Reimbursement and Coding
Hospital Facility-Based Fluid Assessment and Monitoring Procedures

2022 National Average Medicare Payments

Inpatient Prospective Payment System Coding: Acute Care Hospitals (Illustrative)

Background: The Medicare-Severity Diagnosis-Related Group (MS-DRG) is a diagnostic classification system used by the Centers for Medicare and Medicaid Services to pay for inpatient hospital services. Specific cases are classified into MS-DRGs based on the principal diagnosis, up to 24 additional diagnoses, and up to 25 procedures performed during the stay. In certain circumstances, additional factors may be associated with classification.

MS-DRG	Description	Relative Weight	Geometric Mean Length of Stay	*2022 Medicare Facility Payment
870	SEPTICEMIA OR SEVERE SEPSIS WITH MV >96 HOURS	6.4390	12.4	$42,460.31
871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITH MCC	1.8722	4.8	$12,345.74
872	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS WITHOUT MCC	1.0263	3.5	$6,767.67
312	SYNCOPE AND COLLAPSE	0.8387	2.3	$5,530.59
314	OTHER CIRCULATORY SYSTEM DIAGNOSES WITH MCC	2.0847	4.8	$13,747.01
315	OTHER CIRCULATORY SYSTEM DIAGNOSES WITH CC	0.9734	2.8	$6,418.83
316	OTHER CIRCULATORY SYSTEM DIAGNOSES WITHOUT CC/MCC	0.7234	1.9	$4,770.27

Note: These payment amounts are not wage index adjusted, and do not include the indirect medical education adjustment, disproportionate share hospital adjustment, uncompensated care, adjustments for readmission, and other hospital value-based program consideration. These payment amounts are specific to prospective payment for cases and assumes no reduction for the post-acute transfer policy and no additional payments for high-cost outliers.

General: ICD-10 Diagnosis Coding (Illustrative)

Description	ICD-10-CM
Severe sepsis without septic shock (*MCC)	R65.20
Severe sepsis with septic shock (*MCC)	R65.21
Sepsis due to streptococcus, group A (*MCC)	A40.0
Sepsis due to streptococcus, group B (*MCC)	A40.1
Sepsis due to Streptococcus pneumoniae (*MCC)	A40.3
Sepsis due to Methicillin resistant Staphylococcus aureus (*MCC)	A41.02
Postprocedural hypotension	I95.81
Other hypotension	I95.89

*Note: MCCs and CCs apply when listed as a secondary diagnosis.

General: ICD-10 Procedure Coding (Illustrative)

Description	ICD-10-PCS
Monitoring of Cardiac Output, External Approach	4A12X9Z
Monitoring of Cardiac Rate, External Approach	4A12XCZ
Measurement of Cardiac Action Currents, External Approach	4A02XPZ
Measurement of Cardiac Total Activity, External Approach	4A02XM4

Physician Fee Schedule Coding: Physician Services (Illustrative)

Background: The CPT code set is a system used to classify physician procedures and services. RVUs are the mechanism that assigns payment valuations to CPT codes based on consumption of time, effort, and financial cost involved in providing a service to patients. RVUs are converted to dollar amounts using a nationally established 'Conversion Factor'. Many procedure codes, such as those used to report diagnostic tests, may be billed as either a professional or technical component to reflect different aspects of the service. The professional component relates to the physician work (e.g.,

physician time, intensity, supervision, interpretation, and documentation by the physician or other health care professional) and some associated overhead costs. The technical component reflects the direct costs incurred by the billing provider to perform the service (e.g., acquisition and provisioning of equipment, supplies, and clinical personnel) The professional component is reported with a modifier "26" and the technical component is billed with a "TC" modifier. When the same provider performs both aspects of the service, no modifier is necessary and total payment for both aspects of the service is made.

