GUIDEPOINT Reimbursement Resources

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Fiscal Year (FY) 2017 Medicare Hospital Inpatient Final Rule

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

On August 2, 2016, the Centers for Medicare and Medicaid Services (CMS) released the FY2017 Final Rule (FR) for the hospital Inpatient Prospective Payment System (IPPS). These payments and policies 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

Changes to Payment Rates Under IPPS

CMS will increase FY2017 payment rates by 0.95% 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 their update reduced by one-fourth of the 0.95% and for hospitals that do not complete meaningful use on EHR reporting their update will be reduced by three-fourths of the 0.95%. CMS projects total payments will increase by about $746 million in FY2017. (Medicare spends about $135-140 billion on inpatient services each year.)

Impacts on overall payment include:

- **Two-Midnight Rule**: CMS will remove the 0.2% reduction from the two midnight rule. In FY2017, CMS will make a one-time increase of 0.8% to offset the payment reductions that occurred in FY2014, FY2015, and FY2016. Note while the two-midnight timeframe remains in effect, CMS will recognize exceptions based on documentation of the clinical need of the patient.
- **Documentation and Coding**: CMS has finalized 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. CMS will not finalize its proposal to define uncompensated care costs as charity care and non-Medicare bad debt from the Medicare Cost Report Worksheet S-10 to determine payment. Instead, CMS will look to future rulemaking and begin to incorporate Worksheet S-10 data into the computation of Factor 3 no later than FY 2021.

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)).

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

Change highlights for each quality program include:

Inpatient Quality Reporting (IQR)

CMS will 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 has finalized its proposal 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 will remove a total of 15 measures starting in FY2019 in order to better align with the EHR Incentive Program. The measures 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 finalizes implementation of 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 $1.8 billion pool if they have performed above benchmark within the included measures. CMS projects that the number of hospitals receiving an increase from this program will be greater than the number of hospitals that receive a decrease.

CMS finalizes an expansion of 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 finalized that it will 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 FR that may impact cardiovascular procedures.

- MS-DRG 270-272 Endovascular Thrombectomy of the Lower Limbs: CMS finalized assignment of 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 finalized its proposal to move transcatheter mitral valve repair (i.e. the MitraClip® System) from current MS-DRG 273-274 to MS-DRG 228 and 229. CMS finalized deleting MS-DRG 230 and the remaining two MS-DRGs will be reconfigured. Current MS-DRG 228 description will be Other Cardiothoracic Procedures with MCC and MS-DRG 229 without MCC or CC.

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). Edwards did not receive FDA approval by July 1 making it ineligible for approval.
- 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 was approved for NTAP status.

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

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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CARDIOVASCULAR FINAL PAYMENT CHANGES

Interventional Cardiology (% weighted averages shown)

- Drug-eluting stent payment rates to increase 0.77% to $14,643
- Bare metal stent payment rates to increase 1.13% to $14,076

IC Structural Heart (% weighted average)

- Endovascular valves slight decrease of 0.93% to $43,898
- WATCHMAN LAAC payment rates to increase by 4.36% to $17,081

Peripheral Interventions (% weighted averages shown)

- Thrombectomy: CMS is assigning endovascular thrombectomy of the lower limbs to MS-DRGs 270, 271, or 272
- PTA, Stenting, Atherectomy and Embolization payment rates to increase by 2.35%
- Carotid artery stent payment rates to increase by 3.22%

Rhythm Management (% weighted averages shown)

- ICD and CRT-D system implant payment rates are to increase by 0.18%
- ICD and CRT-D system replacement payment rates are to increase 4.19%
- Pacemaker and CRT-P system implant payment rates are to decrease 0.03%
- Pacemaker and CRT-P system replacement payment rates are to increase 4.30%
- WATCHMAN LAAC and Cardiac Ablation payment rates are to increase by 4.36%

COMMENTS / QUESTIONS

If you have questions or would like additional information contact:

