

MEDICARE ISSUES HOSPITAL INPATIENT POLICY AND PAYMENT PROPOSED RULE FOR FY2010

SUMMARY

Boston Scientific is pleased to provide you with the following summary of the Centers for Medicare and Medicaid Services (CMS) Inpatient Prospective Payment System (IPPS) Proposed Rule (PR) for Fiscal Year (FY) 2010 as posted May 1, 2009 at <http://www.cms.hhs.gov/AcuteInpatientPPS/FY2010RULE/>. (Federal Register on May 6, 2009). CMS' final IPPS rule will be published around August 1 and will go into effect on October 1, 2009. See Table 1 at the end of this document for select cardiovascular MS-DRG proposed payment changes for FY2010.

In general, proposed payment changes for interventional cardiology and peripheral interventional procedures are minimal.

While the overall payment rates went up by 0.2% overall, this percent includes a reduction of 1.9% to account for hospitals improving their coding in FY2008 when the new MS-DRG system was implemented.

Note that, due to other proposed policy changes, the actual result is an overall slight decline reflecting a combination of low input inflation plus a combination of downward adjustments required by law. In fact, CMS moderated the reductions required by the coding adjustment in recognition of the current economic conditions faced by hospitals.

While the payment level changes differ between the MS-DRGs, the average percentage changes proposed for select MS-DRGs typically associated with various percutaneous cardiovascular interventions are as follows:

- IC: Increase of 0.1% for select IC procedures
- PI: Increase of 2% for select PI procedures

Hospitals Must Report on 44 Quality Measures in FY2010 to Receive Full Update in FY2011

CMS increased the number of quality measures that hospitals must report to CMS from the current 30 measures to a total of 44 by adding fifteen and retiring one. Of the new measures, 13 were adopted in the FY2009 Final Rule and the remaining 2 were finalized in the Outpatient Final Rule. In 2010, hospitals that failed to submit quality data for 2009 will face a two percentage point decrease applied to their payment rates (in other words receive a 1.8% decrease rather than a 0.2% increase in FY2010). Below is the one retired quality measure and top line summary for 2010-2011:

- The Acute Myocardial Infarction (AMI) measure for beta blocker at arrival is proposed to be retired
- CMS is proposing to retain the 44 FY 2010 quality measures for FY2011

Important -- Please Note: Reimbursement information provided by Boston Scientific Corporation is gathered from third-party sources and is presented for illustrative purposes only. This information does not constitute reimbursement or legal advice. Boston Scientific makes no representation or warranty regarding this information or its completeness, accuracy, timeliness, or applicability with a particular patient. Boston Scientific specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on information in this document. Boston Scientific encourages providers to submit accurate and appropriate claims for services. Laws, regulations and payer policies concerning reimbursement are complex and change frequently. Providers are responsible for making appropriate decisions relating to coding and reimbursement submissions. Accordingly, Boston Scientific recommends that you consult with your payers, reimbursement specialist and/or legal counsel regarding coding, coverage and reimbursement matters.

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No changes proposed to the 10 current categories of preventable conditions (hospital acquired conditions - HACs) for which CMS would not make payment if acquired during an inpatient stay. However two additional diagnosis codes were added in the falls/trauma HAC category. The cardiovascular related HAC category includes CABG surgical site infection.

WHAT ARE SOME OF THE SPECIFIC CHANGES IN PAYMENT?

Overall, the net impact of the proposed changes for hospitals would be basically neutral. However, as noted above, payment would be reduced by 2% for hospitals that did not report quality data in FY2009. Finally, as can be seen below, there would be some variation in the payment impact depending upon the characteristics of the hospital.

- Urban Hospitals: 0.4% decrease
- Rural Hospitals: 1.3% decrease
- Cardiac Specialty Hospitals: 0.3% increase
- Teaching Hospitals with DSH: 0.3% decrease

Following are update highlights for cardiovascular. All payments in this section are weighted average unless otherwise noted:

Drug-eluting and Bare Metal Stent Procedure Reimbursement

- Coronary drug-eluting stent procedure weighted average reimbursement increased 0.2%, while bare-metal stent reimbursement increased by a weighted average of 2.7% due to the case mix across the MS-DRG pairs
 - Payment for MS-DRG 246 patients (i.e. a drug-eluting stent procedure for a patient with major complications or comorbidities) would decrease by 1.1% to \$17,287 (\$186 less than last year)
 - For the treatment of patients with complications or comorbidities, the hospital reimbursement would increase by 0.6% to \$10,682 (an increase of \$62) for MS-DRG 247

