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Internal Medicine Coding Alert

Get a Grip on Coding In-Office Coumadin Monitoring

Do you know the different payer requirements for accurate reporting?

You should understand two crucial aspects of Coumadin monitoring -- in-office finger stick codes (85610 or 36416) and justifying 99211 -- or the denials will start rolling in.

Internists use Coumadin, or warfarin sodium, to thin a patient's blood to prevent heart attacks (410.x), strokes (436), and complications from other disorders, such as deep venous thrombosis (451.1x).

Because too much Coumadin can lead to fatal bleeding, your physician uses a finger stick to monitor the patient's blood clotting speed, which provides your internist with almost instant results.

Also, your physician could adjust the patient's medication on the spot, should heavy bleeding occur, says **Kathy Pride, CPC, CCS-P**, a coding consultant for QuadraMed in Port St. Lucie, Fla.

If you're wondering how to correctly code in-office Coumadin monitoring, review the following four tips.

1. Reserve Finger-Stick Claims for Private Payers

Typically, you should avoid reporting 36416 and G0001 for finger sticks if Medicare insures your internist's patient. CMS will not pay for a heel, ear or finger stick. Medicare carriers, such as Empire Medicare Services in New York, require that you use G0001 (Routine venipuncture for collection of specimen[s]) when your physician performs venipuncture on a patient's neck, thorax or groin.

If a private carrier covers your Coumadin patient, you could report 36416 (Collection of capillary blood specimen [e.g., finger, heel, ear stick]).

2. Modifier -QW Works for Medicare

You should report 85610 (Prothrombin time) when your internist uses the test on a Medicare patient.

Also, most Medicare carriers request that you append modifier -QW (CLIA waived test) to indicate that CMS exempts the test from the Clinical Laboratory Improvement Amendments (CLIA) Congress passed in 1988.

3. Use Reason to Determine Diagnosis

To report Coumadin's primary diagnosis, you should know your physician's medical reason for giving the test, Pride says.

Internists often list V58.61 (Long-term [current] use of anticoagulants). When you use that code as the primary diagnosis, consider including a secondary ICD-9 code to indicate the reason for the test, such as 427.31 (Atrial fibrillation).

Be sure the diagnoses you've listed on the claim form match those your internist documented in the medical record regarding the visit's purpose and the service billed, she adds.

4. Understand Complex Coumadin Visits

If your internist performed the finger-stick test, that doesn't justify your reporting 99211 (Office or other outpatient visit). But you may report 99211 along with 85610-QW when the internist or nurse clearly documents medical necessity for an E/M visit.

For example, if the nurse takes the patient's vital signs, checks for bruising, discusses medication compliance, gives dietary instructions, and documents each service, you should report 99211, says **Bruce Rappoport MD, CPC**, a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for RCH Healthcare Advisors LLC, a Fort Lauderdale, Fla.-based healthcare consulting company.

In most cases, however, internal medicine practices use 99211 in addition to 85610 when the patient encounter requires a certain level of complexity.

For instance, a patient with atrial fibrillation (427.31) reports for his Coumadin monitoring. During questioning, the nurse discovers that he's taken a 5-mg Coumadin tablet daily, although his prescription calls for a 5-mg tablet three days a week, followed by a 7.5-mg tablet the other days. The nurse monitors the patient's Coumadin levels to determine any side effects and counsels that patient on proper Coumadin usage after confirming dosage levels with the internist. In this case, documentation should support medical necessity for 99211, as well as 85610-QW, Rappoport says.