GUIDEPOINT
Reimbursement Resources

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Fiscal Year (FY) 2017 Hospital Inpatient Proposed Rule

Summary Highlights with a focus on Interventional Cardiology -- Peripheral Interventions -- Rhythm Management

On April 18, 2016, the Centers for Medicare and Medicaid Services (CMS) released the FY2017 Proposed Rule (PR) for the hospital Inpatient Prospective Payment System (IPPS). CMS' final payment and policy changes will be published around August 1 and will take effect October 1, 2016.

See Table 1 on pages 5-6 for payment rates for procedures of interest to Interventional Cardiology (IC), Peripheral Interventions (PI) and Rhythm Management (RM).

IPPS RULE HIGHLIGHTS

Proposed Changes to Payment Rates Under IPPS

CMS is proposing to increase FY2017 payment rates by 0.9% for hospitals that successfully participate in the Hospital Inpatient Quality Reporting (IQR) and Meaningful Electronic Health Record (EHR) programs. Hospitals that do not successfully participate in the IQR program will see the 0.9% reduced by one-fourth for a 0.675% increase and for hospitals that do not complete meaningful use on EHR reporting will see the 0.9% reduced by three-fourths for a 0.225% increase. CMS projects total payments will increase by about $539 million in FY2017. (Medicare spends about $135-140 billion on inpatient services each year.)

Impacts on overall payment include:

- **Two Midnight Rule**: The Agency is proposing to permanently remove the 0.2% reduction from the two midnight rule. In FY2017, CMS is proposing a one-time increase of 0.6% to offset the payment reductions that occurred in FY2014, FY2015, and FY2016. Note the actual two-midnight rule *remains in effect.*
- **Documentation and Coding**: CMS is proposing a 1.5% decrease to recoup documentation and coding overpayments. This is the final adjustment per the American Taxpayer Relief Act of 2012.
- **Disproportionate Share** (Uncompensated Care): CMS is proposing to distribute the funds using data from three cost reporting periods instead of one report to limit fluctuations. In FY2018, CMS proposes to specifically define uncompensated care costs as charity care and non-Medicare bad debt from the Medicare Cost Report Worksheet S-10 to determine payment.

PAY-FOR-PERFORMANCE QUALITY PROGRAMS

CMS continues their commitment to shift payment from volume to value through "pay-for-performance" quality programs (e.g., Readmissions Reduction Program (RRP), Value-Based Purchasing (VBP), and Hospital-Acquired Conditions (HAC)).

Change highlights for each quality program include:

Inpatient Quality Reporting (IQR)

CMS is proposing to add four new claims-based measures for the FY2019 payment determination and subsequent years. Aortic Aneurysm Procedure Clinical Episode-Based Payment Measure; and Excess Days in Acute Care after Hospitalization for Pneumonia may impact the cardiovascular space.

CMS is proposing to refine two previously adopted measures starting in FY2018 for the Hospital-level, Risk-standardized Payment Associated with a 30-day Episode-of-Care for Pneumonia (NQF # 2579) and the Patient Safety and Adverse Events Composite PSI-90 (NQF #0531).

CMS is proposing to remove a total of 15 measures starting in FY2019 in order to better align with the EHR Incentive Program. The measures proposed for removal most relevant for cardiovascular include:

- AMI-2: Aspirin Prescribed at Discharge for AMI (NQF #0142)
- AMI-7a: Fibrinolytic Therapy Received Within 30 minutes of Hospital Arrival
- AMI-10: Statin Prescribed at Discharge
- STK-4 Thrombolytic Therapy (NQF #0437);
- STK-01: Venous Thromboembolism (VTE) Prophylaxis (NQF #0434);
- VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy (NQF #0373);
- VTE-4: Venous Thromboembolism Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram);
- VTE-5: Venous Thromboembolism Discharge Instructions;
- VTE-6: Incidence of Potentially Preventable Venous Thromboembolism;

Value-Based Purchasing (VBP) Program

Established by the Affordable Care Act, the Hospital VBP Program adjusts payments to hospitals for inpatient services based on their performance within an announced set of measures. In the rule, CMS proposes to implement payment updates to the Hospital VBP Program, an increase of 0.25% to 2% across the board. Top performing hospitals may earn back a “bonus” that will come from the $1.7 billion pool if they have performed above benchmark within the included measures. CMS projects that a greater number of hospitals will receive an increase from this program than compared to the number of hospitals that receive a decrease.

