Internal Medicine Coding Alert

Keep Reimbursement Flowing: Give Your Coumadin Coding a Checkup

If you're not up to speed on two crucial aspects of Coumadin monitoring - in-office finger stick codes (85610 or 36416) and justifying 99211 - you could be costing your internal medicine practice deserved dollars.

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 questions and answers.

1. Can I report either G0001 or 36416 for finger stick?

You cannot 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 Crompond, N.Y., requires 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. How should I code the in-office finger-stick protime lab test for a Medicare patient?

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. Which diagnosis codes should I use?

To report Coumadin's primary diagnosis, you should know your physician's medical reason for giving the test, Pride says. Often, internists 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. Can I report both a low-level E/M established patient code (99211-9) and a Coumadin test code?

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.