Hospital Care Evaluation and Management (E&M) Codes

CPT Code	Description	History	Examination	Medical Decision Making	Time Spent (bedside/floor/unit)	Facility RVUs	Payment to the MD/DO in the Facility Setting
99221	Initial hospital care, per day, for the evaluation and management of a patient	Detailed or Comprehensive	Detailed or Comprehensive	Straightforward or Low Complexity	30 Minutes (typically)	2.91	$100.70
99222	Initial hospital care, per day, for the evaluation and management of a patient	Comprehensive	Comprehensive	Moderate Complexity	50 Minutes (typically)	3.91	$135.31
99223	Initial hospital care, per day, for the evaluation and management of a patient	Comprehensive	Comprehensive	High Complexity	70 Minutes (typically)	5.73	$198.29
99231*	Subsequent hospital care, per day, for the evaluation and management of a patient	Problem Focused Interval	Problem Focused	Straightforward or Low Complexity	15 Minutes (typically)	1.12	$38.76
99232*	Subsequent hospital care, per day, for the evaluation and management of a patient	Expanded Problem Focused Interval	Expanded Problem Focused	Moderate Complexity	25 Minutes (typically)	2.06	$71.29
99233*	Subsequent hospital care, per day, for the evaluation and management of a patient	Detailed Interval	Detailed	High Complexity	35 Minutes (typically)	2.96	$102.43

*Note: Two of three component (History, Examination, Medical Decision Making) characteristics must be present.

Critical Care E&M Codes

CPT Code	Description	Facility RVUs	Payment to the MD/DO in the Facility Setting
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	6.33	$219.06
99292	Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)	3.18	$110.05

Product Codes

Product Codes	Description
CMMST5	Starling Monitor
CMS5	Starling Sensors (5)
CMS10	Starling Sensors (10)
CMS25	Starling Sensors (25)
CMASRS20S1	Starling Roll Stand
CMASC10	Starling Patient Cable
CMANIBP	Starling Blood Pressure Module
CMALIFT	Passive Leg Raise (PLR) Lift
CMARRTBAG	Starling Rapid Response Team Bag
CMASSIM	Starling Simulator

Disclaimer: This is a selection of codes that may describe diagnoses related to fluid assessment and monitoring procedures. This has been prepared and is intended for informational purposes only. Coding constantly changes so please reference the American Medical Association, the American Hospital Association, the Centers for Medicare and Medicaid Services and your local contractors for additional information. This is not a comprehensive list of codes and is not intended to increase or maximize reimbursement. It does not represent a guarantee, promise or statement that the use of the codes will ensure coverage, reimbursement, payment or charges at any particular level. The decision as to how to complete a claim form, including the amounts to bill, is exclusively the responsibility of the provider. Healthcare professionals and hospitals should confirm with a particular payor or coding authority, such as the American Medical Association or medical specialty society, which codes or combinations of codes are appropriate for a particular procedure or combination procedures.

Notes: Physician payment amounts reflect national Medicare fee-for-service rates in Calendar Year (CY) 2022 as per the CMS published RVU file version A. Medicare reimburses 80% of the listed payment rates for physician services. The remaining 20% is covered by supplemental insurance or paid out-of-pocket by patients. ICD-10 procedure codes are only used for inpatient services and impact inpatient (hospital) reimbursement. Payment information represents Medicare national payment rates. Providers can determine the Medicare payment of their geographical area here https://apps.ama-assn.org/CptSearch/user/search/cptSearch.do.

Definitions: MCC = Major Complications or Comorbidities; CC = Complications or Comorbidities; ICD-10 = International Classification of Diseases, Tenth Revision; CPT = Current Procedural Terminology; RVU = Relative Value Unit

Sources: American Medical Association. 2022 Current Procedural Terminology (CPT) Professional Edition; American Medical Association. ICD-10-CM 2022: The Complete Official Code Book.; CMS. Calendar Year (CY) 2022 Inpatient Prospective Payment Systems (IPPS) Final Rule; CMS. CY 2022 Medicare Physician Fee Schedule (PFS) Final Rule