Sonora Quest Laboratories™
A Subsidiary of Laboratory Sciences of Arizona

Prothrombin Time (PT)

CPT: 85610

Medically Supportive ICD Codes are listed on subsequent page(s) of this document

CMS National Coverage Policy

Coverage Indications, Limitations, and/or Medical Necessity

Basic plasma coagulation function is readily assessed with a few simple laboratory tests: the Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Thrombin Time (TT), or a quantitative fibrinogen determination. The PT test is one in-vitro laboratory test used to assess coagulation. While the PTT assesses the intrinsic limb of the coagulation system, the PT assesses the extrinsic or tissue factor dependent pathway. Both tests also evaluate the common coagulation pathway involving all the reactions that occur after the activation of factor X. Extrinsic pathway factors are produced in the liver and their production is dependent on adequate vitamin K activity. Deficiencies of factors may be related to decreased production or increased consumption of coagulation factors. The PT/INR is most commonly used to measure the effect of warfarin and regulate its dosing. Warfarin blocks the effect of vitamin K on hepatic production of extrinsic pathway factors.

A PT is expressed in seconds and/or as an international normalized ratio (INR). The INR is the PT ratio that would result if the WHO reference thromboplastin was used in performing the test.

Current medical information does not clarify the role of laboratory PT testing in patients who are self monitoring. Therefore, the indications for testing apply regardless of whether or not the patient is also PT self-testing.

Indications

1. A PT may be used to assess patients taking warfarin. The PT is generally not useful in monitoring patients receiving heparin who are not taking warfarin.
2. A PT may be used to assess patients with signs or symptoms of abnormal bleeding or thrombosis. For example:
   - Swollen extremity with or without prior trauma
   - Unexplained bruising
   - Abnormal bleeding, hemorrhage or hematoma
   - Petechiae or other signs of thrombocytopenia that could be due to Disseminated Intravascular Coagulation

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CMS National Coverage Policy (continued)

3. A PT may be useful in evaluating patients who have a history of a condition known to be associated with the risk of bleeding or thrombosis that is related to the extrinsic coagulation pathway. Such abnormalities may be genetic or acquired. For example:

   - Dysfibrinogenemia
   - Afibrinogenemia (complete)
   - Acute or chronic liver dysfunction or failure, including Wilson's disease and Hemochromatosis
   - Disseminated intravascular coagulation (DIC)
   - Congenital and acquired deficiencies of factors II, V, VII, X
   - Vitamin K deficiency
   - Lupus erythematosus
   - Hypercoagulable state
   - Paraproteinemia
   - Lymphoma
   - Amyloidosis
   - Acute and chronic leukemias
   - Plasma cell dyscrasia
   - HIV infection
   - Malignant neoplasms
   - Hemorrhagic fever
   - Salicylate poisoning
   - Obstructive jaundice
   - Intestinal fistula
   - Malabsorption syndrome
   - Colitis
   - Chronic diarrhea
   - Presence of peripheral venous or arterial thrombosis or pulmonary emboli or myocardial infarction
   - Patients with bleeding or clotting tendencies
   - Organ transplantation
   - Presence of circulating coagulation inhibitors

4. A PT may be used to assess the risk of hemorrhage or thrombosis in patients who are going to have a medical intervention known to be associated with increased risk of bleeding or thrombosis. For example:
   - Evaluation prior to invasive procedures or operations of patients with personal history of bleeding or a condition associated with coagulopathy.
   - Prior to the use of thrombolytic medication

Limitations

1. When an ESRD patient is tested for PT, testing more frequently than weekly requires documentation of medical necessity, e.g., other than chronic renal failure or renal failure unspecified.

2. The need to repeat this test is determined by changes in the underlying medical condition and/or the dosing of warfarin. In a patient on stable warfarin therapy, it is ordinarily not necessary to repeat testing more than every two to three weeks. When testing is performed to evaluate a patient with signs or symptoms of abnormal bleeding or thrombosis and the initial test result is normal, it is ordinarily not necessary to repeat testing unless there is a change in the patient's medical status.

3. Since the INR is a calculation, it will not be paid in addition to the PT when expressed in seconds, and is considered part of the conventional PT test.

4. Testing prior to any medical intervention associated with a risk of bleeding and thrombosis (other than thrombolytic therapy) will generally be considered medically necessary only where there are signs or symptoms of a bleeding or thrombotic abnormality or a personal history of bleeding, thrombosis or a condition associated with a coagulopathy. Hospital/clinic-specific policies, protocols, etc., in and of themselves, cannot alone justify coverage.

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The ICD10 codes listed below are the top diagnosis codes currently utilized by ordering physicians for the limited coverage test highlighted above that are also listed as medically supportive under Medicare's limited coverage policy. **If you are ordering this test for diagnostic reasons that are not covered under Medicare policy, an Advance Beneficiary Notice form is required.**
Note—Bolded diagnoses below have the highest utilization

There is a frequency associated with this test. Please refer to the Limitations or Utilization Guidelines section on previous page(s).

Code	Description
D50.9	Iron deficiency anemia, unspecified
D68.9	Coagulation defect, unspecified
I25.10	Atherosclerotic heart disease of native coronary artery without angina pectoris
I26.99	Other pulmonary embolism without acute cor pulmonale
I48.0	Paroxysmal atrial fibrillation
I48.19	Other persistent atrial fibrillation
I48.20	**Chronic atrial fibrillation**
I48.91	**Unspecified atrial fibrillation**
I48.92	Unspecified atrial flutter
I50.9	Heart failure, unspecified
I63.9	Cerebral infarction, unspecified
I73.9	Peripheral vascular disease, unspecified
I82.409	Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity
K74.60	Unspecified cirrhosis of liver
R06.02	Shortness of breath
R79.1	Abnormal coagulation profile
Z51.81	**Encounter for therapeutic drug level monitoring**
Z79.01	**Long term (current) use of anticoagulants**
Z86.718	Personal history of other venous thrombosis and embolism
Z95.2	Presence of prosthetic heart valve

Visit **SonoraQuest.com/Medicare** to view current limited coverage tests, reference guides, and policy information.
To view the complete policy and the full list of medically supportive codes, please refer to the CMS website reference www.cms.gov ▶

Last updated: 01/01/20

Disclaimer:
This diagnosis code reference guide is provided as an aid to physicians and office staff in determining when an ABN (Advance Beneficiary Notice) is necessary. Diagnosis codes must be applicable to the patient's symptoms or conditions and must be consistent with documentation in the patient's medical record. Sonora Quest Laboratories does not recommend any diagnosis codes and will only submit diagnosis information provided to us by the ordering physician or his/her designated staff. The CPT codes provided are based on AMA guidelines and are for informational purposes only. CPT coding is the sole responsibility of the billing party. Please direct any questions regarding coding to the payer being billed.

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