# Part B Insider (Multispecialty) Coding Alert

## PART B CODING COACH: Use 99211 Requirements for Prothrombin Time Payment

E/M specifics give hints on what's needed for this low-level test.

You'll need a blend of upcoming revised codes and old-school E/M knowledge to get your full prothrombin time (PT) test pay.

Take a closer look at the sometimes grey area of PT tests to see if your practice is missing reimbursement opportunities.

Choose 99211 With 85610

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 ...) is your best bet when your physician performs a PT test (85610, Prothrombin time). Report this as "incident to" your physician's initial service (non-hospital place of service) when a nurse meets with a patient in the office to evaluate the status of the patient and discuss prothrombin time test results subsequent to the testing. "Your physician does not have to be present at the visit," says **Marianne Wink, RHIT, CPC, ACS-EM,** with the University of Rochester Medical Center in N.Y.

"Documentation should link to the physician order for the follow-up visit. All other rules of incident-to should be followed." Note Medicare Versus Cigna Differences Under Medicare rules, you may report 99211 with 85610 if you meet the following requirements, says **Quinten A. Buechner, MS, M.Div, CPC, ACSFP/ GI/PEDS, PCS, CCP, CMSCS,** president of ProActive Consultants in Cumberland, Wis.:

• Your practitioner provides face-to-face medication management

• Your documentation establishes a need for clinical evaluation and management of significant new symptoms or clearly demonstrating how the relevant lab information was used to modify therapy

• Current medications are listed with notation of compliance, an indication is documented showing the physician/practitioner's evaluation of the labs and recommendation, and the clear identity and credentials of the staff and practitioner are clearly noted.

Cigna Government Services, however, clarifies in an FAQ that 99211 requires a documented faceto- face E/M service that has an impact on the patient's care. "Merely assessing the patient's vital signs in addition to the lab work would not substantiate separately billing 99211," the policy states.

There should be documentation in the medical record, such as the patient and clinician exchanging medically significant and necessary information, and management of patient's care via medical decision making (such as a change in a medicine regimen).

Although 99211 doesn't require the presence of your physician in the patient's room, the service must be done face-to-face with your physician's appropriate staff, and incident-to your physician's service. In other words, your physician must be in the office suite and immediately available, according to Cigna's policy.

Scenario: A patient on chronic wafarin anticoagulation therapy comes in for a PT evaluation.

Documentation: To report 99211 for this encounter, you must be able to show the following:

• The reason for the patient's visit. Since a physician visit is not usually needed to draw blood for PT tests, the

documentation for code 99211 in this case must demonstrate a need for clinical E/M. Services that would demonstrate that an appropriate E/M was performed include an evaluation of significant new symptoms, such as bruising or hemorrhage. For patients with no new clinical worries, you'll need to provide documentation that laboratory values were obtained, reviewed, and used to guide current and/or future therapy.

• List the patient's current medications. Include a notation of his or her level of compliance.

• Document your physician's evaluation of the information about signs or symptoms, laboratory test results, and management recommendation.

• Always include the identity and credentials of the provider.

Changes to 453.xx May Impact Covered Dx

ICD-9 2010 will revise the embolism and thrombosis codes to allow specification of whether the condition is acute or chronic. Codes 453.40-453.42 will gain "acute" at the beginning of their descriptors.

Example: In 2009, the descriptor for 453.40 reads "Venous embolism and thrombosis of unspecified deep vessels of lower extremity." For ICD-9 2010, the entire descriptor will read, "Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity."

These embolism and thrombosis coding changes may mean payers will be adding covered diagnoses to their PT monitoring policies. Watch out for updates once the new codes go into effect in October.The revised codes are:

• 453.40 -- Acute venous embolism and thrombosis of unspecified deep vessels of lower extremity

• 453.41 -- Acute venous embolism and thrombosis of deep vessels of proximal lower extremity

• 453.42 -- Acute venous embolism and thrombosis of deep vessels of distal lower extremity.

ICD-9 coding is also becoming more detailed in identifying body locations for conditions. These new ICD- 9 codes for 2010 are appropriate to use when documentation supports the diagnoses:

• 453.50 -- Chronic venous embolism and thrombosis of unspecified deep vessels of lower extremity

• 453.51 -- ... of deep vessels of proximal lower extremity

• 453.52 -- ... of distal lower extremity

• 453.6 -- Venous embolism and thrombosis of superficial vessels of lower extremity

• 453.71 -- Chronic venous embolism and thrombosis of superficial veins of upper extremity

• 453.72 -- ...of deep veins of upper extremity.

ICD-9's intent is to provide better anatomic description as tolocation for chronic venous embolism and thrombosis.

Deleted code: For 2010, code 453.8 (Other venous embolism and thrombosis of other specified veins) will not be valid.