



Hospital Inpatient 2012 Medicare Payment and Policy Update

This guide provides a general update of the Centers for Medicare and Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) rule for FY 2012 and relevant information for ischemic stroke intervention. It also provides coding and payment information for endovascular mechanical thrombectomy/embolectomy for acute ischemic stroke. For questions about physician billing, please consult the separately available Concentric Medical Physician Reimbursement Booklet.

Payment Update

The Centers for Medicare and Medicaid Services (CMS) Final Inpatient Prospective Payment Rule for FY 2012 included an overall payment update of 1.1% which corresponds to an overall increase in payments of \$1.13 billion dollars to the 3,400 acute care hospitals operating in the U.S. CMS reduced the 3.15% documentation and coding adjustment that was initially proposed (related to the implementation of the MS-DRG payment system) and instead finalized a reduction of 2.0% with the intent of recouping the remainder of the overpayments in future years.

Quality Measures for Stroke Finalized for FY 2015 Payment Determination

CMS continues to recognize stroke as an area that greatly affects the Medicare population and has potential for quality improvement. In the FY 2012 final rule, CMS finalized the addition of stroke quality measures to the list of Hospital Inpatient Quality Reporting (IQR) Program measures for the FY 2015 payment determination. The rule requires chart-abstracted data to be collected beginning with discharges on or after January 1, 2013. CMS requires the reporting of these quality measures for the full payment update for FY 2015. Currently, hospitals report on more than 50 quality measures and hospitals that do not report quality measures have their overall payments reduced by 2.0%.

The stroke quality measures adopted are:

1. **VTE (venous thromboembolism) prophylaxis** – Percent of patients with an ischemic stroke or a hemorrhagic stroke and who are non-ambulatory who start receiving DVT (deep vein thrombosis) prophylaxis by end of hospital day two.
2. **Antithrombotic therapy for ischemic stroke** – Percent of patients with an ischemic stroke prescribed antithrombotic therapy at discharge.
3. **Anticoagulation therapy for A-fib/A-flutter** – Percent of patients with an ischemic stroke with atrial fibrillation discharged on anticoagulation therapy.
4. **Thrombolytic therapy for acute ischemic stroke** – Percent of acute ischemic stroke patients who arrive at the hospital within 120 minutes (2 hours) of time last known well and for whom IV t-PA was initiated at this hospital within 180 minutes (3 hours) of time last known well.
5. **Antithrombotic therapy by the end of hospital day two** – Percent of patients with ischemic stroke who receive antithrombotic therapy by the end of hospital day two.
6. **Discharged on statin** – Percent of ischemic stroke patients with LDL \geq 100 mg/dL, or LDL not measured, or, who were on cholesterol reducing therapy prior to hospitalization who are discharged on a statin medication.
7. **Stroke education** – Percent of patients with ischemic or hemorrhagic stroke or their caregivers who were given education or educational materials during the hospital stay addressing all of the following: personal risk factors for stroke, warning signs for stroke, activation of emergency response.
8. **Assessed for rehab** – Percent of patients with an ischemic stroke or hemorrhagic stroke who were assessed for rehabilitation services.

Structural Measure: Participation in Stroke Registry

The structural measure finalized in the FY 2010 rule, "Participation in a Systematic Clinical Database Registry for Stroke Care" continues to be in effect. Hospitals are not required to participate in a stroke registry under this structural measure, but must indicate to CMS whether or not they participate in a stroke registry. Hospitals are required to submit data via QualityNet.org from July 1, 2011 – August 15, 2011, regarding participation from July 1, 2010 through December 31, 2010 for the FY 2012 Payment Update. Hospitals will then report to CMS whether or not they participated in a stroke registry in April/May of each year. Data for January 1, 2011 through December 31, 2011 would be submitted between April 1, 2012 and May 15, 2012.

Hospital Inpatient 2012 Medicare Payment

Hospitals submit inpatient claims to Medicare, Medicaid, and private insurers on the UB-04 billing form (also called the CMS-1450). The UB-04 displays ICD-9-CM diagnosis codes (principal diagnosis and up to eighteen additional diagnoses) and ICD-9-CM procedure codes (primary procedure and up to five additional procedure codes) as well as other patient and billing information to describe the patient's stay and use of resources. Many insurers, including Medicare, generally use a 24-hour length of stay to define inpatient hospital care.

Medicare uses a prospective payment system called Medicare Severity Diagnosis Related Groups (MS-DRGs) to reimburse hospitals for inpatient stays. Each inpatient stay is assigned to an MS-DRG that is determined according to the principal diagnosis, major procedures, discharge status, and complicating secondary diagnoses. Each MS-DRG is assigned a flat payment rate, which is adjusted according to the individual hospital's teaching status, disproportionate share services for treating low-income, uninsured and/or under-insured patients, and location in urban versus rural regions. Note that MS-DRGs do not include payment for physician services, which are coded and reimbursed separately.

