

Medicare Announces Final CY2008 Payment Rates for Physicians, Outpatient Hospitals and Ambulatory Surgery Centers (ASCs)



MEDICARE PUBLISHES FINAL RULES (FR) DETAILING PHYSICIAN AND OUTPATIENT HOSPITAL PAYMENT POLICY CHANGES AND CONFIRMING ASC PAYMENT FOR CALENDAR YEAR (CY) 2008

Boston Scientific is providing you with the following update on the Centers for Medicare and Medicaid Services' (CMS') Final Rules, published on November 1, 2007 for physician, outpatient hospital, and ASC payment and policy. The Rules can be found at the CMS website www.cms.hhs.gov. These changes will become effective January 1, 2008.

Sections of this document include: 1) physician top line summary; 2) outpatient hospital top line summary; 3) ASC top line summary; and 4) summary payment tables for select cardiovascular procedures.

PHYSICIAN PAYMENT TOP LINE SUMMARY

Across all categories, physicians will face an estimated 10.1% reduction in payments for CY2008 as a result of the "sustainable growth rate" (SGR), which is CMS' way of calculating the annual adjustment in physicians' fees. The average impacts for select cardiovascular in-facility procedures are as follows:

Interventional Cardiology: Down 11%
Peripheral Interventions: Down 8%

For additional detail on physician payment changes for specific cardiovascular procedures, please refer to Table 1 at the end of this document.

Diagnostic Catheterization Values Published for Offices / Independent Diagnostic Testing Facilities (IDTFs)

CMS published values for numerous cardiac catheterization codes that were previously "carrier priced." This means that physicians will no longer have to negotiate payment with individual Medicare contractors, making claims processing and consistency of payment rates more dependable. Of particular interest, this change will impact the following codes in 2008:

- 93501 Right heart catheterization;
- 93508 Catheter placement;
- 93510 Left heart catheterization;
- 93526 Combined right and left heart catheterization;
- 93539-93540, 93542-93545 Injection; and
- 93555-93556 Imaging supervision and interpretation.

No Changes in 2008 to Payment for Recall-Related Services

CMS declined to make any specific changes in physician payment policy related to recall-related services for 2008; therefore, physicians will continue to be paid for these services. CMS will continue to consider how to address recall-related costs in future rule-making.


Payment for Peripheral Percutaneous Transluminal Angioplasty (PTA) Continues to Decrease

CMS reduced 2008 payment for in-office PTA by an average of 16% (from \$2,815 to \$2,367) and for facility-based PTA by an average of 11% (from \$402 to \$358).

No Expansion of Physician Quality Reporting Initiative (PQRI) Measures of Interest to Interventional Cardiologists, Vascular Surgeons and Interventional Radiologists in 2008

As part of its ongoing quality initiative, CMS had proposed to expand the list of quality measures in 2008 from the 74 used in 2007 including some measures of interest to interventional cardiologists, vascular surgeons and interventional radiologists. Ultimately, CMS declined to finalize measures related to the management of patients with atrial fibrillation, vascular access for patients undergoing hemodialysis and perioperative cardiac risk assessment, as they cannot be implemented by 2008.

In-Office Peripheral Stent Placement Payment Rate Finalized



For the first time, CMS will pay physicians a higher amount for providing peripheral stenting procedures in their offices than they get for treating the patient in the hospital. When physicians perform the procedure in the office the payment will be \$2,183.

OUTPATIENT HOSPITAL PAYMENT TOP LINE SUMMARY

In general, payments to hospitals for outpatient services increase by more than 3.8%. The average impacts for select non-packaged cardiovascular in-facility procedures are as follows:

Interventional Cardiology: Increased 6.6%
Peripheral Interventions: Increased 42.2%
Vascular Surgery: Increase 14.7%

Some of the key impacts of interest to providers of interventional cardiology, vascular surgery and interventional radiology services are described below. For additional detail on outpatient hospital payment changes for specific cardiovascular procedures, please refer to Table 2 at the end of this document.

Drug-Eluting Stents (DES)

DES payment will increase by \$886 (13%) to \$7,543. This increase in payment will help to mitigate the impact of the packaging of IVUS when DES is provided on an outpatient basis.

Non-Drug-Eluting Stents

Bare metal stenting (BMS) payment experienced a smaller increase of \$278 (5%) to \$5,670.

Peripheral Stenting

Payment for peripheral stenting (does not include carotid stenting) will increase by approximately \$1,500 (34%) to \$5,639.

Peripheral PTA and Atherectomy

CMS finalized its proposal to move peripheral atherectomy into the current coronary atherectomy APC, increasing payment to \$5,574 (over 100% from 2007). One important result of this change is that in situations where atherectomy is suboptimal and PTA is provided during the same operative session, total outpatient hospital payment will better address the costs associated with the devices used.

