GUIDEPOINT Reimbursement Resources

Boston Scientific
Advancing science for life™

FY2016 Hospital Inpatient Final Rule (IPPS)

Interventional Cardiology
Peripheral Interventions
Rhythm Management

On July 31, 2015, the Centers for Medicare and Medicaid Services (CMS) released the Final Hospital Inpatient Prospective Payment System (IPPS) rates for FY2016 which apply to approximately 3,400 acute care hospitals. CMS' final payment and policy changes will take effect October 1, 2015.

See Table 1 on page 6 for payment rates for procedures of interest to Interventional Cardiology (IC), Peripheral Interventions (PI) and Rhythm Management (RM).

IPPS RULE HIGHLIGHTS

CMS will increase FY2016 payment rates by 0.9% for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) and demonstrate meaningful use of certified Electronic Health Record (EHR) programs. CMS projects total payments will increase by about $120 million in FY2016. (Medicare spends about $120-125 billion on inpatient services each year.)

CMS has created two new DRGs - 273 and 274 - specifically for "percutaneous intracardiac procedures" including intracardiac ablation and the WATCHMAN™ Left Atrial Appendance Closure (LAAC) Device implant. These new DRGs represent a 19% payment increase over the current national base payment rate for these services, effective October 1, 2015. All hospitals performing intracardiac ablation procedures and WATCHMAN implants will benefit immediately on that date, so the DRG reassignment is positive news for those facilities.

CMS changed the Disproportionate Share (DSH) payment methodology so hospitals now receive 25% of the previous formula amount. The remainder, equal to an estimate of 75%, will be distributed to hospitals based on their relative share of the total amount of uncompensated care. The amount of uncompensated care CMS is distributing in FY2016 is $6.4 billion, a decrease of $1.2 billion in FY2015.

See page 5 for important information about the uses and limitations of this document.

The FY2016 IPPS policies that impact payment include four quality pay-for-performance programs (Inpatient Quality Reporting, Value-Based Purchasing, Hospital Acquired Conditions Program, Readmission Reduction Program,) discussed below.

QUALITY PAY FOR PERFORMANCE PROGRAMS

CMS continues to refine various "pay-for-performance" programs to drive improvements in quality and patient outcomes. Change highlights for each program include:

Inpatient Quality Reporting (IQR)

CMS adds seven new measures impacting FY2018 and FY2019 payment determination. For FY2018, two cardiovascular related, claims based measures added include AMI Excess Days and HF Excess Days. The new measures add to the existing list of cardiovascular related measures, which include:

Venous Thromboembolism (VTE) Prophylaxis, Discharged on Statin Medication, Stroke Education, Intensive Care Unit Venous Thromboembolism Prophylaxis, Venous Thromboembolism Patients with Anticoagulation Overlap Therapy, Aspirin Prescribed at Discharge for AMI, and 30 Day Mortality for AMI, HF, Pn, COPD and CAGB.

Value-Based Purchasing (VBP) Program

The VBP program builds upon the current Inpatient Quality Reporting Program, using performance data to adjust payments. In FY2016, the VBP will redistribute 1.5% of hospital payments, which CMS estimates will allow for $1.5 billion in incentive payments. The VBP incentive payments for 2016 will be based on four domains: Outcomes, Efficiency, Clinical Process and Patient Experience. For FY2016 reporting impacting FY2018 payments, CMS is adding a care coordination measure. For FY2018 payment determination, CMS is adding a 30-day mortality measure for chronic obstructive pulmonary disease.

Hospital Acquired Conditions (HAC) Program

Starting in FY2015, hospital acquired condition performance began reducing all inpatient payments by 1% for the poorest performing quartile (25%) of hospitals nationally. For FY2016, CMS will continue reducing payments by 1% for the bottom quartile of hospitals with a few changes to the measurement methodology, including expanding the measured population, adjusting measurement weighting and allowing certain case exemptions.

