Diagnostics

CoaguChek® Systems Quick Reference Guide To Medicare Part B Reimbursement

Reimbursement

Frequently Asked Questions

Coding the Test on Claims

Under which code should reimbursement claims for an anticoagulation test be filed?

Under Medicare Part B, Current Procedural Terminology (CPT) codes are used to identify medical tests and procedures including laboratory tests. Prothrombin time (PT) testing performed with a CoaguChek system is billed under CPT code 85610.[1]

This is interpreted as follows:

85610 – Prothrombin time

Modifiers are often added to a CPT code to provide additional information to Medicare. When an outpatient PT test is performed with a CoaguChek system as a CLIA-waived test, by a CLIA-waived entity, the QW modifier must be added to the CPT code to obtain Medicare Part B reimbursement.

This is interpreted as follows:

85610QW* – CLIA-waived PT test

*CLIA-waived versus moderately complex testing depends on the quality controls (QCs) conducted in conjunction with the prothrombin time test (see package insert). If performed as a moderately complex test, the QW modifier is not used.

May a provider bill under an additional code for drawing the sample by means of a fingerstick?

No. Medicare does not reimburse blood samples collected via capillary (finger, heel, ear) access.

Note: Medicare does reimburse for medically necessary *venous* blood collection.

Reimbursement Pricing

How does Medicare pay for anticoagulation tests performed in a physician's office?

Payment for traditional Medicare Part B lab tests is made according to a fixed fee schedule published annually by CMS. Medicare pays 100% of the fee schedule amount or the charge submitted – whichever is less. The 2007 national fee cap for a PT test is $5.49.** As of the date of printing, all states are reimbursing $5.49, except for Iowa ($4.89), Maryland ($5.25), and Wyoming ($4.44).

**Fee schedule information obtained through CMS Internet Web site; no independent verification of data is claimed or implied.

Billing E&M Services

Evaluation & Management (E&M) Services Associated with PT Testing

How are E&M services coded on reimbursement claims?

Physicians may report medically necessary E&M services associated with PT testing provided by themselves or their staff using CPT codes. As with any other medically necessary service, however, there are explicit criteria that must be met and documented to obtain reimbursement for these services. Generally, only one E&M code may be used to characterize a specific patient encounter on a particular date of service.

For physicians and specific advanced practitioners employed by the physician, a range of E&M codes is available reflecting different levels of service. The nature and amount of work and documentation reflected in an E&M code varies, for example, by type of service, place of service, and patient's status within the practice (e.g., new or established).

For all other E&M services provided *incident* to a physician's services by nonphysician staff, only one E&M code applies – 99211.

This guide is offered for informational purposes only as a courtesy for our customers.
The information presented should not be interpreted as legal or regulatory advice or counsel.

Anticoagulant Management Services

Is it true that I can no longer report CPT code 99211 to describe medically necessary nonphysician E&M services associated with PT testing?

Two new E&M codes, 99363 and 99364, which describe outpatient physician management of anticoagulant therapy, were established by the CPT Editorial Panel, effective January 1, 2007. ***Medicare does not recognize these new codes*** as separately reported or reimbursed services. These codes are listed as "bundled" services on the 2007 Medicare Part B physician fee schedule. Thus, for 2007, the CPT codes under which to report medically necessary E&M services provided to Medicare patients in conjunction with PT testing have not changed.

Information regarding the CPT rationale and intent for the use of CPT codes 99363-99364 may be obtained directly from the American Medical Association. Information regarding Medicaid and private payer coverage, reimbursement and documentation guidelines for these new codes may be obtained from the respective Medicaid programs or private payers.

Incident to Services

What qualifies as an *incident to* service?

§2050. of the Medicare Carriers Manual specifies that services are covered as *incident* to a physician's services when they are:

- An integral, although incidental, part of the physician's professional service
- Commonly rendered either without charge or included in the physician's bill
- A type of service commonly furnished in physicians' offices
- Furnished under the direct personal supervision of the physician
- Furnished by the physician or by auxiliary personnel under the physician's direct supervision

To qualify as an *incident to* service, the service must meet all of the above requirements.

Additional Information

Resources for Additional Information

Where can I obtain additional reimbursement-related information concerning CoaguChek systems?

Professional customers (physicians, other qualified healthcare practitioners, etc.) with reimbursement questions related to CoaguChek systems may obtain additional information from the following resources:

- Reimbursement Voicemail Inquiry Line
  1-800-428-5074, x13967
  Response generally within one business day
- *Medicare Reimbursement Handbook* for CoaguChek systems
- Your local Roche Diagnostics Account Manager or Sales Specialist

For additional information regarding CPT codes 99363-99354, or to purchase a copy of the CPT manual or *CPT Changes 2007: An Insider's View*, contact the American Medical Association, 515 North State Street, Chicago, IL 60610, 1-800-621-8335.

For additional information regarding E&M Documentation Guidelines and General Principles of Medical Record Documentation, contact your respective professional medical societies or visit the CMS or AMA Web sites – www.cms.hhs.gov or http://www.ama-assn.org/.

To contact the Medicare Part A or Medicare Part B contractor in your region, visit the CMS contractor directory Web page: http://www.cms.hhs.gov/apps/contacts/incardir.asp or see the provider information entry under "Medicare" in the business white pages of your telephone directory.

To review specific Medicare guidelines, consult the appropriate Medicare Manual. Manuals are available from your local Medicare contractor or via the CMS Web site, http://www.cms.hhs.gov/Manuals/.

[1] Current Procedural Terminology (CPT) and *CPT Changes 2007: An Insider's View*. American Medical Association, 2006.
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