Coumadin Clinic Billing and Reimbursement

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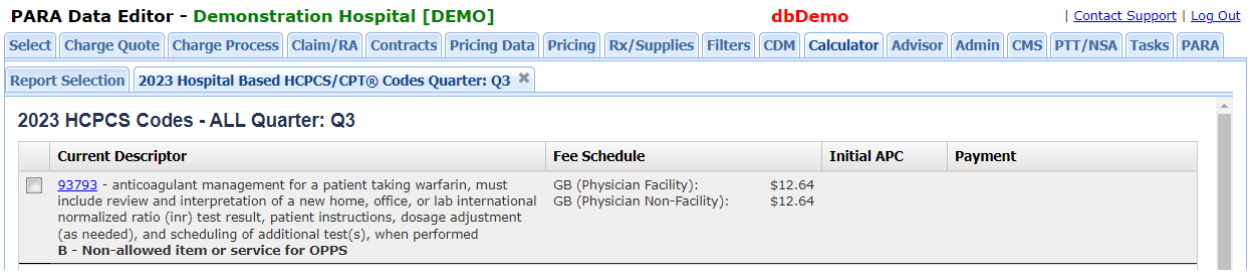
Background

The purpose of an Anticoagulation Management Program, also referred to as a Coumadin Clinic, is to effectively manage a patient's oral anticoagulant therapy to produce positive outcomes and preventing embolic and bleeding events. Some common medical conditions that may require anticoagulation monitoring and management are atrial fibrillation, valve replacements, recent heart attack, cerebrovascular accidents (CVA), deep vein thrombosis (DVT) and pulmonary embolus.

A typical visit will include a PT/INR lab test performed by a nurse (RN, not ARNP) or a pharmacist, by finger stick. The results of the lab test are reviewed, and

- **If the PT/INR values are within therapeutic range**, then no further action is required, and the visit is complete.
- **If the PT/INR results are not within therapeutic range**, the nurse/PharmD will communicate with the patient's physician to indicate an adjustment in medication should be considered.

CPT® 93793 is available to report professional fees for Coumadin Clinic services, but it is not appropriate on an outpatient facility fee claim. Under Medicare's OPPS facility payment system, 93793 is status B – Non-allowed item or service.



The limited scope of service at a typical Coumadin Clinic visit is insufficient to support an outpatient hospital evaluation and management facility fee charge.

This paper explores the compliant options for reimbursement under Medicare rules for both professional and facility fees.

Professional Fee Billing for Coumadin Clinic Services

When performed by a "Qualified Healthcare Practitioners" (QHP) – those providers eligible to bill a professional fee to Medicare, such as an MD, DO, ARNP, or PA – the rendering professional may report CPT® 93793 (*Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed*.) This CPT® code is reimbursed at the same professional fee rate in the facility and non-facility setting.

"Incident To" billing – Coumadin Clinic services performed by qualified auxiliary personnel (i.e. RN, PharmD) *in a freestanding clinic* under the supervision of a QHP may be billed under the supervising practitioner's NPI, even if the practitioner did not personally see the patient, provided that the service follows an established plan of care for the individual patient (not a new diagnosis or a first-time patient) and provided that the supervising practitioner is in the office suite and immediately available at the time the service was rendered. (See also our guidance on "Incident-To" Billing in the Clinic and Hospital Settings.)

However, "incident to" professional fee billing is not permitted in the facility setting, including provider-based clinics which operate as a department of a hospital. In the facility setting, only the services personally performed by the billing provider may be reported to Medicare.

Visit documentation of the face-to-face professional fee should include:

1. A record of the patient's established need for anticoagulant therapy, current dose, Prothrombin Time (PT) and International Normalized Ratio (INR) results and target;
2. Notes regarding the patient assessment, including signs and symptoms of bleeding/adverse effects due to anticoagulant therapy, changes in health status that may impact or account for fluctuations in laboratory results (e.g.; new or changed medications);
3. Notes describing any medically necessary education provided;
4. Identity the referring QHP, the rendering staff/QHP or supervising physician, and/or any QHP with whom test results or progress is reported.

Facility Fee Billing for Coumadin Clinic Services

In the outpatient facility setting, documentation of a Coumadin Clinic service alone will not support a facility fee charge for an outpatient visit (i.e. G0463 or 99202-99215.) However, if the patient has consented to a care management program under a facility-based Qualified Healthcare Practitioner, the time spent by facility staff in reviewing the PT/INR lab result and providing patient education may be counted toward the monthly time requirement for Principal Care Management (PCM) or Chronic Care Management (CCM). (For detailed information on these options, see our paper on Transitional Care Management (TCM), Remote Physiologic Monitoring (RPM), Chronic Care Management (CCM), and Principal Care Management (PCM).)