Readmission Reduction Program (RRP)

CMS is finalizing a refinement of the pneumonia readmission measure that expands the measure cohort. The Hospital RRP will continue to assess hospitals' readmission performance using five readmissions measures endorsed by the National Quality Forum (NQF): heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease, and hip/knee arthroplasty. For FY2016, the maximum reduction in hospital payment for excessive readmissions remains 3%. CMS plans to add a readmission measure for coronary artery bypass graft (CABG) surgical procedures in FY2017.

Short Inpatient Stay (Two-Midnight Rule)

CMS notes that hospitals and physicians continue to voice concern over the two-midnight rule. CMS is considering this feedback and MedPAC recommendations, stating further discussion related to short inpatient hospitals stays and long outpatient stays will be included with the CY2016 Hospital Outpatient rule that will be released November 2015.

See page 5 for important information about the uses and limitations of this document.

MS-DRG RECLASSIFICATIONS

WATCHMAN and cardiac ablation procedures are positively affected by reclassifications into two newly created DRGs for "percutaneous intracardiac procedures" (MS-DRG 273 and 274) from the prior assignment (MS-DRG 250 and 251). This change represents a 19% increase in the national base payment rate for these services.

New MS-DRGs also include MS-DRGs 270-272, 252- 254, or 263. Thrombectomy will now map to one of these seven MS-DRGs as a result of the implementation of ICD-10 procedure codes. Former MS-DRGs applicable to thrombectomy have been deleted.

NEW TECHNOLOGY ADD-ON PAYMENT (NTAP) APPLICATIONS

For FY2016, CMS received a total of nine NTAP applications with five applications specific to medical devices. CMS approves NTAPs on the merits of meeting all criteria for newness, high cost threshold, and substantial clinical improvement. One device application, the Angel Medical Guardian® Ischemic Monitoring Device, was withdrawn.

WATCHMAN™ LAAC Device: CMS did not approve the NTAP for the WATCHMAN™ LAAC Device. The NTAP decision has no impact on the National Coverage Determination (NCD) which is evaluated separately and based upon different criteria. It is anticipated that CMS will release a proposed draft of the NCD for LAAC in late November with the opportunity for public comments.

Lutonix® (CR Bard) and IN. PACT™ Admiral™ (Medtronic), peripheral drug-coated balloon (DCB): CMS evaluated both technologies as one application for NTAP. CMS approved the NTAP application for both DCB products, and depending on the actual charges for each case, the hospital can receive an NTAP of up to $1,035.

DIAMONDBACK 360® Coronary Orbital Atherectomy System: CMS did not approve the NTAP application based concerns regarding uniqueness, and other limitations of the clinical trial ORBIT II.

CMS will discontinue NTAP payment for FY2016 for Zilver PTX effective September 30, 2015. CMS will continue NTAP payment for FY2016 for the MitraClip® System and the CardioMEMS Heart Failure System.

TRANSPARENCY OF HOSPITAL CHARGES

CMS reminds hospitals that the Affordable Care Act requires them to provide a list of standard charges to the public and indicated that it will continue disclosing charges itself (as it did with hospital charges and payments to individual physicians). Also, CMS states that charges from hospitals participating in the Bundled Payment Care Initiative would still be used in the rate setting process.

BUNDLED PAYMENT CARE INITIATIVE

In 2011, CMS launched the Bundled Payment Care Initiative (BPCI) linking payment for multiple services during an episode of care into a bundled payment. CMS is continuing to implement the initiative, which is testing four models of care with hundreds of providers across the country.

See page 5 for important information about the uses and limitations of this document.

ICD-10

For inpatient stays with discharge on or after October 1, 2015, ICD-10 diagnosis and procedure codes will replace the current ICD-9 code set (unless Congress once again delays implementation). Hospital customers may find this disruptive as they transition to the new coding system for inpatient procedures and all setting diagnosis codes.