Disclaimer: The presence of an ICD-9 code, CPT® code or Revenue Code does not by itself guarantee coverage or payment at a particular level. Insurers have widely varying coverage and payment policies. Providers should always confirm with individual insurance companies the codes to bill and the coverage policies that will apply to a particular patient.

Other health insurers may reimburse hospitals for inpatient care using per diem rates, DRGs, case rates, or a percentage of charges. Some health insurers may also provide separate payment for single-use disposable devices, such as the Merci Retrieval System®, used in endovascular mechanical embolectomy/thrombectomy procedures. Your hospital's contracting department should know if your hospital's private insurance contracts allow this separate payment, known as a device carve-out.

V 45.88 - Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility

Patients who receive IV tPA at one facility and are then transferred to another facility are eligible to be coded with this "history of" code, or V-code.

Concentric Medical, Inc. does not guarantee that use of the information presented above will ensure coverage or payment for the product or the procedure. This document is for educational purposes only. Physicians and hospitals should use independent judgment when selecting codes that most appropriately describe the services rendered to a patient. Providers are responsible for compliance with individual insurance company billing and reimbursement requirements.

ICD-9-CM Procedure Code

By definition, code 39.74 is assigned for procedures using mechanical methods of removing embolus or thrombus, including the Merci Retrieval System. This code is specifically used for an endovascular approach. It includes the pre-cerebral vessels in the neck, such as the common carotid artery, and the cerebral (intracranial) vessels of the head, such as the middle cerebral artery.

39.74 Endovascular removal of obstruction from head and neck vessel(s)

- Endovascular embolectomy
- Endovascular thrombectomy of pre-cerebral and cerebral vessels
- Mechanical embolectomy or thrombectomy

Code also:

- Any injection or infusion of thrombolytic agent (99.10)
- Number of vessels treated (00.40-00.43)
- Procedure on vessel bifurcation (00.44)

Excludes:

- Endarterectomy of intracranial vessels and other vessels of head and neck (38.11–38.12)
- Occlusive endovascular embolization of head or neck vessel(s) using bare coils (39.75)
- Occlusive endovascular embolization of head or neck vessel(s) using bioactive coils (39.76)
- Open embolectomy or thrombectomy (38.01–38.02)

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Adjunct and Additional ICD-9 CM Procedure Codes

As indicated by the notes, additional ICD-9-CM procedure codes should be assigned with 39.74 when appropriate.

ICD-9 CM Procedure Codes	Additional Notes
Patients with IV tPA Injected at Transfer Hospital V 45.88 – Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to current facility	First, code the primary diagnosis, the condition requiring tPA administration such as: acute cerebral infarction (433.0-433.9 with fifth digit 1, 434.0-434.9 with fifth digit 1) or acute myocardial infarction (410.00-410.92). The diagnosis code will indicate whether the lytic was administered for a stroke or an MI.
Thrombolytic Infusion 99.10 Injection or infusion of thrombolytic agent	Code 39.74 represents the mechanical removal of a thrombus or embolus. If a thrombolytic agent such as tPA is infused, this should also be coded.
Diagnostic Angiography 88.41 Arteriography of cerebral arteries	Diagnostic angiography is performed to identify the site of the thrombus or embolus. This should be coded separately as well. Note that code 88.41 is used for angiography of both cerebral and pre-cerebral vessels.
Number of Vessels Treated 00.40 Procedure on single vessel 00.41 Procedure on two vessels 00.42 Procedure on three vessels 00.43 Procedure on four or more vessels	These codes are to be used in conjunction with other therapeutic procedure codes to provide additional information on the number of vessels upon which a procedure was performed. In all cases, a separate code from the 00.40–00.43 series is assigned to show the number of individual vessels treated. Typically, only one vessel is treated, therefore code 00.40 for procedure on single vessel would be assigned.
Procedure on Vessel Bifurcation 00.44 Procedure on vessel bifurcation	As applicable, a separate code is also assigned when a thrombus or embolus is removed from a vessel bifurcation. Use this code only once per operative episode, irrespective of the number of bifurcations in vessels.

Revenue Codes and C-Codes

All charges on hospital bills are categorized into general revenue codes representing the major cost centers for hospital services. Costs for the Merci Retrieval System may be categorized to revenue codes for supplies.

Possible Revenue Codes

270 – Medical/Surgical Supply

272 – Sterile Supply

Note: For devices used in an FDA-approved IDE trial, revenue code 624 is used for the investigational device.