Vena Cava Filters


Outpatient hospital payment for placement of vena cava filters will increase 27% to \$2,714.

Intravascular Ultrasound (IVUS)

Separate payment to hospitals for IVUS, intracardiac echocardiography (ICE) and fractional flow reserve (FFR) will be eliminated in 2008. Moving forward, the cost of these procedures will be packaged into the payment rate for the "primary procedure" (i.e. stent procedures, diagnostic catheterizations, etc.). Notably, CMS will increase outpatient hospital payment for many procedures that utilize IVUS to recognize the costs associated with IVUS and other newly-bundled imaging procedures.

While this change will certainly have an impact on facilities offering IVUS, it is important to note that the majority of IVUS procedures are done on an inpatient basis (only approximately 22% of coronary IVUS, 13% of drug-eluting-stent-related IVUS procedures and 35% of peripheral IVUS procedures are done on an outpatient basis).

Expanded Packaging and Composite APCs Finalized



In order to promote greater efficiency – and try and slow the increase in spending on hospital services – CMS is continuing to reduce the number of procedures that are paid for separately and is instead creating larger “buckets” of payment. This process is being referred to as “packaging,” and it can have a range of payment effects on procedures and the technologies that go with them. CMS finalized packaging for 388 procedures including guidance services, image processing services, intraoperative services (IVUS falls here), imaging supervision and interpretation services, diagnostic radiopharmaceuticals, contrast agents, and observation services. CMS believes packaging creates incentives for efficient delivery of care and that hospitals will continue to make decisions for improved clinical outcomes.

As part of the efficiency initiative, CMS finalized the use of composite APCs. CMS expressed composite APCs encourage even greater hospital efficiencies than their packaging expansion when a single payment for a combination of hospital outpatient services is provided on the same day. Two composite APCs constitute payment for extended outpatient visits with observation.

Outpatient Hospital Quality of Care

CMS will implement new quality measures that are specific to hospital outpatient services. To receive the full OPPTS payment update for CY2009, hospitals must, in 2008, report to Medicare on seven consensus measures specifically chosen for hospital outpatient care. Non-reporting will result in a 2% payment reduction in 2009.

Outlier Payments

The FR decreases the outlier fixed-dollar threshold to \$1,575 in CY2008 from \$1,825 in CY2007. CY2008 outlier payments will be provided when the cost of furnishing a service exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a \$1,575 fixed-dollar threshold.

ASC PAYMENT TOP LINE SUMMARY

As part of the effort to foster efficiency and better equalize payment rates across various sites of service, CMS finalized plans to pay ASCs approximately 65% of Medicare outpatient hospital rates for the same procedure. In addition, CMS is again expanding the list of procedures allowed in the ASC. Specifically, iliac PTA and atherectomy will be added and AV graft and thrombectomy will continue to be covered in ASCs in 2008.

The average impacts for select cardiovascular ASC procedures are as follows:

Peripheral Interventions: Increased 8.7%
Dialysis: Increased 35.2%

For additional detail on ASC payment changes for specific cardiovascular procedures, please refer to Table 3 at the end of this document.

AV Fistula Payment

Payment for AV fistula creation and revision increased by approximately \$1,000 to \$1,605 due to the change in payment calculation methodology.

Other ASC Information

2008 ASC payment for a procedure is capped at the lesser of the OPPTS, ASC or in-office payment rate.

QUESTIONS



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For a more complete list of select cardiovascular products, go to www.bostonscientific.com/ and choose “Reimbursement” to find the document entitled: 2008 Final Physician, Hospital Outpatient and ASC Fee Schedules.