Specifically, the rule proposes to expand the number of hospital departments to which two National Healthcare Safety Network measures are applicable, catheter associated urinary tract infections and central line associated blood stream infections, will apply beginning with the FY2019 program year. CMS also proposes to add two condition-specific hospital level risk-standardized episode payment measures for acute myocardial infarction and a second for heart failure beginning with the FY2021 program year.

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 FY 2017, CMS is not proposing any changes to the measure set used to identify those hospitals in the lowest 25% quartile that will receive the 1% penalty.

Readmission Reduction Program (RRP)

The Hospital Readmissions Reduction Program requires a reduction to a hospital’s base operating DRG payment of as much as 3% to account for excess readmissions associated with selected applicable conditions. For FY2017, the reduction is based on a hospital’s risk-adjusted readmission rate during a three-year baseline period from 2012 through 2015. The current conditions include acute myocardial infarction (AMI), heart failure (HF), pneumonia, chronic obstructive pulmonary disease (COPD), and total hip arthroplasty/total knee arthroplasty (THA/TKA). Effective for FY2017 coronary artery bypass graft (CABG) will be included in RRP.

CMS is proposing to update the public reporting policy so that excess readmission rates will be posted to the Hospital Compare website as soon as feasible following the hospitals’ preview period.

See page 4 for important information about the uses and limitations of this document.

MS-DRG RECLASSIFICATIONS-CARDIOVASCULAR

In the Major Diagnostic Category (MDC) 5 for Diseases and Disorders of the Circulatory System there were several DRGs of interest discussed in the PR that may impact cardiovascular procedures.

- MS-DRG 270-272 Endovascular Thrombectomy of the Lower Limbs: CMS proposes assigning all procedures describing endovascular thrombectomy of the lower limbs be assigned to MS-DRGs 270, 271 and 272
- MS-DRGs 228-230 Other Cardiothoracic Procedures: CMS is proposing to move transcatheter mitral valve repair (i.e. the MitraClip® System) from current MS-DRG 273-274 and reconfigure current MS-DRGs for Other Cardiothoracic Procedures. If the proposed change is finalized, CMS will delete MS-DRG 230 without MCC or CC and change MS-DRG-229 to include all non-MCC procedures.

CMS invites public comment on each of the proposed MS-DRG classification changes described in this rule, as well as the proposals to maintain certain existing MS-DRG classifications:

NEW TECHNOLOGY ADD-ON PAYMENT (NTAP) APPLICATIONS

New Technology Add-On Payment (NTAP) is based on the merits of meeting all criteria for newness, high cost threshold, and substantial clinical improvement. CMS received nine applications for FY2017, five of which are for medical device technologies and four for drugs. Of the five devices, the following are in the cardiovascular space as noted below.

- EDWARDS INTUITY Elite™ Valve System – a device that uses a rapid deployment valve system and serves as a prosthetic aortic valve, which is inserted using surgical aortic valve replacement (AVR).
- GORE® EXCLUDER® Iliac Branch Endoprosthesis (IBE) – a device that consists of both the Iliac Branch Component (IBC) and the Internal Iliac Component (IIC) and each endoprosthesis is pre-mounted on a customized delivery and deployment system allowing for controlled endovascular delivery via bilateral femoral access for the treatment of patients requiring repair of common iliac or aortoiliac aneurysms.

CMS is proposing to continue new technology add-on payments in FY2017 for CardioMEMS™ HF (Heart Failure) Monitoring System and LUTONIX® Drug-Coated Balloon (DCB) Percutaneous Transluminal Angioplasty (PTA) Catheter and IN.PACT™ Admiral™ Paclitaxel Coated Percutaneous Transluminal Angioplasty (PTA) Balloon Catheter.