Peripheral Procedures

- Carotids proposed to have a weighted average increase of 1.0%
- Peripheral vascular stenting proposed to have a weighted average increase of 1.2%
- Biliary and esophageal stenting proposed to have a weighted average **decrease** of 1.6%

Cardiac Rhythm Management and EP Procedures

- Payment rates for ICD and CRT-D system implants would remain flat
- Payment rates for pacemaker and CRT-P system implant decrease by a weighted average of 1.2%
- Overall payment rates for ICD and CRT-D replacements would increase by a weighted average of 2.6%

Overall, payment rates for cardiac ablation cases would decrease by a weighted average of 0.2%.

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DRAFTING AND SENDING PUBLIC COMMENTS

Boston Scientific will continue to analyze the FY2010 Proposed Rule for inpatient hospital payment, and we look forward to addressing CMS' proposed changes through the public comment process.

Whether you or your institution agrees or disagrees with the proposed changes, you should determine whether you want to participate in the public comment process. Providing detailed comments to CMS regarding the impact of these changes to both your hospital and your patients may make a difference in the final payment policy for hospital inpatient services for FY2010 and beyond.

Comments must be submitted to CMS no later than 5 p.m. on Tuesday, June 30, 2009.

When commenting to CMS on this proposed rule be sure to reference the file code CMS-1406-P when submitting comments. Comments can be submitted electronically at <http://www.regulations.gov>, via regular or Express/overnight mail or delivered by hand or courier to either CMS' Washington, DC or Baltimore, MD offices. For address information, please refer to pages 2-4 of the display copy of the PR, which can be found under regulations at the following link: <http://www.cms.hhs.gov/AcuteInpatientPPS/FY2010RULE/> Please allow enough time for comments to be received by CMS before the close of the comment period.

COMMENTS/QUESTIONS

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USPG5446.160.0 0 May09

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Table 1: Summary of Proposed FY2010 Select Cardiovascular MS-DRG Payments*

Procedure	MS-DRG	MS-DRG Descriptor	PR2010 Urban Payment	FY2009 Urban Payment (Final)	\$ Variance 2009 vs. 2010 Proposed	% Variance 2009 vs. 2010 Proposed
Interventional Cardiology						
Drug-eluting Stents	246	Perc cardiovasc proc w drug-eluting stent w MCC or 4+ vessels/stents	\$17,287	\$17,473	(\$186)	(1.06%)
	247	Perc cardiovasc proc w drug-eluting stent w/o MCC	\$10,682	\$10,620	\$62	0.58%
Non-drug-eluting or Bare Metal Stents	248	Perc cardiovasc proc w non-drug-eluting stent w MCC or 4+ ves/stents	\$15,857	\$15,573	\$284	1.82%
	249	Perc cardiovasc proc w non-drug-eluting stent w/o MCC	\$9,384	\$9,103	\$281	3.09%
ICD	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	\$47,242	\$48,011	(\$769)	(1.60%)
	223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	\$34,781	\$34,906	(\$125)	(0.36%)
	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	\$42,115	\$44,155	(\$2,040)	(4.62%)
	225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	\$32,594	\$32,764	(\$170)	(0.52%)
PTCA	250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	\$15,296	\$16,611	(\$1,315)	(7.92%)
	251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	\$9,161	\$8,905	\$256	2.87%
Diagnostic Cath (may include IVUS)	286	Circulatory disorders except AMI, w card cath w MCC	\$10,897	\$10,977	(\$80)	(0.73%)
	287	Circulatory disorders except AMI, w card cath w/o MCC	\$5,741	\$5,693	\$48	0.84%
Peripheral Interventions						
Carotid Stenting	034	Carotid artery stent procedure w MCC	\$17,863	\$17,890	(\$27)	(0.15%)
	035	Carotid artery stent procedure w CC	\$11,281	\$11,231	\$50	0.45%
	036	Carotid artery stent procedure w/o CC/MCC	\$8,828	\$8,703	\$125	1.44%
PTA, Peripheral Vascular Stenting	252	Other vascular procedures w MCC	\$16,410	\$16,408	\$2	0.01%
	253	Other vascular procedures w CC	\$12,728	\$12,518	\$210	1.68%
	254	Other vascular procedures w/o CC/MCC	\$8,802	\$8,565	\$237	2.77%
Peripheral Stenting-Biliary	005	Liver transplant w MCC or intestinal transplant	\$59,922	\$60,068	(\$146)	(0.24%)
	006	Liver transplant w/o MCC	\$27,682	\$27,118	\$564	2.08%
	420	Hepatobiliary diagnostic procedures w MCC	\$23,378	\$22,814	\$564	2.47%
	421	Hepatobiliary diagnostic procedures w CC	\$9,632	\$10,527	(\$895)	(8.50%)
	422	Hepatobiliary diagnostic procedures w/o CC/MCC	\$6,580	\$6,821	(\$241)	(3.53%)
	435	Malignancy of hepatobiliary system or pancreas w MCC	\$9,608	\$9,553	\$55	0.58%
	436	Malignancy of hepatobiliary system or pancreas w CC	\$6,562	\$6,619	(\$57)	(0.86%)
	437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	\$4,935	\$5,292	(\$357)	(6.75%)
	444	Disorders of the biliary tract w MCC	\$8,342	\$8,653	(\$311)	(3.59%)
	445	Disorders of the biliary tract w CC	\$5,739	\$5,769	(\$30)	(0.52%)
446	Disorders of the biliary tract w/o CC/MCC	\$4,010	\$4,015	(\$5)	(0.12%)	