In the absence of a care management program supervised by a facility-based provider, the facility is limited in claiming reimbursement because the documentation will fall short of a medically necessary outpatient hospital service. Here are the two most common scenarios:

1. **If the PT/INR values are within therapeutic range**, then no further action is required, and the visit is complete. The hospital may bill for the PT/INR test only (usually 85610 – Prothrombin time) – but not an outpatient visit.
2. **If the PT/INR results are not within therapeutic range**, the nurse/PharmD will communicate with the patient's physician to indicate an adjustment in medication should be considered. Again, this does not constitute sufficient documentation to warrant an outpatient visit – we do not recommend reporting a visit fee in the facility setting for reviewing a lab result and relaying that information to the patient's physician/practitioner.

Consequently, unless the medical evaluation is performed by an enrolled Qualified Healthcare Practitioner (MD, DO, ARNP, PA, etc.), visits to review the PT/INR results for a patient on anticoagulant therapy are not billable as an outpatient facility fee – **hospitals should report only the PT/INR lab test.** Documentation of a Coumadin clinic service performed in the outpatient facility setting by non-QHP staff, including nurses and pharmacists, will not support a charge for an outpatient facility visit, and therefore should not be reported with an outpatient facility fee such as *G0463 - Hospital outpatient clinic visit for the assessment and management of a patient,* or the 99202-99215 Evaluation and Management code set used by Critical Access Hospitals.

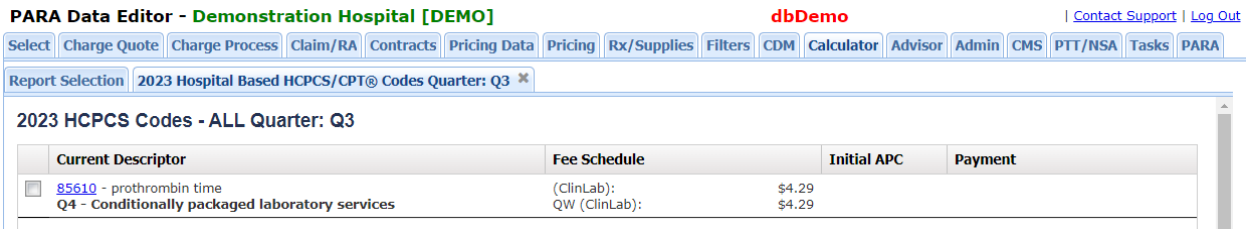
To support billing an outpatient facility charge for an encounter (such as G0463 or 99202-99215), the clinical documentation should include:

- **An order** from the referring physician/non-physician practitioner.
- **Medical Necessity –** if the patient's PT/INR results are therapeutic range, there is little to support the medical necessity of an outpatient visit. Report only the lab test.
- **An evaluation by a qualified healthcare practitioner (QHP),** For professional fees, only "Qualified Healthcare Practitioners" (QHP) are eligible for reimbursement. QHP's include:
    - Physician Assistants (PA)
    - Nurse Practitioners (NP)
    - Clinical Nurse Specialist (CNS)
    - Certified Nurse-Midwife (CNM)

  Note: Although facilities may charge for evaluation and management services performed by auxiliary personnel appropriate to their licensure/certification (e.g. Obstetrics Nurse, Registered Polysomnographic Technologist, Certified Wound and Ostomy Care Nurse), Medicare considers the services of pharmacists as a component of the overall facility fee billed by hospitals for each patient visit. We do not recommend charging a facility fee for a pharmacist's evaluation.

Laboratory Testing – PT/INR

Prothrombin time and International Normalized Ratio (PT/INR) testing must be performed regularly to monitor Coumadin clinic patients. The test is reported using HCPCS 85610; if the test is performed at an independent clinic which operates under a CLIA "certificate of waiver", the QW modifier may be required. Most payors, including Medicare, will not reimburse for capillary specimen collection.



To qualify for reimbursement under Medicare, a PT/INR test must meet certain medical necessity criteria as outlined below:

- The test must be ordered by a licensed medical practitioner (as allowed by the practitioner's specific license)
- The test must be medically necessary
- The test results must be documented within the patient's medical record

Medicare's National Coverage Determination 190.17 outlines the complete requirements to support PT/INR laboratory test billing.

PT/INR testing in Long Term Care Facilities (LTC) may be separately reimbursed if a Medicare beneficiary is not in a covered Medicare Part A stay. When coverage and payment for medically necessary PT/INR testing provided in a LTC facility is not bundled into the comprehensive facility service charge, the facility has the appropriate CLIA certification and the patient is enrolled in Medicare Part B, the test is eligible for coverage and payment under Medicare Part B. The payment amounts will be based on the Medicare Part B Clinical Lab Fee Schedule (CLFS).