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SOURCE INFORMATION

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

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

MS-DRG	MS-DRG Description	FY 2017 Final Rate	FY 2016 Final Rate	$ Change (FY2016 to FY2017)	% Change (FY2016 to FY2017)
Interventional Cardiology					
Drug-Eluting Stents					
246	Percutaneous cardiovascular proc w drug-eluting stent w MCC	**$19,396**	$19,192	$204	1.06%
247	Percutaneous cardiovascular proc w drug-eluting stent w/o MCC	**$12,658**	$12,585	$73	0.58%
Bare Metal Stents					
248	Percutaneous cardiovasc proc w non-drug-eluting stent w MCC	**$18,156**	$18,130	$26	0.14%
249	Percutaneous cardiovasc proc w non-drug-eluting stent w/o MCC	**$11,544**	$11,305	$239	2.12%
Angioplasty or Atherectomy without Stent					
250	Perc cardiovasc proc w/o coronary artery stent w MCC	**$15,683**	$15,932	-$249	-1.56%
251	Perc cardiovasc proc w/o coronary artery stent w/o MCC	**$10,059**	$9,960	$99	1.00%
Endovascular Cardiac Valve Replacement (TAVR)					
266	Endovascular Cardiac Valve Replacement w MCC	**$50,053**	$50,786	-$733	-1.44%
267	Endovascular Cardiac Valve Replacement w/o MCC	**$38,595**	$38,730	-$135	-0.35%
WATCHMAN™ LAAC Procedure					
273	Percutaneous Intracardiac Procedures w MCC	**$21,495**	$20,967	$529	2.52%
274	Percutaneous Intracardiac Procedures w/o MCC	**$15,089**	$14,291	$798	5.58%
Peripheral Interventions					
PTA, Stent & Atherectomy					
252	Other vascular procedure w MCC	**$19,754**	$19,415	$339	1.75%
253	Other vascular procedure w CC	**$15,768**	$15,373	$395	2.57%
254	Other vascular procedure w/o MCC/CC	**$10,593**	$10,178	$416	4.08%
Thrombectomy of the Lower Limbs					
270	Other major cardiovascular procedures w/ MCC	**$28,379**	$27,966	$414	1.48%
271	Other major cardiovascular procedures w/ CC	**$18,649**	$18,561	$88	0.47%
272	Other major cardiovascular procedures w/o MCC/CC	**$13,787**	$13,294	$494	3.71%
Carotid Artery Stenting					
034	Carotid artery stent procedure w MCC	**$22,961**	$21,765	$1,196	5.49%
035	Carotid artery stent procedure w CC	**$13,934**	$13,613	$321	2.36%
036	Carotid artery stent procedure w/o CC/MCC	**$10,428**	$10,147	$281	2.77%
Rhythm Management					
ICD Systems					
222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	**$50,144**	$50,314	-$170	-0.34%
223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	**$38,833**	$37,816	$1,018	2.69%
224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	**$45,234**	$44,970	$264	0.59%
225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	**$34,116**	$34,588	-$472	-1.36%
226	Cardiac defibrillator implant w/o cardiac cath w MCC	**$41,115**	$41,189	-$74	-0.18%
227	Cardiac defibrillator implant w/o cardiac cath w/o MCC	**$32,537**	$32,376	$161	0.50%
ICD Replacements					
245	AICD generator procedures	**$28,473**	$27,679	$794	2.87%
265	AICD Lead procedures	**$19,149**	$17,530	$1,619	9.23%
Pacemaker Systems					
242	Permanent cardiac pacemaker implant w MCC	**$22,068**	$22,347	-$279	-1.25%
243	Permanent cardiac pacemaker implant w CC	**$15,707**	$15,619	$88	0.56%
244	Permanent cardiac pacemaker implant w/o CC/MCC	**$12,758**	$12,636	$122	0.96%

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Pacemaker Revisions and PG Placements					
258	Cardiac pacemaker device replacement w MCC	**$18,100**	$16,886	$1,214	7.19%
259	Cardiac pacemaker device replacement w/o MCC	**$11,870**	$11,491	$379	3.30%
260	Cardiac pacemaker revision except device replacement w MCC	**$22,443**	$22,030	$413	1.87%
261	Cardiac pacemaker revision except device replacement w CC	**$11,679**	$11,009	$670	6.09%
262	Cardiac pacemaker revision except device replacement w/o CC/MCC	**$9,551**	$8,933	$618	6.92%
WATCHMAN™ LAAC Procedure and Cardiac Ablations					
273	Percutaneous Intracardiac Procedures w MCC	**$21,495**	$20,967	$529	2.52%
274	Percutaneous Intracardiac Procedures w/o MCC	**$15,089**	$14,291	$798	5.58%

Source: Medicare IPPS Final FY2017 Table 5 and IPPS Final FY2016 Table 5 CN.
The labor, non-labor and capital standardized amounts are from IPPS FY 2017 FR table 1a-1e.
The calculated rates assume the hospital submits quality data and is a meaningful EHR user

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