

CMS Proposes Severity-Adjusted Device Payments

BY ALICIA AULT

Associate Editor, Practice Trends

Under the Medicare final inpatient payment rule for fiscal 2008, many procedures to implant medical devices would see substantial payment increases, a development that has physicians and surgeons cautiously applauding.

A year ago, when the Centers for Medicare and Medicaid Services unveiled its inpatient payment proposal for fiscal

2007, it was met with dire predictions that access to crucial technologies would be diminished.

Interested parties argued that the agency's reliance on outdated cost data would end up chopping reimbursement for some procedures by as much as 30%.

The deep cuts disappeared in the final rule, however, and more recent data were used to calculate 2007 payments. For next fiscal year, CMS is still using a cost-based method, but with updated data, and is

proposing to adjust payments based on illness severity with a new set of Medicare Severity diagnosis-related groups (MS-DRGs). Those 745 new DRGs—which have three levels of severity—replace the 538 current DRGs, which have only two levels.

As a result, payments for some procedures will rise if the rule is adopted.

To prevent hospitals from upcoding, CMS proposed about a 2% reduction in overall payments.

The bottom line: Hospitals will receive a 3.3% payment increase. To receive the full increase, hospitals must report to CMS on 27 quality measures, 6 more than last year. Some of the new measures are:

- ▶ Whether venous thromboembolism (VTE) prophylaxis was ordered for a surgery patient.
- ▶ Whether VTE prophylaxis was given within 24 hours before or after surgery.
- ▶ Whether antibiotics were given prophylactically for surgery patients.
- ▶ 30-day mortality for AMI patients.
- ▶ 30-day mortality for heart failure patients.

Under the proposed rule, hospitals will also now have a way to account for the receipt of free replacement devices sent by manufacturers after a recall. In the past, Medicare has paid for the devices because there was no way to cull them from the

DRG for the replacement procedure. The new accounting method will also require hospitals to keep closer track of how often recalled devices are replaced.

In addition, hospitals will have to report secondary diagnoses present when patients are admitted.

AdvaMed, a trade group for the industry, said it was generally happy with the proposed rule 'to acknowledge ... advancements in medical technology.'

This is to fuel an effort to stop paying for conditions that develop in the hospital as a result of poor quality care, such as surgical infections. Beginning in fiscal 2009, CMS will not pay for some of these conditions under a higher DRG rate unless they were present at admission.

AdvaMed, a trade group for the medical device industry, said it was generally happy with the proposed final rule.

"The MS-DRGs maintain improvements to the patient classification system that have been made over the last few years to acknowledge rapid advancements in medical technology while improving the ability of the system to more precisely reflect the costs of more severely ill patients," said AdvaMed President and CEO Stephen J. Ubl in a statement.

In a briefing with reporters, Mr. Ubl said that CMS's proposal still creates "charge compression," by which the cost of low-technology devices is overstated and high technology, understated. The organization is also uncertain how hospitals will compensate when payments are reduced in some areas—a concern echoed by a spokesman for one surgeons' group and by the Heart Rhythm Society.

"On the face of it, it does make sense to pay hospitals more for patients who are sicker," added Amy Melnick, vice president of health policy for HRS. The group is pleased with what it has seen so far, but is still reading through the proposal to analyze its potential impact, said Ms. Melnick.

CMS will publish a final rule before Oct. 1.



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