

GuidePoint

Simplifying Reimbursement

Cardiac, Rhythm and Vascular

Boston Scientific is pleased to provide you with the following summary of the August 1, 2011 Centers for Medicare & Medicaid Services (CMS) hospital Inpatient Prospective Payment System (IPPS) Final Rule (FR) for fiscal year (FY) 2012. This rule is effective October 1, 2011. See the table at the end of this document for select cardiovascular MS-DRG payment changes for FY2012.

IPPS HIGHLIGHTS

Overall, FY2012 Final reimbursement rates increased 1.0% on average compared to 2011 rates. The annual inflation update (+3.0%) is adjusted downward to (1) pay for insurance coverage expansion under health reform and (2) offset higher payments by Medicare in FY2008 and FY2009 as hospitals improved coding and billing in response to the new DRG system introduced in FY2008.

Focus on Quality and Outcomes

Medicare continues to increase incentives for hospitals to improve quality and outcomes. One example is the Hospital Readmissions Reduction program required under the Affordable Care Act. Under this program, CMS has instituted measures for 30-day readmission rates for conditions such as acute myocardial infarction and heart failure, with additional conditions to be added in future years. Hospitals that are determined to have excess readmissions within 30 days of discharge for these conditions will receive lower reimbursement effective FY2013.

Details around two other programs at the center of Medicare's pay-for-outcomes transition were also addressed in the process of making this FR. The first, the Inpatient Quality Reporting (IQR) program, requires hospitals to submit quality data to Medicare. The second, the Value-based Purchasing Program (VBP), rewards hospitals that perform better than their peers as measured on a subset of IQR quality measures. As we've noted in the past, CMS envisions expanding the scope of both programs moving forward.

Under the IQR and consistent with previous years, annual payment updates will be reduced 2% for hospitals not submitting quality data. The program will be expanded in FY2014 and FY2015 by increasing the number of measures from 45 to 76. A few cardiovascular measures will be removed from the IQR program including four acute myocardial infarction (AMI) measures and one heart failure (HF) measure. While CMS did not finalize the addition of the quality measure under hospital acquired conditions titled "Acute Renal Failure after Contrast Administration" or contrast-induced acute kidney injury, reconsideration is planned as part of ICD-10 implementation in FY2013. CMS also proposed possible future quality measures related to cardiovascular procedures including mortality for aortic valve replacement, percutaneous coronary intervention (PCI) 30-day risk standardized readmission rate, and ICD complications. Whether these particular measures will be put in place is undecided at this time.

In an effort to promote bundled care approaches, Medicare has added a new measure of resource use to the data collection requirements. This measure will require reporting of total Medicare spending per episode of care. The episode will include three days before through 30 days after an inpatient admission. Hospitals will need to capture total spending during this time period, including spending for physicians and other non-hospital providers, thus incenting hospitals to focus on the overall episode of care, rather than simply hospital costs.

Changes to Rule Components

- Medicare payment for replacement devices was finalized to be consistent with Outpatient Prospective Payment System (OPPS) partial credit policy for these devices. The Final Rule stipulates the IPPS policy applies where the hospital receives a credit equal to 50% or more of the cost of the replacement device.
- Two new cardiac-specific complications; 425.11 Hypertrophic obstructive cardiomyopathy, and 425.18 Other Hypertrophic cardiomyopathy were added to the MS-DRG CC list. (Note: 425.1 Hypertrophic obstructive cardiomyopathy will be deleted).
- Implementation of the new ICD-10 code set is planned for October 1, 2013. As part of this process, the last regular updates to the ICD-9 and -10 code lists will be made October 1, 2011. October 2012 and 2013 updates will include only those codes necessary for new technologies and diseases. Regular updates to the new ICD-10 code list will begin October 1, 2014.
- Final regulations were updated to expand the definition of “discharges” as it applies to Medicare beneficiaries with End Stage Renal Disease (ESRD) who receive dialysis during their hospital stay. The update will include all beneficiaries covered under Medicare Part A.

