Priority Health	BILLING POLICY No. 122
HOME PROTHROMBIN TIME OR INR MONITORING	
Date of origin: Aug. 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Prothrombin time (PT) is a blood test that determines the duration it takes for blood to clot. This test can help identify bleeding disorders and is also used to monitor the effectiveness of medications designed to prevent blood clots.

A PT test may also be referred to as an INR test. INR, which stands for international normalized ratio, is a method used to standardize the results of prothrombin time tests regardless of the testing technique.

MEDICAL POLICY

Home Prothrombin Time or INR Monitoring (#91507)

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Coding specifics

93792	Patient/caregiver training for initiation of home international normalized ratio (INR) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the INR monitor, obtaining blood sample, instructions for reporting home INR test results, and documentation of patient's/caregiver's ability to perform testing and report results
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed
G0248	Demonstration, prior to initial use, of home INR monitoring for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the INR monitor, obtaining at least one blood sample, provision of instructions for reporting home INR test results, and documentation of patient ability to perform testing and report results

G0249 Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; includes provision of materials for use in the home and reporting of test results to physician; not occurring more frequently than once a week; testing materials, billing units of service include 4 tests

G0250 Physician review, interpretation, and patient management of home INR testing for a patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests.

- Several codes have specific MUE limits. Review the NCCI manual for accurate unit reporting to avoid denials.
- Significant and separately identifiable evaluation and management services can only be reported separately with select services when supported by documentation. Review NCCI for allowed modifier scenarios.
- CPT 93793 should not be reported in addition to evaluation and management on the same day. This will result in denials.
- Self-testing with the device is limited to a frequency of once per week.
- Time spent in 93792 and 93793 cannot be counted in the time of 99439, 99487, 99489, 99490 and 99491 when reported in the same calendar month.
- When telephone or online digital evaluation and management services (98012, 98013, 98014, 98015, 98016, 98966, 98967, 98968, 98970, 98971, 99421, 99422 and 99423) address home and outpatient INR monitoring – 93792 or 93793 should not be reported in addition to.
- 93792 and G0250 have a payment indicator of 2 – Professional component only codes
- 93793, G0248 and G0249 have a payment indicator of 3 – Technical component only codes

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

At a minimum, documentation must support what is stated in the CPT code and code lay description for the billed code.

Some examples of documentation may include:

- Training instructions which include use and care of monitoring device, instructions for obtaining blood samples
- Determination of patient/caregiver's ability to perform and report testing
- Ordering, review and interpretation of new INR test results
- Patient instructions
- Dosage adjustments
- Additional tests that are scheduled

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

- 25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
- 59 – Distinct Procedural Service

Billing details

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Type of Bill

- 013 – Hospital Outpatient
- 085 – Critical Access Hospital

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

Related denial language

- z58 – Unbundled scenario
- t60 – procedure has unbundled relationship
- t65 – maximum frequency has been exceeded
- t18 – maximum frequency exceeded

REFERENCES

- Prothrombin Time (PT/INR) Test | Cigna
- AMA CPT Professional Manual CPT® (Current Procedural Terminology) | AMA

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding

accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made