DIVISION SPECIFIC FINAL PAYMENT CHANGES

Interventional Cardiology (% weighted averages shown)

- Drug-eluting stent payment rates to increase by 2.89% ($14,400)
- Bare metal stent payment rates to increase by 1.92% ($13,755)

IC Structural Heart—Aortic Valves (% weighted average shown)

- 266 Endovascular Cardiac Replacement with MCC to decrease by 3.86%
- 267 Endovascular Cardiac Replacement without MCC to decrease by 2.35%

Peripheral Interventions (% weighted averages shown)

- Peripheral PTA, Stenting, Atherectomy & Embolization payment rates increase by 1.62%
- Thrombectomy payment rates will decrease as a result of MS-DRGs 237 and 238 being deleted and the implementation of ICD-10 procedure codes. Thrombectomy will now map to one of seven MS-DRGs which range in payment from $10,175 to $27,958.

Rhythm Management (% weighted averages shown)

- ICD and CRT-D system implant payment rates increase 0.68%
- ICD and CRT-D system replacement payment rates increase 1.92%
- Pacemaker and CRT-P system implant payment rates are increase 0.54%
- Pacemaker and CRT-P system replacement payment rates increase 1.12%
- Intracardiac Ablation and WATCHMAN payment rates increase by 19.33%
    - CMS reassigned WATCHMAN and Intracardiac Ablation procedures from MS-DRGs 250 and 251 to new MS-DRGs 273 and 274 to better reflect higher resource costs and the alignment to ICD-10 procedure coding.

See page 5 for important information about the uses and limitations of this document.

COMMENTS / QUESTIONS

If you have questions or would like additional information contact:

Interventional Cardiology (IC)
Deb Lorenz – IC
763-494-2112
Deb.lorenz@bsci.com

Peripheral Interventions (PI)
Brent Hale – PI
763-494-1448
Brent.Hale@bsci.com

Rhythm Management (RM)
Call 1-800-CARDIAC (request Reimbursement Support)
CRM.Reimbursement@bsci.com

ADDITIONAL INFORMATION

Read the full FY2016 Final IPPS Rule (CMS-1632-F) at the following link:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Regulations.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending