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Peripheral Interventions Continued						
Chemoembolization of Liver Tumors	435	Malignancy of hepatobiliary system or pancreas w MCC	\$9,608	\$9,553	\$55	0.58%
	436	Malignancy of hepatobiliary system or pancreas w CC	\$6,562	\$6,619	(\$57)	(0.86%)
	437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	\$4,935	\$5,292	(\$357)	(6.75%)
	846	Chemotherapy w/o acute leukemia as secondary diagnosis w MCC	\$12,102	\$11,811	\$291	2.46%
	847	Chemotherapy w/o acute leukemia as secondary diagnosis w CC	\$5,281	\$5,231	\$50	0.96%
	848	Chemotherapy w/o acute leukemia as secondary diagnosis w/o CC/MCC	\$4,566	\$4,425	\$141	3.19%
Uterine Fibroid Embolization	760	Menstrual & other female reproductive system disorders w CC/MCC	\$4,403	\$4,406	(\$3)	(0.07%)
	761	Menstrual & other female reproductive system disorders w/o CC/MCC	\$2,752	\$2,789	(\$37)	(1.33%)
Biopsy	264	Other circulatory system O.R. procedures	\$13,890	\$14,064	(\$174)	(1.24%)
	584	Breast biopsy, local excision & other breast procedures w CC/MCC	\$8,215	\$7,956	\$259	3.26%
	585	Breast biopsy, local excision & other breast procedures w/o CC/MCC	\$4,783	\$4,462	\$321	7.19%
Drainage	405	Pancreas, liver & shunt procedures w MCC	\$31,307	\$31,319	(\$12)	(0.04%)
	406	Pancreas, liver & shunt procedures w CC	\$15,002	\$15,468	(\$466)	(3.01%)
	407	Pancreas, liver & shunt procedures w/o CC/MCC	\$10,086	\$10,210	(\$124)	(1.21%)
	408	Biliary tract proc except only cholecyst w or w/o c.d.e. w MCC	\$23,473	\$23,645	(\$172)	(0.73%)
	409	Biliary tract proc except only cholecyst w or w/o c.d.e. w CC	\$13,006	\$14,242	(\$1,236)	(8.68%)
	410	Biliary tract proc except only cholecyst w or w/o c.d.e. w/o CC/MCC	\$9,020	\$9,143	(\$123)	(1.35%)
	656	Kidney & ureter procedures for neoplasm w MCC	\$18,125	\$18,203	(\$78)	(0.43%)
	657	Kidney & ureter procedures for neoplasm w CC	\$10,322	\$10,342	(\$20)	(0.19%)
	658	Kidney & ureter procedures for neoplasm w/o CC/MCC	\$7,673	\$7,643	\$30	0.39%
	659	Kidney & ureter procedures for non- neoplasm w MCC	\$18,335	\$18,518	(\$183)	(0.99%)
660	Kidney & ureter procedures for non- neoplasm w CC	\$10,125	\$10,505	(\$380)	(3.62%)	
661	Kidney & ureter procedures for non- neoplasm w/o CC/MCC	\$7,178	\$6,976	\$202	2.90%	

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*Source: FY2009 Oct 3, 2008 Federal Register (update) National average (Full Update) MS- DRG rates calculated using the national full update standardized labor, non-labor and capital amounts (\$5,552.58). FY2010 calculated using the national full update standardized labor, non-labor and capital amounts (\$5,548.23).