compliance

Anticoagulant Management

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Anticoagulation therapy is widely used to prevent and treat thromboembolic disorders, and is most commonly associated with mechanical valve management, atrial fibrillation, post-cerebrovascular accident, acute myocardial infarction, pulmonary embolism, and other valvular heart diseases. Failure to receive anticoagulant drugs, when indicated, can increase a patient's risk of thrombosis and embolism. Insufficient or excessive levels of a blood thinner can increase a patient's risk of bleeding.

The goal of oral anticoagulation is to maintain levels of anticoagulation capable of preventing thromboembolic events without increasing the risk of hemorrhagic complications. The duration of anticoagulation therapy varies with the underlying indication and with the patient's response to therapy. Some conditions require anticoagulation therapy for only a few months, while other conditions require long-term and possibly life-long anticoagulation treatment.

According to the Centers for Medicare & Medicaid Services (CMS), there are at least three strategies for managing anticoagulation:

1. Physician office-based testing and management (that treat approximately 75 percent of patients)
2. Anticoagulation clinics (that treat approximately 20 percent of patients)
3. Home PT/INR (prothrombin time/international normalized ratio) monitoring with patient reporting or physician-directed self-management (less than 5 percent of patients are anticoagulated this way).

Medicare provides coverage for home PT/INR monitoring for beneficiaries who:[1]

- Require chronic oral anticoagulation with warfarin for a mechanical heart valve, chronic atrial fibrillation, or venous thromboembolism; and
- Have been anticoagulated for at least three months prior to the use of the home INR device; and
- Have undergone a face-to-face educational program on anticoagulation management and demonstrated the correct use of the device prior to its use in the home; and
- Continue to correctly use the device in the context of the management of the anticoagulation therapy following initiation of home monitoring; and
- Home-testing with the device occurs no more frequently than once a week.

Home management is typically focused on patients who require long-term or life-long anticoagulation therapy.

Management Codes

The procedure codes for anticoagulant services are intended to describe the outpatient management of warfarin therapy, including ordering, review and interpretation of INR testing, communication with patient, and dosage adjustments as appropriate.[2] It is important to note that these procedures can only be billed by the treating physician on an office or outpatient basis, including domiciliary, rest homes, or home settings. These codes would not be reported for patient care initiated or continued during patient admission to a hospital or observation unit. When this situation occurs, any anticoagulant management services provided after discharge should be reported with the subsequent outpatient management code (**99364**) and not with the initial therapy code because the initial course of therapy has already been captured as part of the inpatient services.

Last, the procedure codes listed below for anticoagulation management are not reported in connection with home INR testing for a patient with a mechanical heart valve (refer to HCPCS codes **G0248** to **G0250**) or when the services are being managed by another source (e.g., outpatient pharmacist/nurse anticoagulation clinic).

These codes were effective Jan. 1, 2007, and were created to report physician management of patients receiving long-term anticoagulant therapy:

- **99363.** Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of INR testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements).

Management is typically significantly more intensive during the initial 90 days of service. For each prothrombin time test, a physician (and/or his or her staff) must access the patient's medical record, review the results, and determine whether any dosage adjustment and/or change in care plan is necessary. The physician may make dosage adjustments and/or care plan changes to account for acute illness and/or

possible drug interactions; diet changes affecting vitamin K intake; and/or changes to procedures that require withholding or alternative anticoagulation. The physician then must make a notation in the medical record, contact the patient to convey the results/instructions, and arrange repeat testing at the appropriate interval.

- **99364.** Each subsequent 90 days of therapy (must include a minimum of 3 INR measurements).

When the physician reports a charge for anticoagulant management, this same work cannot also be used to support a patient visit code during the same reporting period. In addition, short-term anticoagulant management of less than 60 continuous outpatient days is not reported and the codes cannot be billed if the specified number of services per reporting period is not performed. Physician-patient encounters—both non-face-to-face (e.g., telephone calls and electronic communications) and face-to-face—are captured in these codes. This means that the procedure codes for telephone management and online medical management related to anticoagulant management are not billed in addition to codes **99363** and **99364**.

Typical physician services during the patient's course of therapy include reviewing, interpreting, and ordering initial and repeat prothrombin time tests; making dosage adjustments and/or care plan changes as needed; and communicating to the patient to convey results and provide instructions. The blood draw and the prothrombin time test can be reported separately by the provider that furnishes the respective service.[3]

Medicare does not pay codes **99363** or **99364** to the hospital. The 2015 Outpatient Prospective Payment System (OPPS) payment list indicates that both of these codes are status "B," which means that neither of these codes is recognized under the OPPS for separate reimbursement. In addition, while both codes include relative value units (RVUs) on the Medicare Physician Fee, that payment under the Physician Fee schedule is bundled into the reimbursement for other services provided to the patient.