SPECIFIC PAYMENT CHANGES

Cardiac Rhythm Management (CRM) and Electrophysiology (EP)

The weighted average financial impact to Cardiac Rhythm Management (CRM) and select Electrophysiology (EP) MS-DRGs increased overall for FY2012:

- ICD and CRT-D system implant base payment rates increase by 1.21%.
- Pacemaker and CRT-P system implant base payment rates increase by 0.53%.
- ICD and CRT-D system replacement base payment rates decrease by 0.19%.
- Pacemaker and CRT-P system replacement base payment rates increase by 2.39%.
- EP/Ablation base payment rates increases by 2.78%.*

Interventional Cardiology

- Drug-eluting stent procedure weighted average base payment increase of 1.28% for the two DRGs related to DES
 - Payment for MS-DRG 246 patients (i.e. a drug-eluting stent procedure for a patient with major complications or comorbidities) increased by 0.60% (\$107) to \$17,866.
 - For the treatment of patients without major complications or comorbidities (MS-DRG 247), hospital reimbursement will increase by 1.54% (\$169) to \$11,165.
- Bare-metal stent procedure weighted average increase of 2.48% across the two MS-DRGs
 - MS-DRG 248 up 1.35% (\$221) to \$17,103 and MS-DRG 249 up 3.12% (\$309) to \$10,210.

Structural Heart

Valves

- Five new hospital inpatient ICD-9-CM procedure codes for valve via either an endovascular or transapical approach are effective October 1, 2011 (FY2012). The new codes are grouped with open valve procedures DRGs with a reimbursement range of \$24,500 to \$54,500.
 - Two Aortic codes, one for endovascular (35.05) and one for transapical (35.06) approach
 - Two Pulmonary codes, one for endovascular (35.07) and one for transapical (35.08) approach.
 - One generic endovascular valve code (35.09 includes intercostal or transventricular approach).

Peripheral Interventions

- MS-DRGs related to peripheral percutaneous vascular interventions (e.g. MS-DRGs 252,253, and 254 that include PTA, stenting and embolization procedures) **increase** 2.15% to \$13,357.

* BSC has no ablation catheter FDA-approved for treatment of Atrial Fibrillation.

SELECT CARDIOVASCULAR MS-DRG FY2012 FINAL PAYMENT CHANGES

The table below shows the final FY2012 MS-DRG payment rates for select cardiovascular procedures and the percent change as compared to FY2011 MS-DRG rates. The rates and percent changes shown are base payments. Actual rates may vary for individual hospitals due to geographic wage differences.

FY 2012 MS DRG*	Procedure	FY 2012 Final Rate	% Change (FY 2011-FY 2012)
ICD & CRT-D System Implants			
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC***	\$48,882	2.71%
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	\$35,650	(0.64%)
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	\$43,447	2.62%
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	\$33,512	(0.32%)
226	Cardiac defibrillator implant w/o cardiac cath w MCC	\$38,233	6.13%
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	\$29,000	(0.01%)
Weighted Average ** ICD & CRT-D Percent change (FY11-FY12)		\$32,964	1.21%
ICD Replacements			
245	AICD generator procedures	\$23,632	(0.39)%
265	ICD lead procedures	\$13,027	0.74%
Weighted Average ICD Replacements Percent change (FY11-FY12)		\$20,643	(0.19%)
Pacemaker System Implants			
242	Permanent cardiac pacemaker implant w MCC	\$20,742	(0.36%)
243	Permanent cardiac pacemaker implant w CC	\$14,845	0.29%
244	Permanent cardiac pacemaker implant w/o CC/MCC	\$11,565	1.54%
Weighted Average Pacemaker System Implants Percent change (FY11-FY12)		\$14,561	0.53%
Pacemaker Revisions and PG Replacements			
258	Cardiac pacemaker device replacement w MCC	\$16,732	3.75%
259	Cardiac pacemaker device replacement w/o MCC	\$10,258	0.20%
260	Cardiac pacemaker revision except device replacement w MCC	\$20,439	3.10%
261	Cardiac pacemaker revision except device replacement w CC	\$9,432	2.57%
262	Cardiac pacemaker revision except device replacement w/o CC/MCC	\$6,620	5.41%
Weighted Average Pacemaker Rev or Repl. Percent Change (FY11 – FY12)		\$11,173	2.39%
Electrophysiology Procedures			
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	\$16,286	1.14%
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	\$10,388	3.39%
Weighted Average Electrophysiology Procedures Percent Change (FY11-FY12)		\$11,509	2.78%
Interventional Cardiology			
246	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents	\$17,866	0.60%
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	\$11,165	1.54%
Weighted Average Drug-Eluting Stent Procedures Percent change (FY11-FY12)		\$12,415	1.28%
248	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents	\$16,553	1.35%
249	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	\$10,210	3.11%
Weighted Average Bare Metal Stent Procedures Percent change (FY11-FY12)		\$11,827	2.48%

