

MEDICARE ISSUES HOSPITAL INPATIENT POLICY AND PAYMENT FINAL RULE FOR FY2009

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) Final Rule (FR) for Fiscal Year (FY) 2009 as posted July 31, 2008 at <http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1390-F.pdf>. (Federal Register on August 19, 2008). Final payment rates and policies become effective October 1, 2008. Please note that the final payment rates for select cardiovascular-related procedures can be found at the end of this document. While CMS noted the rates are considered tentative at this time due to mandated wage index reclassifications, they expect to publish a subsequent update following rule publication.

In general, final payments for interventional cardiology and peripheral intervention procedures remain relatively stable. In addition, CMS continue to build on policies initiated over the past two years to improve the quality of care received by beneficiaries and the methodology used to determine payment accuracy.

The overall average market basket update is 3.6%. Additionally, Medicare is expanding the list of quality measures by thirteen, bringing the total to 42, that hospitals will be required to report. Hospitals that fail to submit quality data will face a two percentage point decrease in the market basket increase (1.6%) that would otherwise apply to their payment rates. In addition, FY2009 will be the final year of a three-year transition to cost-based weighting for procedures, meaning that procedure payments will be calculated based on costs as opposed to reported charges.

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: Neutral at (0.1%) for select IC procedures.
- PI: Increase of 4.4% for select PI procedures.

CMS Adds 13 New Quality Measures That Link to Future Payment

CMS increased the number of quality measures that hospitals must report to CMS. In 2009, hospitals that failed to submit quality data for 2008 will face a two percentage point decrease in the increase that would otherwise apply to their payment rates (in other words receive only a 1.6% increase rather than a 3.6% increase in FY2009).

- Of the new quality measures reportable in 2009, cardiovascular-related measures include heart failure readmission, AAA mortality rates and cardiac surgery for participation in a systematic database. Appropriate treatment of AMI, and the mortality associated with it, remains on the quality measure list.
- CMS is considering using the data currently being collected by clinical data registries to satisfy quality reporting requirements in 2011. ACC CARE and SVS vascular registries are among those being considered.

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CMS added three new preventable conditions (hospital acquired conditions - HACs) for which it would not make payment if acquired during an inpatient stay. Vascular-catheter associated infections and air embolism remain on the list from 2008. CMS most likely will continue to build its list of HACs in future years for which it will not pay to include surgical site infections following certain orthopedic surgeries or bariatric surgery for obesity; certain manifestations of poor control of blood sugar levels, and deep vein thrombosis or pulmonary embolism following total knee replacements and hip replacements.

CMS chose **not to make short-term adjustments for the hospital practice known as charge compression** (this is the practice where hospitals have lower cost-to-charge ratios for more expensive devices, resulting in lower than expected payments). However, CMS decided to set the stage for a long-term fix by creating an “implantable medical device cost center.” This will lead to a 3-5% increase in payment rates for drug-eluting stent procedures, but it will not take effect until FY2012.

CMS finalized a 0.9% reduction in rates for FY2009 to eliminate the effect of improved coding and documentation resulting from the shift to MS-DRGs.

WHAT ARE SOME OF THE SPECIFIC CHANGES IN PAYMENT?

Overall, the net impact of the proposed changes for hospitals would be positive (4.7% increase). However, it must be noted that the increase would be reduced by 2% for hospitals that did not report quality data in FY2008. Finally, as can be seen below, there would be some variation in the payment impact depending upon the characteristics of the hospital.

- Urban Hospitals: 4.8% increase.
- Large Urban Hospitals: 5% increase.
- Rural Hospitals: 3.9% increase.
- Cardiac Specialty Hospitals: 2.1% increase.
- Non-Teaching Hospitals with DSH: 4.6% increase.
- Teaching Hospitals with DSH: 4.9% increase.

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

- **Drug-eluting Stent (DES) and Bare Metal Stent (BMS) Procedures**
 - Payment for DES MS-DRG 246 (patients with major complications or comorbidities (MCC) or four or more vessels or stents) increases by non-weighted average of 11% to \$17,460 (an increase of \$1,727 over FY2008). Non-weighted payment for other DES MS-DRG 247 (DES without MCC) decreases by 8% to \$10,613 (a reduction of \$900). Due to the case mix across both DES MS-DRGs, the total weighted average decrease in payment for DES procedures is 4.6%.
- MS-DRGs for **BMS** decrease by 2.7%.
- **Carotid artery stenting** increases 2%.
- **Biliary stenting** will increase slightly (just less than 1%).
- **Peripheral stenting**, including renal, increases by 3%.

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- **Cardiac Rhythm Management (CRM and electrophysiology (EP))** procedures change as follows:
 - The weighted financial impact of the changes for CRM devices are positive overall:
 - Final payment rates for ICD and CRT-D system implants increases by 3%.
 - Final payment rates for Pacemaker and CRT-P system implants increases by 3%.
 - CMS has separated ICD pulse generator replacements from ICD lead replacements resulting in a proposed payment increase for ICD pulse generator replacements of 31%.
 - Overall, **cardiac ablation** payment rates will decrease by 0.5%.

