Clinical Policy: Home INR Monitor

Reference Number: IL.CP.MP.502
Last Review Date: 03/21

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Patients receiving long-term oral anticoagulation therapy can monitor their own coagulation control with portable devices that measure capillary whole-blood prothrombin time (PT). After testing, patients either notify their physicians of the results or use an individualized algorithm to adjust their warfarin dosage to maintain PT levels within a target zone. The goal of self-monitoring and self-management of PT levels is to improve anticoagulation control and reduce the frequency of adverse events.

The International Normalized Ratio (INR) is the ratio of the patient's prothrombin time compared to the mean prothrombin time for a group of normal individuals. Maintaining patients within the therapeutic range minimizes adverse events associated with inadequate or excessive anticoagulation such as serious bleeding or thromboembolic events. Patient self-testing and self-management through the use of a home INR monitor may be used to improve the time in therapeutic rate (TTR) for select groups of patients. Increased TTR leads to improved clinical outcomes and reductions in thromboembolic and hemorrhagic events.

Policy/Criteria

It is the policy of MeridianHealth affiliated with Centene Corporation® that home INR monitors are **not a covered benefit.**

I. Home INR monitors are **not a covered benefit.**

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description

HCPCS ®* Codes	Description

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date		6/6/2016

References

Illinois DHFS. Handbook for Providers of Hospital Services, Chapter 100, Section 104 Noncovered services, Policy and Procedures for Hospitals Services. Accessed Date: 1/21/21.

State of Illinois Contract between the Department of Healthcare and Family Services and Meridian Health Plan of Illinois, 2018-24-601, Preauthorization and Concurrent Review Requirements, 1.1.2.3.3

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.