Hospital Anticoagulation Clinic

Pharmacists perform medication therapy management services (MTMS, procedure codes **99605**, **99606**, and **99607**) for patients that require multiple medications. These MTMS should not be confused with pharmacist-managed anticoagulation clinics. (For a refresher on coding for pharmacy services, see my "Compliance" column in the May-June 2012 *Oncology Issues*. It is available to ACCC members at mynetwork.accc-cancer.org.)

Prior to Jan. 1, 2014, hospitals generally reported anticoagulation clinic services performed by a pharmacist or hospital nurse with procedure code **99211**, the lowest level established patient visit code. However, effective Jan. 1, 2014, Medicare replaced all the patient visit procedure codes with one HCPCS Level II code:

- **G0463.** Hospital outpatient clinic visit for assessment and management of a patient.

In addition, CMS defined an outpatient encounter to include direct personal contact in the hospital between a patient and a physician, or other person who is authorized by state law and, if applicable, by hospital staff bylaws to order or furnish services for diagnosis or treatment of the patient. While CMS previously included Questions & Answers (Q&As) on its website relating to anticoagulation clinics, incident-to and hospital charges, these Q&As have been deleted and were not replaced with updated information at the time this article was published.

Office or Freestanding Anticoagulation Clinic

While the standard E/M codes are no longer available in the hospital outpatient department, these codes continue to be reported for office-based services. WPS Medicare provides specific information on its website regarding billing **99211** for anticoagulation management. (Remember: this guidance may not apply to any other Medicare contractor):[4]

Services billed to Medicare under CPT code **99211** must be reasonable and necessary for the diagnosis and treatment of an illness or injury. This would include appropriately performed and documented anticoagulation management.

99211 for Anticoagulation Management "Do's"

- Document the patient's indication for anticoagulant therapy, current dose, and prothrombin time and INR results

- Assess the patient in person for signs and symptoms of bleeding and/or adverse effects to anticoagulant therapy
- Assess the patient for changes in health status that may impact or account for fluctuations in lab results (for example, new or changed medications that may cause a drug interaction with the anticoagulant therapy)
- Provide medically necessary education as needed based on the patient's individual circumstances
- Document the identity of the ancillary staff performing the service "incident to" the supervising physician
- Document the identity of the billing physician who was notified of the results, gave orders, and provided direct supervision.

99211 for Anticoagulation Management "Don'ts"

Procedure code **99211** should not be billed in these circumstances:

- When the in-person encounter with the patient was only for the diagnostic test
- For telephone care, i.e., instructions on changing doses, assessment, and/or education
- When the only documentation would be vital signs, the patient's current and future dose of anticoagulant, and when the lab work is to be repeated
- When direct physician supervision is not met or is not performed by the physician treating the patient's medical problem requiring anticoagulant therapy (i.e., as seen in some Coumadin® clinics)
- Based on the delivery of repetitive education that does not serve the medical needs of the individual patient.

Additionally (not just limited to anticoagulation management), code **99211** should not be used for:

- Routine, in-person prescription renewals unless the patient's condition requires re-evaluation prior to the renewal determination
- Routine blood pressure checks that have no impact on the patient's care
- Performing diagnostic or therapeutic procedures.

WPS Medicare has also published information regarding Comprehensive Error Rate Testing (CERT) errors related to the reporting of procedure code **99211** (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified healthcare professional. Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.). The following are examples of documentation that did not meet the requirements for payment of procedure code **99211**:[5]

- Provider billed CPT **99211(25)**, established patient office visit which does not require the presence of a physician. The documentation received included the PT/INR result, result of C-Difficile Toxin. No documentation to support the service billed.
- Submitted documentation includes progress note from previous week and lab results. No medical documentation submitted to support the evaluation and management code billed.
- Missing documentation to support any evaluation and management services provided. Only documented service is a PT/INR sheet with typed vital signs, dosage and typed initials, and PT/INR results.

When procedure code **99211** is billed, medical record documentation must support a medically necessary face-to-face patient encounter that includes both evaluation and management. The evaluation portion of the encounter is supported when the individual patient medical record includes documentation of a clinically relevant and necessary exchange of information between the provider and the patient. The management portion of the visit then requires documentation of an influence on patient care.

