

Internal Medicine Coding Alert

Avoid the Top Five Coumadin Coding Errors

Mistakes in coding for Coumadin monitoring can cause denials or, even worse, compliance problems. There are five major areas where practices most often make mistakes, says **Lisa Johnson, CPC, CCS-P**, senior consultant at Gates, Moore & Company in Atlanta.

Using 99211 or 99212 when the patient was managed over the phone.

The nurse, ancillary staff or physician must see the patient face-to-face and sufficiently document the encounter to bill the appropriate E/M code. If the patient comes to the office just for the test, but the results and recommendations are given by phone, the only code that may be reported is 85610-QW.

Coding 85610 for a blood draw sent to an outside laboratory.

"Some offices have heard that Coumadin is now on the CLIA list, and so they are charging 85610 when they are only drawing blood (by venipuncture) and sending it off to the lab to be tested," Johnson says. That's incorrect coding: Use 85610 only for the in-office finger stick tests.

Using a venipuncture code (36415 or G0001) for the finger stick.

Most carriers consider the finger stick incidental to the procedure and will not pay for it separately. Check with carriers for their billing specifications.

Using 99211 for Coumadin management when the medical record contains little or no documentation to support an E/M service

Merely writing "VP for Prottime" or "Pt on Coumadin" in a patient's chart is insufficient documentation to code a nurse visit for Coumadin management, Johnson says.

Incorrect linkage of ICD-9 and CPT coding on the HCFA 1500 claim form, resulting in payment denial.



To find the covered diagnoses for the in-office Prottime test, read your Medicare carriers' local medical review policy (LMRP) for "Prothrombin Time," Johnson says. Link the proper ICD-9 code indicating the reason for the Prottime test with CPT code 85610-QW on the HCFA 1500 form.

The primary diagnosis should be the medical reason the patient is having the test. Often, the primary diagnosis code for Coumadin monitoring is V58.61 (Long-term [current] use of anticoagulants). When you use that code as the primary diagnosis, you may also include a secondary diagnosis code to indicate the reason the patient is on Coumadin, such as 427.31 (Atrial fibrillation). Be sure the diagnoses listed on the claim form reflect what is documented in the medical record regarding the reason for the visit and/or the service billed.