CMS is proposing to discontinue new technology add-on payments in FY 2017 for MitraClip® System.

CMS is also proposing to begin conducting the annual New Technology Town Hall meeting as a webcast/conference call meeting only and will accept comments on the proposal to change the meeting format change.

ICD-10

For inpatient stays with discharge on or after October 1, 2015, ICD-10 diagnosis and procedure codes replaced the current ICD-9 code set. CMS indicates ICD-10 Coordination and Maintenance Committee will have the oversight for the creation, deletion, or revision of ICD-10-PCS Section “X” codes for new technologies or services. All NTAP procedures will be assigned a Section “X” code within the structure of the ICD-10-PCS.

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DIVISION SPECIFIC PROPOSED PAYMENT CHANGES

Interventional Cardiology (% weighted averages shown)
- Drug-eluting stent payment rates proposed to increase 1.08% to $14,689
- Bare metal stent payment rates proposed to increase 1.24% to $14,095

IC Structural Heart—Aortic Valves (% weighted average: $44,217)
- 266 Endovascular Cardiac Replacement with MCC proposed to decrease 0.80% to $50,381
- 267 Endovascular Cardiac Replacement without MCC proposed to increase 0.43% to $38,898

Peripheral Interventions (% weighted averages shown)
- Thrombectomy: CMS proposes to assign all procedures describing endovascular thrombectomy of the lower limbs to be assigned to MS-DRGs 270, 271, or 272
- PTA, Stenting & Atherectomy payment rates proposed to increase by 2.30%
- Embolization payment rates proposed to increase by 1.98%
- Carotid artery stent payment rates proposed to increase by 4.98%

Rhythm Management (% weighted averages shown)
- ICD and CRT-D system implant payment rates are proposed to increase by 0.76%
- ICD and CRT-D system replacement payment rates are proposed to increase 4.87%
- Pacemaker and CRT-P system implant payment rates are proposed to increase 0.17%
- Pacemaker and CRT-P system replacement payment rates are proposed to increase 4.34%
- WATCHMAN and Cardiac Ablation payment rates are proposed to increase by 4.58%

COMMENTS / QUESTIONS

If you have questions or would like additional information contact:

Interventional Cardiology (IC)	Peripheral Interventions (PI)	Rhythm Management (RM)
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SOURCE INFORMATION

Read the full FY2017 Proposed IPPS Rule (CMS-1655-P) at the following link:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Proposed-Rule-Home-Page.html

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Table 1: Interventional Cardiology, Peripheral Interventions, and Rhythm Management MS-DRGs of Interest