PT/INR testing by a Home Health Agency is covered if the patient is under a certified plan of care (POC); the test must be ordered by the physician and performed in the patient's home. The Home Health Agency (HHA) must own the PT/INR testing equipment and supplies and use them in the patient's home to perform the test.

Physician-Directed Home PT/INR Monitoring Supplies

Medicare permits both free-standing clinics and outpatient hospital clinics to provide and be reimbursed for home PT/INR monitoring service equipment and supplies. Reimbursement is limited by the conditions of National Coverage Determination 190.11:

> https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=269&ncdver=2&DocID=190.11&bc=gAAAAAgAAAAA&
>
> **National Coverage Determination (NCD) for Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management (190.11)**

Home PT/INR testing supplies and equipment must be provided under the direction of a physician. Reimbursement is made to the billing entity and differentiates between the technical and professional components of the diagnostic services.

CMS has designated 3 codes to report home PT/INR monitoring: G0248, G0249, and G0250. All three codes are payable under the Medicare physician fee schedule for free-standing clinics, but hospitals may report only G0248 and G0249 as facility fees. G0250 is a professional fee code.

HCPCS/CPT®
G0248 - DEMONSTRATION, PRIOR TO INITIATION OF HOME INR MONITORING, FOR PATIENT WITH EITHER MECHANICAL HEART VALVE(S), CHRONIC ATRIAL FIBRILLATION, OR VENOUS THROMBOEMBOLISM WHO MEETS MEDICARE COVERAGE CRITERIA, UNDER THE DIRECTION OF A PHYSICIAN; INCLUDES: FACE-TO-FACE DEMONSTRATION OF USE AND CARE OF THE INR MONITOR, OBTAINING AT LEAST ONE BLOOD SAMPLE, PROVISION OF INSTRUCTIONS FOR REPORTING HOME INR TEST RESULTS, AND DOCUMENTATION OF PATIENT'S ABILITY TO PERFORM TESTING AND REPORT RESULTS
G0249 - PROVISION OF TEST MATERIALS AND EQUIPMENT FOR HOME INR MONITORING OF PATIENT WITH EITHER MECHANICAL HEART VALVE(S), CHRONIC ATRIAL FIBRILLATION, OR VENOUS THROMBOEMBOLISM WHO MEETS MEDICARE COVERAGE CRITERIA; INCLUDES: PROVISION OF MATERIALS FOR USE IN THE HOME AND REPORTING OF TEST RESULTS TO PHYSICIAN; TESTING NOT OCCURRING MORE FREQUENTLY THAN ONCE A WEEK; TESTING MATERIALS, BILLING UNITS OF SERVICE INCLUDE 4 TESTS
G0250 - PHYSICIAN REVIEW, INTERPRETATION, AND PATIENT MANAGEMENT OF HOME INR TESTING FOR PATIENT WITH EITHER MECHANICAL HEART VALVE(S), CHRONIC ATRIAL FIBRILLATION, OR VENOUS THROMBOEMBOLISM WHO MEETS MEDICARE COVERAGE CRITERIA; TESTING NOT OCCURRING MORE FREQUENTLY THAN ONCE A WEEK; BILLING UNITS OF SERVICE INCLUDE 4 TESTS

- G0248 may only be billed once, as the long descriptor refers to initial training in the use of the home PT/INR testing monitor
- G0249 includes all equipment and supplies necessary to provide home PT/INR monitoring. The equipment and supplies may not be billed separately to Medicare. Covered equipment and supplies may include, but are not limited to, the following:
    - CoaguChek PST System

- CoaguChek PST Strips
- CoaguChek Controls
- Alcohol swabs
- Lancets
- Lancing device
- Software for analysis and reporting of test results

G0249 and G0250 may be billed only once for every four tests. However, CMS has assigned a Medically Unlikely Edit (MUE) or 3 for G0249, therefore hospitals may report up to 3 units of G0249 on one claim, which allows coverage of up to 12 tests. The service is billable on a date when a patient would attend the clinic for a face to face visit.

If a Coumadin Clinic is enrolled with Medicare as an Independent Diagnostic Testing Facility (IDTF), only codes G0248 and G0249 may be billed as technical components. An IDTF cannot provide the professional component (G0250). Most Coumadin Clinics are enrolled as departments of a hospital or under a Medical Group enrollment, however.

When physician-directed, diagnostic services are rendered from an outpatient hospital clinic, the services are reimbursed under the payment guidelines of CMS OPPS. This payment system affects which codes can be billed and how they will be paid.

References

- CorroHealth Document - "Incident-To" Billing in the Clinic and Hospital Settings"
- CorroHealth Document – "Transitional Care Management (TCM), Remote Physiologic Monitoring (RPM), Chronic Care Management (CCM), and Principal Care Management (PCM)"
- 190.17 - National Coverage Determination for Prothrombin Time (PT)
- (NCD) 190.11 - National Coverage Determination for Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management

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