COMMENTS/QUESTIONS

If you have questions or would like additional information from Boston Scientific, contact:

Tom Meskan
Director, Cardiovascular
763-494-2016
Tom.Meskan@bsci.com

Deb Lorenz
Sr. Manager, Interventional Cardiology (IC)
763-494-2112
Deb.Lorenz@bsci.com

Maria Stewart
Sr. Manager, Peripheral Interventions (PI)
508-652-5020
Maria.Stewart@bsci.com

Angelica Oyugi
Analyst, IC and PI
763-494-2801
Angelica.Oyugi@bsci.com

**Boston
Scientific**

Boston Scientific Corporation
One Boston Scientific Place
Natick, MA 01760-1537
www.bostonscientific.com

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Table 1: FY2009 Final Rule MS-DRG National Average Hospital Payment Rates for Select Cardiovascular Procedures*

Procedure	MS-DRG	MS-DRG Description	FR2009 Urban Payment	FR2008 Urban Payment	\$ Variance 2008 vs. 2009	% Variance 2008 vs. 2009
Interventional Cardiology						
Drug-eluting Stents	246	Perc cardiovasc proc w DE stent w MCC or 4+ vessels/stents	\$17,460	\$15,733	\$1,727	10.98%
	247	Perc cardiovasc proc w DE stent w/o MCC	\$10,613	\$11,513	(\$900)	(7.82%)
Non-drug-eluting Stents	248	Perc cardiovasc proc w non-DE stent w MCC or 4+ ves/stents	\$15,561	\$13,639	\$1,922	14.09%
	249	Perc cardiovasc proc w non-DE stent w/o MCC	\$9,097	\$9,817	(\$720)	(7.33%)
ICD	222	Cardiac defib implant w cardiac cath w AMI/HF/shock w MCC	\$47,976	\$43,460	\$4,516	10.39%
	223	Cardiac defib implant w cardiac cath w AMI/HF/shock w/o MCC	\$34,881	\$37,272	(\$2,391)	(6.42%)
	224	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w MCC	\$44,122	\$39,639	\$4,483	11.31%
	225	Cardiac defib implant w cardiac cath w/o AMI/HF/shock w/o MCC	\$32,740	\$34,102	(\$1,362)	(3.99%)
PTCA	250	Perc cardiovasc proc w/o coronary artery stent or AMI w MCC	\$16,598	\$13,471	\$3,127	23.21%
	251	Perc cardiovasc proc w/o coronary artery stent or AMI w/o MCC	\$8,899	\$9,468	(\$569)	(6.01%)
Diagnostic Cath (IVUS)	286	Circ disorders except AMI, w card cath w MCC	\$10,969	\$9,028	\$1,941	21.50%
	287	Circ disorders except AMI, w card cath w/o MCC	\$5,688	\$6,182	(\$494)	(7.99%)
Peripheral Interventions						
Carotid Stenting	034	Carotid artery stent procedure w MCC	\$17,877	\$13,779	\$4,098	29.74%
	035	Carotid artery stent procedure w CC	\$11,223	\$10,289	\$934	9.08%
	036	Carotid artery stent procedure w/o CC/MCC	\$8,696	\$9,196	(\$500)	(5.44%)
PTA, Atherectomy, PV Stenting, Thrombectomy	252	Other vascular procedures w MCC	\$16,396	\$14,930	\$1,466	9.82%
	253	Other vascular procedures w CC	\$12,509	\$12,207	\$302	2.47%
	254	Other vascular procedures w/o CC/MCC	\$8,559	\$9,092	(\$533)	(5.86%)
Peripheral Stenting-Biliary	005	Liver transplant w MCC or intestinal transplat	\$60,024	\$57,482	\$2,542	4.42%
	006	Liver transplant w/o MCC	\$27,098	\$39,305	(\$12,207)	(31.06%)
	420	Hepatobiliary diagnostic procedures w MCC	\$22,797	\$18,878	\$3,919	20.76%
	421	Hepatobiliary diagnostic procedures w CC	\$10,519	\$12,219	(\$1,700)	(13.91%)
	422	Hepatobiliary diagnostic procedures w/o CC/MCC	\$6,816	\$10,526	(\$3,710)	(35.25%)
	435	Malignancy of hepatobil sys or pancreas w MCC	\$9,546	\$8,483	\$1,063	12.53%
	436	Malignancy of hepatobiliary sys or pancreas w CC	\$6,614	\$6,991	(\$377)	(5.39%)
	437	Malignancy of hepatobiliary system or pancreas w/o CC/MCC	\$5,288	\$6,343	(\$1,055)	(16.63%)
	444	Disorders of the biliary tract w MCC	\$8,646	\$7,445	\$1,201	16.13%
	445	Disorders of the biliary tract w CC	\$5,764	\$5,975	(\$211)	(3.53%)
446	Disorders of the biliary tract w/o CC/MCC	\$4,012	\$4,616	(\$604)	(13.08%)	

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*Source: July 31, 2008 Medicare Program Changes to the Hospital Prospective Payment Systems and Fiscal Year 2009 Rates as posted on www.cms.hhs.gov. National average (Full Update) MS- DRG rates calculated using the national full update standardized labor, non-labor and capital amounts (\$5,548.52). Note Subsequent to this final rule, CMS will publish final standardized amounts based on the implementation of section 124 of Pub. L 110-275.