ThermoSuit® Reimbursement Information

Life Recovery Systems

PHYSICIAN REIMBURSEMENT

Physicians providing therapeutic hypothermia may bill for their professional services by utilizing CPT codes. The most common category of professional services is Critical Care, which describes the direct delivery by a physician of medical care for a critically ill or critically injured patient. Critical care CPT codes are reported by the total time spent engaged in work directly related to the individual patient's care, whether that time was spent at the immediate bedside or elsewhere on the floor or unit. When Critical Care services are furnished, the physician cannot provide services to any other patient during the same period of time.

Critical care codes are time based; thereby any additional time and work associated with the various phases of hypothermia management should be documented in the medical record by the physician. The critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. Code 99291 is used to report the first 30 - 74 minutes of critical care on a given date. It should be used only once per date even if the time spent by the physician is not continuous on that date. Code 99292 is used to report additional block(s) of time, of up to 30 minutes each, beyond the first 74 minutes. Critical care of less than 30 minutes total duration on a given date should be reported with the appropriate E/M code. The table below illustrates national Medicare payments for critical care services that could account for the physician work rendered for temperature management.

CPT Code	Description	2010 Medicare National Professional Payment
99291	Critical Care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	$204
99292	Critical Care, each additional 30 minutes (List separately in addition to code for primary service)	$102

HOSPITAL REIMBURSEMENT

Candidates for therapeutic hypothermia will always be admitted as inpatients. Medicare and most non-Medicare payers reimburse hospitals for inpatient services based on Diagnosis Related Groups (DRGs). Procedures are classified into clinically cohesive groups that exhibit similar use of hospital resources and length-of-stay. Under DRGs, hospitals receive a fixed payment to treat a particular patient during an admission. Regardless of actual costs or length of stay, hospitals receive a single payment for all services provided, based on the DRG assigned to the discharge. However severity of illness will determine if a higher payment paying DRG should be assigned at discharge.

Medicare transitioned from a DRG system to Medicare Severity DRGs (MS-DRGs) to recognize patients' relative severity of illness for payment purposes. Severity is measured by the presence or absence of a complication or comorbidity (CC) or a major complication or comorbidity (MCC), resulting in assignment to a higher paying MS-DRG for treating patients, requiring more resources. Acute conditions are designated on the CC or MCC list if their impact on hospital resource use would be expected to be comparable to representative diseases such as acute MI, stroke, acute respiratory failure, acute renal failure, pneumonia or septicemia; often cases that may require temperature management.

The MS-DRGs shown below are those assigned to some typical inpatient admission scenarios.

MS-DRG	Descriptor	FY 2010 Medicare National Payment
021	Intracranial Vascular Procedures with a Principal Diagnosis of Hemorrhage with Major Complication or Comorbidity (MCC)	$41,748
224	Cardiac defibrillator implant with cardiac cath with AMI/HF/Shock with MCC	$42,670
231	Coronary Bypass with PTCA with MCC	$43,409
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC or 4+ vessels/stents	$17,500
296	Cardiac arrest, unexplained w MCC	$6,628

MS-DRG rates were calculated using DRG weights and wage indices published in the CMS 2010 IPPS final rule: CMS-1390-F, http://www.cms.hhs.gov/

THERAPEUTIC HYPOTHERMIA CODING

Therapeutic hypothermia can and should be coded and charged. While hospitals are typically reimbursed a fixed rate based on the discharge diagnoses (DRG), some commercial payers do pay on a cost-of-service basis. Also, coding and cost reporting of all services and supplies provided to a patient are both required by CMS and beneficial to facilities because historical charges affect future reimbursement rates.

Therapeutic hypothermia can be coded and charged, allowing facilities to:

- document a higher severity of illness
- recognize the procedure and supply charge as gross revenue
- recognize the procedure as a unit of service
- code the procedure and supply cost on the claim form

Typical hospital claims require the following four coding components:

- Diagnoses code to justify the need for therapeutic hypothermia
- Procedure code to document that therapeutic hypothermia was performed
- Procedure fee determined by the provider. Typically $300.00.
- Supply fee determined by the provider. Typically $6,000.00.

Diagnosis Codes:

The patient's condition is reported by using ICD-9-CM diagnosis codes that indicate the reason(s) a procedure or service is performed. Below are select diagnosis codes that may be appropriate for patients requiring therapeutic temperature management (TTM). In addition, these examples frequently can be coded with MCC designations.

ICD-9 Code	Descriptor
427.5	Cardiac Arrest
434.01	Cerebral Thrombus W Infarct
434.11	Cerebral Embolism W Infarct
780.60-780.62	Fever and other physiologic disturbances of temperature regulation

- Providers should report the ICD-9-CM code that most accurately reflects a patient's condition.
- Providers should refer to individual health plan policies for additional coding information. Some payors may require multiple diagnosis codes in certain cases.

Inpatient Procedure Code:

ICD-9 procedure codes describe the surgical, interventional, or diagnostic procedures performed on a inpatient. These codes are required for inpatient hospital claims. The following may be reported when hypothermia is induced.

ICD-9 Procedure Code	Descriptor
99.81	Hypothermia (central)(local)

Source: ICD-9-CM 2010

Disclaimer:

The information in this document is for illustrative purposes only. It does not guarantee coverage or reimbursement, and Life Recovery Systems makes no other representations as to selecting codes for procedures or compliance with any other billing protocols or prerequisites. As with all claims, individual physicians and hospitals are responsible for exercising their independent clinical judgment in selecting the codes that most accurately reflect the patient's condition and procedures performed for a patient. Before filing any claims, physicians and hospitals should refer to current, complete, and authoritative publications such as AMA CPT lists or insurer policies for coverage information and selecting codes based on the care rendered to an individual patient and may wish to verify such information with individual carriers, fiscal intermediaries or other third party payers as needed. The Medicare reimbursement rates shown do not reflect actual payments made to individual providers, as payments are adjusted based on specific geographic regions. The data presented are current as indicated. All information is subject to change without notice. In addition, payers or local carriers may have their own coding and billing requirements.

Source: CMS Federal Register August 27, 2009; Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2010.