluation (e.g. from a cardiovascular or respiratory standpoint); and 3. Proof that you have returned your opinion and advice to the requesting provider. The Past Prior to 2001, most Medicare carriers were denying preoperative medical evaluations, both examinations and diagnostic tests, on the grounds that they were “routine physical checkups” and thus excluded from Medicare coverage by law. Even carriers who did not deny payment on this basis had conflicting policies about which ICD-9 codes should be used for these claims. Some required physicians to use one of the V codes for preoperative evaluations, some required the codes for the reason for surgery, and still others accepted only codes for comorbid conditions (e.g., hypertension) that necessitated a physician evaluation. The Present The purpose of this article is to clarify what the central billing office is requesting from our providers. Medical preoperative examinations and diagnostic tests done by, or at the request of, the attending surgeon should be paid, assuming, of course, that the insurance carrier determines the services to be “medically necessary.” All such claims must be accompanied by the appropriate ICD-10 code for preoperative examination (i.e., Z01.810 – Z01.818). Additionally, you must document on the claim the appropriate ICD-10 code for the condition that prompted surgery. If there are other diagnoses and conditions affecting the patient, you should also document those on the claim. Putting It All Together Let’s say an ophthalmologist requests a preoperative clearance from you for a patient who has diabetes and hypertension and is scheduled for cataract surgery, right eye. You document the requesting provider’s name and the reason for the preoperative medical evaluation. Then you perform an evaluation and management service and forward a copy of your findings and recommendations to the ophthalmologist clearing the patient for surgery. When you bill for this service, the primary diagnosis on the claim, and the one attached to the EM code on the line item, will be a Z code (e.g., Z01.818, “Encounter for other preprocedural examination”). The secondary diagnosis will be the reason for the surgery, the cataract in the right eye (e.g., H25.031, “Anterior subcapsular polar age-related cataract, right eye”). Finally, if appropriate, you would also code the patient’s diabetes (e.g., E11.9, controlled, type 2 diabetes) and hypertension (e.g., I10, hypertension, benign).

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