C-Codes

C-Codes (or HCPC III codes) are used to identify devices on outpatient Medicare claims. C-codes are NOT used when submitting inpatient claims to Medicare. Medicare restricts endovascular mechanical embolectomy/thrombectomy to the inpatient setting; therefore, no category C-code should appear on the inpatient claim (UB or electronic form) when performing mechanical thrombectomy using the Merci Retrieval System®. However, C-codes are often used internally by hospitals for inventory or utilization purposes.

Merci Retriever®

C 1757 Catheter, thrombectomy/embolectomy - when used for thrombus removal

C 1773 Retrieval device, insertable – when used for foreign body retrieval

Merci® Microcatheter, DAC® Catheter and Balloon Guide Catheters

C 1887 Catheter, guiding, intended for the introduction of interventional/diagnostic devices into the coronary or peripheral vascular systems

For additional information, please see the C-code list available at www.concentric-medical.com/reimbursement

2012 National Average Urban MS-DRG Payments (Select Stroke Related MS-DRGs)

Mechanical Thrombectomy / Embolectomy

MS-DRG assignment is based on a patient's principal diagnosis, primary procedure and secondary diagnoses. With acute ischemic stroke (occlusion with infarct) as the principal diagnosis and endovascular removal of an obstruction of head/neck vessels as the primary procedure, patients may be assigned to MS-DRG 23 or 24. Other MS-DRG assignments are possible if a different condition is designated as the principal diagnosis.

2012 MS-DRG	Description	Relative Weight	Average Length of Stay	2012 National Average Urban Payment
23	Craniotomy w major device implant or acute complex CNS PDX w MCC	5.3625	11.7	\$30,197
24	Craniotomy w major device implant or acute complex CNS PDX w/o MCC	3.6327	7.5	\$20,456
25	Craniotomy & endovascular intracranial procedures w MCC	4.6927	10.9	\$26,425
26	Craniotomy & endovascular intracranial procedures w CC	2.9770	7.0	\$16,764
27	Craniotomy & endovascular intracranial procedures w/o CC/MCC	2.1317	3.7	\$12,004
31	Ventricular Shunt Procedure w MCC	4.4529	12.5	\$25,075
32	Ventricular Shunt Procedure w CC	1.9491	5.2	\$10,976
33	Ventricular Shunt Procedure w/o CC/MCC	1.4085	2.6	\$7,931
907	Other OR procedures for injuries w MCC	3.9661	11.3	\$22,334
908	Other OR procedures for injuries w CC	1.9298	6.0	\$10,867
909	Other OR procedures for injuries w/o CC/MCC	1.1612	3.3	\$6,539
957	Other OR Procedure for multiple significant trauma w MCC	6.6017	14.5	\$37,175
958	Other OR Procedure for multiple significant trauma w CC	3.7491	9.2	\$21,112
959	Other OR Procedure for multiple significant trauma w/o CC/MCC	2.4711	5.7	\$13,915

Acute Ischemic Stroke with use of Lytic

2012 MS-DRG	Description	Relative Weight	Average Length of Stay	2012 National Average Urban Payment
61	AIS with use of thrombolytic agent w MCC	2.8804	8.0	\$16,220
62	AIS with use of thrombolytic agent w CC	1.9506	5.4	\$10,984
63	AIS with use of thrombolytic agent w/o CC/MCC	1.5361	3.8	\$8,650

Medical Management of Stroke

2012 MS-DRG	Description	Relative Weight	Average Length of Stay	2012 National Average Urban Payment
64	Intracranial hemorrhage or cerebral infarct w MCC	1.8555	6.8	\$10,449
65	Intracranial hemorrhage or cerebral infarct w CC	1.1485	4.6	\$6,467
66	Intracranial hemorrhage or cerebral infarct w/o CC/MCC	0.8105	3.1	\$4,564

In-Patient Rehabilitation

2012 MS-DRG	Description	Relative Weight	Average Length of Stay	2012 National Average Urban Payment
945	Rehabilitation with CC/MCC	1.3312	10.0	\$7,496
946	Rehabilitation w/o CC/MCC	1.2889	7.6	\$7,258

MCC = Major Complication or Comorbidity
CC = Complication or Comorbidity

The 2012 Fiscal Year begins October 1, 2011. Teaching and disproportionate share hospitals may receive additional payments per discharge. Providers should verify all coding and payment rules with third party payers. Medical records and documentation must support billing and the use of all procedure and diagnosis codes.

Reference: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2012 Rates; Federal Register / Vol. 76, No. 160, Thursday, August 18, 2011.



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APM0311/F/4898, 2011-09