MS-DRG	MS-DRG Description	FY 2017 Proposed Rate	FY 2016 Final Rate	$ Change (FY2016 Final - FY2017 Proposed)	% Change (FY2016 Final - FY2017 Proposed)
Interventional Cardiology					
Drug-Eluting Stents					
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC	**$19,415**	$19,192	$223	1.16%
247	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC	**$12,713**	$12,585	$128	1.02%
Bare Metal Stents					
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC	**$18,174**	$18,130	$44	0.24%
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC	**$11,558**	$11,305	$253	2.24%
Angioplasty or Atherectomy without Stent					
250	Perc cardiovasc proc w/o coronary artery stent w MCC	**$15,679**	$15,932	-$253	-1.59%
251	Perc cardiovasc proc w/o coronary artery stent w/o MCC	**$10,072**	$9,960	$112	1.13%
Endovascular Cardiac Valve Replacement (TAVR)					
266	Endovascular Cardiac Valve Replacement w MCC	**$50,381**	$50,786	-$405	-0.80%
267	Endovascular Cardiac Valve Replacement w/o MCC	**$38,898**	$38,730	$168	0.43%
WATCHMAN™ LAAC Procedure					
273	Perc cardiovasc proc w/o coronary artery stent w MCC	**$21,552**	$20,967	$585	2.79%
274	Perc cardiovasc proc w/o coronary artery stent w/o MCC	**$15,116**	$14,291	$825	5.77%
Peripheral Interventions					
PTA, Stent & Atherectomy					
252	Other vascular procedure w MCC	**$19,749**	$19,415	$334	1.72%
253	Other vascular procedure w CC	**$15,778**	$15,373	$405	2.64%
254	Other vascular procedure w/o MCC/CC	**$10,533**	$10,178	$355	3.49%
Thrombectomy & Embolization *					
270	Other major cardiovascular procedures w/ MCC	**$28,396**	$27,966	$430	1.54%
271	Other major cardiovascular procedures w/ CC	**$18,645**	$18,561	$84	0.45%
272	Other major cardiovascular procedures w/o MCC/CC	**$13,695**	$13,294	$401	3.02%
252	Other vascular procedure w MCC	**$19,749**	$19,415	$334	1.72%
253	Other vascular procedure w CC	**$15,778**	$15,373	$405	2.64%
254	Other vascular procedure w/o MCC/CC	**$10,533**	$10,178	$355	3.49%
263	Vein Ligation and Stripping	**$12,249**	$12,317	-$68	-0.55%
Carotid Artery Stenting					
034	Carotid artery stent procedure w MCC	**$23,150**	$21,765	$1,385	6.36%
035	Carotid artery stent procedure w CC	**$13,966**	$13,613	$353	2.59%
036	Carotid artery stent procedure w/o CC/MCC	**$10,417**	$10,147	$270	2.66%
Rhythm Management					
ICD Systems					
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	**$50,349**	$50,314	$35	0.07%
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	**$38,975**	$37,816	$1,159	3.07%
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	**$45,408**	$44,970	$438	0.97%
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	**$34,368**	$34,588	-$220	-0.64%
226	Cardiac defibrillator implant w/o cardiac cath w MCC	**$41,372**	$41,189	$183	0.45%
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	**$32,744**	$32,376	$368	1.14%
ICD Replacements					
245	AICD generator procedures	**$28,641**	$27,679	$962	3.47%
265	AICD Lead procedures	**$19,317**	$17,530	$1,787	10.19%
Pacemaker Systems					
242	Permanent cardiac pacemaker implant w MCC	**$22,128**	$22,347	-$219	-0.98%
243	Permanent cardiac pacemaker implant w CC	**$15,728**	$15,619	$109	0.70%
244	Permanent cardiac pacemaker implant w/o CC/MCC	**$12,781**	$12,636	$145	1.15%

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Table 1: Interventional Cardiology, Peripheral Interventions, and Rhythm Management MS-DRGs of Interest

MS-DRG	MS-DRG Description	FY 2017 Proposed Rate	FY 2016 Final Rate	$ Change (FY2016 Final - FY2017 Proposed)	% Change (FY2016 Final - FY2017 Proposed)
Pacemaker Revisions and PG Placements					
258	Cardiac pacemaker device replacement w MCC	**$18,202**	$16,886	$1,316	7.79%
259	Cardiac pacemaker device replacement w/o MCC	**$11,938**	$11,491	$447	3.89%
260	Cardiac pacemaker revision except device replacement w MCC	**$22,466**	$22,030	$436	1.98%
261	Cardiac pacemaker revision except device replacement w CC	**$11,640**	$11,009	$631	5.73%
262	Cardiac pacemaker revision except device replacement w/o CC/MCC	**$9,508**	$8,933	$575	6.43%
WATCHMAN™ LAAC Procedure and Cardiac Ablation					
273	Percutaneous Intracardiac Procedures w MCC	**$21,552**	$20,967	$585	2.79%
274	Percutaneous Intracardiac Procedures w/o MCC	**$15,116**	$14,291	$825	5.77%

Source: Medicare IPPS Proposed FY2017 Table 7A and IPPS Final FY2016 Table
* Thrombectomy and Embolization MS-DRG assignment is variable depending in part on anatomical location of intervention

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

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