General Overview of How Medicare Payment Works

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GuidePoint
Simplifying Reimbursement

Cardiac Rhythm Management and Electrophysiology

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This document is an introduction to the general mechanisms of the Medicare reimbursement systems that govern CRM procedures (i.e., payment definitions, Medicare codes, etc.).

Medicare Payment System

Medicare is a federally-funded national health insurance program providing coverage to approximately 40 million Americans who are 65 years of age or older, certain younger people with disabilities and individuals with end-stage renal disease (ESRD) (permanent kidney failure with dialysis or a transplant).There are several payment systems within the Medicare program, including payment for inpatient hospital services, outpatient hospital services, home health, physicians and skilled nursing. This document contains information specific to hospital and physician payment systems.

Reimbursement Process

Reimbursement is the culmination of a series of steps that includes the patient, the provider, and the payer. It is important to remember that reimbursement consists of three main elements—coding, coverage, and payment.

Coding — a language used to describe patient conditions and procedures:
As a physician there are two main types of codes you will be concerned with:

1) Procedure codes: Numerical descriptions of the procedures or services provided. CPT® procedure codes are used to describe procedures done in a hospital outpatient setting as well as physician services. In a hospital inpatient setting, ICD-9 procedure codes are used.

   For example: 33249: *Insertion or repositioning of electrode lead(s) for single-chamber pacing cardioverter-defibrillator and insertion of pulse generator*

2) Diagnosis codes: Numerical descriptions from the ICD-9 coding system to describe the diagnosis of the patient.

   For example: 427.41 *Ventricular fibrillation*

Coverage - the terms and conditions that define which products and services are eligible for payment.

Payment - the amount of money paid to a hospital/facility, physician, or supplier for services. Keep in mind that payment is based on the site of services in which the procedure is performed. There are three mechanisms of payment from Medicare based on site of service –

1) Physician Payment
2) Hospital Outpatient
3) Hospital Inpatient

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	Diagnosis Codes	Procedure Codes	Payment Method
Physician	ICD-9 Diagnosis Codes	CPT Codes	PFS
Hospital Outpatient	ICD-9 Diagnosis Codes	CPT Codes	APC
Hospital Intpatient	ICD-9 Diagnosis Codes	ICD-9 Procedure Codes	DRG

PFS: Physician Fee Schedule, APC: Ambulatory Payment Classification, DRG: Diagnosis Related Group

Physician Payment

Physicians receive payment for services rendered based on the Medicare physician fee schedule. These payments are determined annually by Medicare based on the complexity of the case, physician's time, and other factors.

Hospital Outpatient

If a patient is treated in an outpatient setting, the facility is reimbursed through the Outpatient Prospective Payment System. Remember the physician payment is reimbursed by the Physician Fee Schedule as noted above. Medicare assigns all services to an Ambulatory Payment Classification (APC). Each APC contains procedures that are similar both clinically and in terms of resources used. This payment is intended to cover all facility expenses (overhead, capital equipment, supplies, etc.) and includes the cost of devices. Depending on the services provided, hospitals may be paid for more than one APC for an encounter. Payment may be reduced for certain procedures performed in combination with others.

As an example, suppose a hospital outpatient department reports CPT® code 33208:

33208 Dual-chamber pacemaker insertion with RA and RV lead insertion

Medicare will classify this procedure under APC 0655, Insertion/Replacement/Conversion of a Permanent Dual Chamber Pacemaker, for which the 2009 national base payment rate is $ $9,512.21[1]. Medicare will adjust this amount by a local wage index, and reimburse the hospital.

Major changes in this year's Outpatient Prospective Payment System and national average reimbursement rates for common CRM procedures can be accessed on our website.

Hospital Inpatient

** For a procedure to be performed in the inpatient setting, the physician must issue clear admission orders ("admit to hospital" versus "place in observation"), and the patient's medical record must clearly and accurately document the medical justification[2].

If a patient is formally admitted to the hospital as an inpatient, the hospital is reimbursed through the Inpatient Prospective Payment System (IPPS). This payment is intended to cover all facility expenses (overhead, capital equipment, supplies, etc.) with the exception of physician labor. Remember the physician payment is reimbursed by the Physician Fee Schedule as noted above.

[1] MedPAR Preliminary 2008 Database.
[2] *See Medicare Quality Improvement Organization Manual, Chapter 4, "Case Review," for a discussion of inpatient criteria. The chapter is available online at http://www.cms.hhs.gov/manuals/downloads/qio110c04.pdf.*

See page 4 for important information about the uses and limitations of this document.

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MS-DRG Basics

Hospital inpatient care is assigned to a Medicare Severity- Diagnosis Related Group (MS-DRG).The MS-DRG system represents a classification of patients into clinically cohesive groups having similar consumption of hospital resources and length of stay patterns This payment is intended to cover all facility expenses (overhead, capital equipment, supplies, etc.) including the cost of the device. CMS categorizes each inpatient case into an MS-DRG on the basis of several factors:

- Principal diagnosis and up to eight additional diagnoses
- Principal procedure and up to five additional procedures
- Patient's age
- Patient's sex
- Patient's discharge status
- Any existing comorbities which are classified by Medicare as a complication and comorbitiy (CC), major complication and comorbidity (MCC) or non-complication or comorbidity.

Complications and Cormorbidities (CC) list
http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=2&sortOrder=ascending&itemID=CMS1209834&intNumPerPage=10

Major Complications and Comorbidities (MCC) List:
http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS1209835&intNumPerPage=10

As an example a patient has an existing single-chamber pacemaker for bradycardia. The patient develops class III heart failure and conduction delay. The single-chamber pacemaker is upgraded to a Cardiac Resynchronization Therapy- Pacemaker (CRT-P) system.

Under the MS-DRG system, the heart failure unspecified code (428.0) is designated as a non-complication or cormorbidity (CC); therefore, MS-DRG 244 is assigned. However, if the patient presented with chronic combined systolic and diastolic heart failure, code 428.42 is used, this code is designated as a complication or cormorbidity (CC) and, MS-DRG 243 would be assigned, If the patient had acute combined systolic and diastolic heart failure, code 428.41, MS-DRG 242 would be assigned, as this code is classified as a major complication or comorbidity (MCC).

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Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

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