Table 1: CY2008 Final Physician Payments for Select Cardiovascular Procedures

Division	Select CPT® Codes	Modifier As Applicable	Description	FR 2008 In-Office \$ Total	FR 2008 Facility \$ Total	\$ Variance FR 2008 vs. FR 2007 Facility	% Variance FR 2008 vs. FR 2007 Facility
INTERVENTIONAL CARDIOLOGY							
Diagnostic Cath	93501 to 93533	26	Right and/or left heart catheterization	\$760 to \$1762	\$144 to \$458	(\$68) to (\$15)	(13%) to (9%)
PTCA	92982		Percutaneous coronary balloon angioplasty; single vessel	NA	\$535	(\$56)	(9%)
BM & DE Stent	92980		Percutaneous placement of an intracoronary stent(s)	NA	\$721	(\$75)	(9%)
IVUS	92978	26	IVUS initial vessel	NA	\$84	(\$9)	(10%)
PERIPHERAL INTERVENTIONS / VASCULAR SURGERY							
Non-Coronary Angioplasty	35470 to 35476		Percutaneous non-coronary balloon angioplasty	\$1586 to \$3155	\$271 to \$471	(\$55) to (\$34)	(11%) to (10%)
Carotid Stents	37215-37216		Percutaneous placement of an intravascular stent(s), cervical carotid artery with, without embolic protection	NA	\$849 to \$949	(\$114) to (\$138)	(11%) to (14%)
Radiological S&I (Non-Coronary Angioplasty)	75962 to 75978	26	Percutaneous balloon S&I angioplasty, radiological	\$212 to \$416	\$16 to \$59	(\$268) to (\$2)	(91%) to (10%)
Vena Cava Filters	37620		Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular	\$376	\$566	(\$70)	(11%)
Thrombectomy	36870		Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft	\$1,762	\$265	(\$35)	(12%)
Peripheral Stents	37205		Percutaneous placement of an intravascular stent(s), (non-coronary vessel); initial vessel	\$2,183	\$388	(\$60)	(13%)
PV Stent Radiological S&I	75960	26	Non-coronary stent, radiological S&I	\$357	\$37	(\$4)	(11%)
AV Graft	36830		Creation of arteriovenous fistula by other than direct arteriovenous; nonautogenous graft	\$417	\$576	(\$85)	(13%)
Open Aortic Abdominal Aneurysm (AAA)	34830		Open repair of infrarenal aortic aneurysm or dissection	NA	\$1,617	(\$243)	(13%)
	34831		aorto-bi-iliac prosthesis	NA	\$1,694	(\$230)	(12%)
	34832		aorto-bifemoral prosthesis	NA	\$1,751	(\$249)	(12%)

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Table 2: CY2008 Final Outpatient Hospital Payments for Select Cardiovascular Procedures

Procedure	APC 2008 Group	2008 Status Indicator*	FR2008 Final Rate	\$ Payment Variance 2008 vs 2007	% Payment Variance 2008 vs 2007
INTERVENTIONAL CARDIOLOGY					
Diagnostic Cath	80	T	\$2,479	\$201	9%
Atherectomy	82	T	\$5,574	\$1,136	26%
PTCA & Valvuloplasty	83	T	\$2,891	(\$723)	(20%)
Drug-eluting Stent	656	T	\$7,543	\$886	13%
Bare-Metal Stent	104	T	\$5,670	\$278	5%
IVUS - Initial Vessel	Bundled	N	\$0	(\$1,985)	(100%)
IVUS - Additional Vessel	Bundled	N	\$0	(\$2,001)	(100%)
PERIPHERAL INTERVENTIONS					
Non-Coronary Angioplasty	83	T	\$2,891	\$252	10%
Non-Coronary Atherectomy	82	T	\$5,574	\$2,935	111%
Radiological S&I (Non-Cor Angioplasty)	83	Q	\$2,891	\$2,507	653%
Radiological S&I (Non-Cor Atherectomy)	Bundled	N	\$0	(\$384)	(100%)
Vena Cava Filters	91	T	\$2,714	\$579	27%
Thrombectomy	653	T	\$2,577	\$587	29%
Non-Coronary IVUS	Bundled	N	\$0	(\$2,001)	(100%)
Radiological S&I (Non-Cor IVUS)	267	Q	\$152	\$0	0%
Radiological S&I (Non-Cor IVUS Addtl vessel)	Bundled	N	\$0	(\$96)	(100%)
Intravascular Stents	229	T	\$5,639	\$1,431	34%
Radiological S&I (intravascular stent)	Bundled	N	\$0	(\$384)	(100%)
VASCULAR SURGERY					
Hernia Repair	154	T	\$1,954	\$158	9%
Grafts (Vessel repair)	653	T	\$2,577	\$587	29%
AV Fistula	88	T	\$2,469	\$149	6%

Table 3: CY2008 Final ASC Payments for Select Cardiovascular Procedures

Division	CPT®	Abbreviated (Partial) Description	FR2008 Payment)	\$ Variance 2008 vs. 2007	% Variance 2008 vs. 2007
PERIPHERAL INTERVENTIONS \ DIALYSIS					
Thrombectomy	36870	Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)	\$1,423	\$84	6%
PTA (AV Dialysis Access)	G0392	Transluminal balloon angioplasty, percutaneous; hemodialysis access fistula or graft; arterial	\$1,474	\$135	10%
	G0393	Transluminal balloon angioplasty, percutaneous; hemodialysis access fistula or graft; venous	\$1,474	\$135	10%
AV Fusion	36818 - 36821	AV Fusion	\$784	\$274	54%
AV Graft	36830	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis; nonautogenous graft	\$874	\$244	39%
AV Thrombectomy	36831	Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)	\$1,406	\$67	5%
AV Revision	36832	Revision, open,arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	\$874	\$224	39%
	36833	Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)	\$874	\$224	39%

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