MS-DRG	Procedure	FY 2016 Final Rate	FY 2015 Final Rate	$ Change (FY2016 Final - FY2015 Final)	% Change (FY2016 Final - FY2015 Final)
Interventional Cardiology					
Drug-Eluting Stents					
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC	**$19,187**	$19,009	$178	0.94%
247	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC	**$12,581**	$12,090	$491	4.06%
Bare Metal Stents					
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC	**$18,125**	$17,860	$265	1.48%
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC	**$11,302**	$11,046	$256	2.32%
Angioplasty or Atherectomy without Stent					
250	Perc cardiovasc proc w/o coronary artery stent w MCC	**$15,928**	$17,551	($1,623)	-9.25%
251	Perc cardiovasc proc w/o coronary artery stent w/o MCC	**$9,957**	$11,980	($2,023)	-16.89%
Endovascular Cardiac Valve Replacement (TAVR)					
266	Endovascular Cardiac Valve Replacement w MCC	**$50,772**	$52,808	($2,036)	-3.86%
267	Endovascular Cardiac Valve Replacement w/o MCC	**$38,720**	$39,652	($932)	-2.35%
WATCHMAN™ LAAC Device					
273	Perc cardiovasc proc w/o coronary artery stent w MCC ***	**$20,961**	$17,551	$3,410	19.43%
274	Perc cardiovasc proc w/o coronary artery stent w/o MCC ****	**$14,288**	$11,980	$2,308	19.27%
Peripheral Interventions					
Peripheral PTA, Stent, Atherectomy & Embolization					
252	Other vascular procedure w MCC	**$19,410**	$19,172	$238	1.24%
253	Other vascular procedure w CC	**$15,369**	$14,994	$375	2.50%
254	Other vascular procedure w/o MCC/CC	**$10,175**	$10,162	$13	0.12%
Peripheral Thrombectomy (Deleted) **					
237	Major cardiovascular procedures w MCC *	**N/A**	$29,859	N/A	N/A
238	Major cardiovascular procedures w/o MCC *	**N/A**	$20,109	N/A	N/A
Peripheral Thrombectomy (New Mapping) **					
270	Other major cardiovascular procedures w/ MCC *	**$27,958**	N/A	N/A	N/A
271	Other major cardiovascular procedures w/ CC *	**$18,556**	N/A	N/A	N/A
272	Other major cardiovascular procedures w/o MCC/CC *	**$13,290**	N/A	N/A	N/A
252	Other vascular procedure w MCC **	**$19,410**	$19,172	$238	1.24%
253	Other vascular procedure w CC **	**$15,369**	$14,994	$375	2.50%
254	Other vascular procedure w/o MCC/CC **	**$10,175**	$10,162	$13	0.12%
263	Vein Ligation and Stripping **	**$12,314**	$10,961	$1,353	12.34%
Rhythm Management					
ICD Systems					
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	**$50,301**	$50,841	($540)	-1.06%
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	**$37,806**	$36,954	$852	2.31%
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	**$44,959**	$45,064	($105)	-0.23%
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	**$34,579**	$34,421	$158	0.46%
226	Cardiac defibrillator implant w/o cardiac cath w MCC	**$41,178**	$40,859	$319	0.78%
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	**$32,367**	$32,003	$364	1.14%
ICD Replacements					
245	AICD generator procedures	**$27,672**	$27,300	$372	1.36%
265	AICD Lead procedures	**$17,526**	$16,820	$706	4.20%
Pacemaker Systems					
242	Permanent cardiac pacemaker implant w MCC	**$22,341**	$21,872	$469	2.15%
243	Permanent cardiac pacemaker implant w CC	**$15,614**	$15,677	($63)	-0.40%
244	Permanent cardiac pacemaker implant w/o CC/MCC	**$12,633**	$12,659	($26)	-0.20%
Pacemaker Revisions and PG Placements					
258	Cardiac pacemaker device replacement w MCC	**$16,882**	$16,217	$665	4.10%
259	Cardiac pacemaker device replacement w/o MCC	**$11,488**	$11,701	($213)	-1.82%
260	Cardiac pacemaker revision except device replacement w MCC	**$22,024**	$21,997	$27	0.12%
261	Cardiac pacemaker revision except device replacement w CC	**$11,006**	$10,895	$111	1.02%
262	Cardiac pacemaker revision except device replacement w/o CC/MCC	**$8,931**	$8,209	$722	8.79%
Cardiac Catheter Ablation					
273	Percutaneous Intracardiac Procedures w MCC ***	**$20,961**	$17,551	$3,410	19.43%
274	Percutaneous Intracardiac Procedures w/o MCC ****	**$14,288**	$11,980	$2,308	19.27%

* MS-DRGs 237-238 have been deleted in FY16 and replaced with new MS-DRGs 268-272.

** Implementation of ICD-10 Procedure Codes will result in select thrombectomy procedures mapping to other existing DRGs in FY2016 compared to FY2015

***CMS has moved intra-cardiac ablation procedures and WATCHMAN procedures from MS-DRG 250 to MS-DRG-273. Therefore the FY15 rate is for MS-DRG 250 and the FY16 rate is for new MS-DRG 273.

****CMS has moved intra-cardiac ablation procedures and WATCHMAN procedures from MS-DRG 251 to MS-DRG-274. Therefore the FY15 rate is for MS-DRG 251 and the FY16 rate is for new MS-DRG 274.

Please Note: Boston Scientific currently has no FDA-approved ablation catheters for the treatment of atrial fibrillation

See page 5 for important information about the uses and limitations of this document.