Last, consider this example from the April 2015 issue of *Healthcare Business Monthly* (a publication of the American Academy of Professional Coders):

"A patient presents for a prothrombin time and international normalized ratio (PT/INR). A nurse performs the test, gives the results to the provider, and relays a medication change to the patient. The visit no longer meets incident-to requirements because there was a change in medication. You may not bill 99211; you may bill only the PT/INR. To bill for evaluation and management (E/M), the provider must have seen the patient."

The term "change in medication" may be interpreted differently by different payers. While some insurers may consider a change in dosage of the same medication to be acceptable for incident-to billing, other payers may consider this to be a reason for the physician to see the patient and explain the dose change. It is certain, however, that if the patient will discontinue one medication and begin a different medication for the same diagnosis, the physician must meet with the patient to explain this change in prescription.

Modifier 25

When a significant, separately identifiable patient visit occurs on the same day as another billable service, **modifier 25** can be appended to the patient visit code. The official definition of this modifier includes:

"It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual pre-operative and post-operative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided."

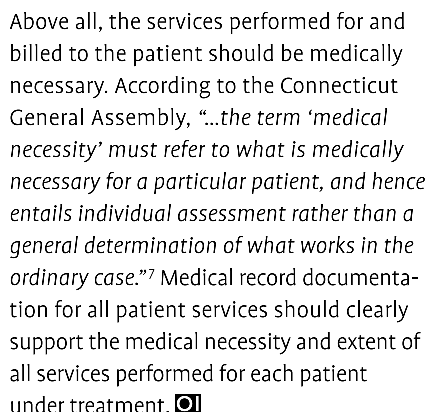
This means that in order to report a patient encounter, even an encounter at the lowest level of service, there must be documentation that supports patient evaluation and management that is separate from the work required to take vital signs, obtain the specimen, process the laboratory test, and communicate the test results to the patient. For example, Cahaba Medicare provides the following scenarios regarding proper use of code **99211** in the office setting:[6]

- A new anticoagulant patient where education is required regarding dietary modifications, medicine restrictions, bleeding/trauma precautions, etc. This type of education would not be medically necessary at every visit, especially if the patient has been on anticoagulant therapy for an extended time. A periodic educational update (i.e., every three to six months) may be medically necessary, for example, when a patient's therapy target has been difficult to optimize.
- A patient who presents with a history of bleeding or adverse effect from anticoagulant therapy.
- A new caregiver presents with the patient to ensure compliance and needed education as noted above.

Billing Summary

All physicians, freestanding cancer centers, and hospital outpatient departments who perform anticoagulant clinic services should verify coverage and correct code assignment with the individual insurance payer. Services considered for billing include:

1. Venipuncture (code **36415**, collection of venous blood by venipuncture) or finger-stick (code **36416**, collection of capillary blood specimen [e.g., finger, heel, ear stick]). Note: procedure code **36416** does not have a separate Medicare reimbursement; this service is considered to be bundled into laboratory tests or any other services performed on the same service date.
2. Prothrombin time (code **85610**), and append **modifier QW** (CLIA waived test) when appropriate.
3. With the creation of the new Medicare HCPCS Level II code for the hospital clinic visit, there may not be an available visit charge for anticoagulation clinic visits that do not have a physician or qualified non-physician healthcare professional component on the same service date.
4. The freestanding center or physician office may be able to report code **99211** with **modifier 25** when medical record documentation supports a medically necessary, significant, separately identifiable evaluation and management service performed under the direct supervision of a physician or qualified non-physician healthcare practitioner. (If the physician reports a charge for anticoagulant management, this same work cannot also be used to support a patient visit during the same reporting period.)
5. And remember, if the reason for the patient encounter is to monitor the effectiveness of anticoagulation medication, the primary diagnosis code for the service should be **V58.83** (Encounter for therapeutic drug monitoring) in conjunction with code **V58.61** (Long-term [current]use of anticoagulants). Then report the underlying reason for the anticoagulant therapy as a secondary diagnosis(es).



Above all, the services performed for and billed to the patient should be medically necessary. According to the Connecticut General Assembly, "*...the term 'medical necessity' must refer to what is medically necessary for a particular patient, and hence entails individual assessment rather than a general determination of what works in the ordinary case.*"[7] Medical record documentation for all patient services should clearly support the medical necessity and extent of all services performed for each patient under treatment. OI

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