FY 2012 MS DRG*	Procedure	FY 2012 Final Rate	% Change (FY 2011-FY 2012)
PTCA\Atherectomy			
250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	\$16,286	1.14%
251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	\$10,388	3.39%
Weighted Average PTCA\Atherectomy Procedures Percent Change (FY11-FY12)		\$11,509	2.78%
Diagnostic Catheterization (May include Intravascular Ultrasound-IVUS or ICD)			
286	Circulatory disorders except AMI, w card cath w MCC	\$11,465	2.59%
287	Circulatory disorders except AMI, w card cath w/o MCC	\$6,050	(0.42%)
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	\$48,882	2.71%
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	\$35,650	(0.63%)
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	\$43,447	2.62%
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	\$33,512	(0.32%)
Weighted Average Diagnostic Cath-Procedures Percent Change (FY11-FY12)		\$9,314	0.56%
Structural Heart-Valves			
216	Cardiac valve & oth maj cardiothoracic proc w card cath w MCC	\$54,578	(2.49%)
217	Cardiac valve & oth maj cardiothoracic proc w card cath w CC	\$36,595	(3.68%)
218	Cardiac valve & oth maj cardiothoracic proc w card cath w/o CC/ MCC	\$29,132	(2.11%)
219	Cardiac valve & oth maj cardiothoracic proc w/o card cath w MCC	\$45,508	0.82%
220	Cardiac valve & oth maj cardiothoracic proc w /ocard cath w CC	\$29,621	(1.38%)
221	Cardiac valve & oth maj cardiothoracic proc w/o card cath w/o CC/ MCC	\$24,587	(1.72%)
Weighted Average Heart Valve Procedures Percent Change (FY11-FY12)		\$38,446	(1.27%)
Peripheral Interventions			
252	Other vascular procedures w MCC	\$16,817	1.22%
253	Other vascular procedures CC	\$13,758	2.60%
254	Other vascular procedures w/o CC/MCC	\$9,303	3.15%
Weighted Average Other Vascular Procedures (Includes PTA, stenting and Embolization) (FY11-FY12)		\$13,357	2.15%
34	Carotid artery stent procedure w MCC	\$19,711	0.16%
35	Carotid artery stent procedure w CC	\$12,084	0.94%
36	Carotid artery stent procedure w/o CC/MCC	\$9,320	1.84%
Weighted Average Carotid Artery Stenting (FY11-FY12)		\$11,023	1.29%
760	Menstrual & other female reproductive system disorders w CC/MCC	\$4,444	(5.12%)
761	Menstrual & other female reproductive system disorders w/o CC/MCC	\$2,900	(0.48%)
Weighted Average Uterine Artery Embolization (FY11-FY12)		\$3,925	(4.01%)

* Medicare Severity Diagnosis Related Group

** Weighted Average based on 2010 MedPAR inpatient volume distribution in MS DRGs

*** Major Complications and Comorbidities

COMMENTS/QUESTIONS

For questions related to the reimbursement of **CRM** products, call **1-800-CARDIAC (1-800-227-3422)** and ask for the reimbursement call center.

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Additional Information

Read the full FY [2012 Final IPPS Final Rule](http://www.cms.gov/AcuteInpatientPPS/FR2012/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1250103&intNumPerPage=10)¹
<http://www.cms.gov/AcuteInpatientPPS/FR2012/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1250103&intNumPerPage=10>

- Centers for Medicare and Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2012 Rates; Hospitals' FTE Resident Caps for Graduate Medical Education Payment. August 1, 2011 (Federal Register August 18, 2011).

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