

These documents are Trinity's internal recommendation and not an official CMS document.

DRAFT - Trinity Health OIAS
Attachment B: Anticoagulation FAQ
May 12, 2009

Q1. After a patient's INR level has stabilized within the established therapeutic range, how often should anticoagulation services be provided to a patient?

A1. OIAS recommends treating each patient's anticoagulation management on an individual basis. Treatment should be rendered according to the care plan established between the physician and the servicing clinic based upon each person's response to anticoagulant therapy. Documentation of medical necessity of services must be present for each visit, measuring the current state of therapy toward the established goals. Services should be provided based upon the established plan of care.

Note: Monitoring INR through lab tests and providing full anticoagulation services are different.

The American College of Chest Physicians (ACCP) recommends individualizing management as the optimal frequency of INR monitoring varies according to patient compliance, dosing decisions, duration of therapy and changes in health, diet, or medications. The ACCP, the American Heart Association, Micromedex DrugPoints System, Goodman and Gilman's *Pharmacological Basis of Therapeutics*, and Cecil's *Textbook of Medicine* all recommend monthly monitoring once stable. The Institute for Clinical Systems Improvement's *Anticoagulation Therapy Supplement Management and Managing Oral Anticoagulation Therapy Clinical and Operational Guidelines* also recommend monthly monitoring for stable patients, but suggest that the interval can be increased to 6 weeks for selected stable patients.

Q2. The OIP Alert states not to charge for anticoagulation services if the patient has a visit with their physician on the same date of service, can you please clarify if that is any physician, or the physician that is supervising/ordering/referring the patient for anticoagulation?

Facilities will utilize caution when billing anticoagulation services on the same date as a visit with the patient's physician or receiving other services within hospital departments and/or provider-based clinics.

A2. If the physician's office is not a provider-based department of the hospital, then the anticoagulation services provided by the hospital are billable, provided a separately identifiable E/M service is medically necessary and documented in the medical record.

If the physician office is a provider-based clinic of the hospital, then there are specific billing requirements to consider.

The anticoagulation services rendered must be distinct and separately identifiable from the physician office visit and not an extension of the E/M service provided in the provider-based clinic.

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Scenario's where services may be considered an extension; not significant separately identifiable are:

If the anticoagulation clinic services are an extension of the physician E/M visit, generated from the services provided at the office visit, or the anticoagulation visit prompted the physician office visit to assume management of anticoagulation, then the services would be considered part of the physician office E/M visit.

When the INR level is sub/supra therapeutic, and when contacting the provider the physician feels the need to evaluate the patient and manage the anticoagulation services. The anticoagulation clinic should not bill for E/M services, the physician should. The anticoagulation clinic can generate the charges for the INR.

If the services provided at the physician's office and the anticoagulation clinic are separate and distinct, then two facility E/M visits have occurred and one physician E/M service, the beneficiary will be responsible for three co-payments.

If a separately identifiable E/M and significant procedure (status indicator S or T) have been performed on the same date of service, it is necessary for a modifier-25 to be appended to the E/M level.

When the facility bills to Medicare the claim will have to include the following modifiers and condition codes on the hospital claim to identify separate and distinct services were provided.

Modifier -27 defined as "multiple outpatient hospital evaluation and management encounters on the same date." Modifier -27 should be appended only to the evaluation & management (E/M) service codes. Hospitals append modifier -27 to the second and subsequent E/M code when more than one E/M service is provided to indicate that the E/M service is a "separate and distinct E/M encounter" from the service previously provided that same day in the same or different hospital setting. When reporting modifier -27, report with condition code G0 when multiple medical visits occur on the same day in the same revenue centers.

Q3. When the patient is going to see a different physician on the same date of service (e.g. orthopedist) can the anticoagulation clinic charge for their E/M services?

A3. If the orthopedist is not managing or providing anticoagulation services and the documentation in the anticoagulation department indicates a significant separately identifiable service, then an E/M code is warranted. If the physician's office is a provider-based provider of the hospital follow the billing information provided in A2.

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Q4. If a patient has a trip to the emergency room before or after anticoagulation clinic, can the anticoagulation clinic charge for its services?

A4. If the reason for the emergency room visit is managing anticoagulation, then the anticoagulation clinic should not bill for an E/M service. If the reason for the visit is separate and distinct from anticoagulation, then both services may be billed. Refer to the billing information provided in A2.

Q5. If an anticoagulation patient on Coumadin for a Mechanical Aortic Valve goes to see their family Dr for the assessment of a painful leg and an INR is drawn at the office, and the office calls or faxes the INR result to our clinic and then sends the patient over to the anticoagulation clinic to assess that INR, can that be billed?

A5. If the physician's office is a provider-based department then the documentation must indicate distinct separately identifiable services, in order for the anticoagulation clinic to bill an E/M service. See billing instructions in A2.

Q6. Patient has an appointment for a pacemaker check (INR is not drawn at appointment) on the same day he has an anticoagulation appointment. Can AMS bill for INR and assessment?

A6. If the anticoagulation clinic services are separate and distinct from the procedure being performed, then the anticoagulation clinic may bill an E/M level. See billing instructions in A2.