As seen in **Cath Lab Digest**

The FY 2018 Reimbursement Outlook: The Cath Lab Impact

By Kristin Truesdell

Healthcare is an ever-changing entity — so it is no wonder hospitals can encounter difficulty in keeping aware of updates, especially throughout this year of continued headlines for the industry! Hospitals must be aware of shifting regulations, increasing scrutiny on quality outcomes, pressure to achieve greater profit margins, and the list goes on. All of these internal and external influences can directly impact the viability of a hospital, so it is imperative that all organizations be prepared for what is to come well in advance of the effective date of any changes.

The following summary provides a high-level look at the upcoming fiscal year (FY) 2018 changes in terms of financial and quality standards for the cardiovascular service line, and the cath lab in particular. Corazon believes understanding these updates can help hospital and program leaders become aware of new criteria, along with how the changes, either major or minor, will affect clinical, operational, and financial performance.

Payment Updates

Inpatient Payments

Under the Centers for Medicare and Medicaid Services (CMS) FY2018 hospital inpatient final rule, the market basket update is 2.7% for acute care hospitals; however, hospitals will only see a net increase of 1.2% in overall operating payment rates due to adjustments. These adjustments include the following:

1) **Productivity Adjustment = 0.6% decrease.** This adjustment was implemented in FY2012 to address economic productivity.
2) Accountable Care Act (ACA) Adjustment = 0.75% decrease. This adjustment was implemented in FY2011 to address the needs of the ACA and healthcare cost savings. CMS plans to continue this adjustment until FY2019.
3) **Two-Midnight Policy Adjustment = 0.6% decrease.** In FY2017, the two-midnight negative adjustment was removed and replaced with a one-time +0.6% increase. This positive adjustment was expected to offset the estimated costs hospitals incurred in FY2014-FY2016. Now that hospitals recouped the losses due to the two midnight rule, CMS has implemented a 0.6% decrease in FY2018.
4) **21st Century Cures Act = 0.4588% increase.** Signed into law in December 2016, the Cures Act required CMS to make adjustments in order to expedite the discovery, development, and delivery of new treatments and cures.

Table 1. FY2018 Inpatient Reimbursement Changes.

MS-DRGs	Description	FY18 Average CMS Payment	% Change FY17-FY18
Interventional Cardiology			
286-287	Diagnostic Cath	$10,258	+ 2.0%
246-247	PCI with DES	$16,053	+ 0.2%
248-249	PCI without DES	$15,085	+ 1.6%
250-251	PCI without Stent	$12,565	- 2.4%
Vascular			
034-036	Carotid Stent	$16,040	+ 1.7%
252-254	Peripheral Vascular	$15,234	- 0.9%
Electrophysiology			
273, 274	Ablation	$19,133	+ 4.6%
245, 265	ICD Replacement	$26,492	+ 14.7%
222-227	ICD System	$40,321	+ 0.0%
242-244	Pacemaker System	$16,987	+ 0.8%
258-262	Pacemaker Revise/Replace	$14,883	+ 1.0%

FY-fiscal year; Medicare Severity-Diagnosis Related Group (MS-DRG); CMS-Centers for Medicare and Medicaid Services; PCI-percutaneous coronary intervention; DES-drug-eluting stent; ICD-implantable cardioverter defibrillator

One adjustment that hospitals have become accustomed to has finally ended: the documentation and coding adjustment. CMS has successfully recovered approximately $11 billion due to past overpayments related to the conversion to MS-DRGs in FY2008.

Even though hospitals lost 1.5% in operating payments due to adjustments, facilities should still realize a gain in inpatient reimbursement rates over the last fiscal year. Table 1 highlights a comparison of average weighted payments from FY2017 to FY2018 for the most common inpatient cath lab procedures. With the exception of PCI without Stent and Peripheral Vascular, ALL cath lab procedures will receive an increase for inpatient payments.

Notable Changes

Although there were no MS-DRG numbering additions/deletions within the cardiovascular service line, there were some changes that will affect coding and reimbursement:

- **PCI MS-DRG Description Revision:** CMS revised the MS-DRG descriptions for 246 and 248 to replace "vessel" with "artery." CMS made this change to better match the ICD-10 procedure coding selections.
- **Revisions to Cardiac-Related ICD-10 Diagnosis Codes:**
  - *Myocardial infarction (MI) codes:* Two new codes have been created to take into consideration the type of MI the patient is having; specifically, a Type 2 MI. A Type 2 MI is secondary to ischemia from a supply-and-demand mismatch (e.g., coronary spasm, embolism, low or high blood pressures, anemia, or arrhythmias). The two new codes include: I21.A1 (myocardial infarction type 2) and I21.A9 (other myocardial infarction type), while a Type 1 is defined as a spontaneous MI related to ischemia from a primary coronary event (e.g., plaque rupture, thrombotic occlusion). Notes have been added under ST-elevation MI codes (I21.0-I21.4) to clarify that the condition is a type 1 MI.
  - *Heart failure codes:* The code set has new codes for various types of right heart failure, including acute (I50.811), chronic (I50.812), acute on chronic (I50.813), and unspecified (I50.810). There are also new codes for right heart failure due to left heart failure (I50.814), biventricular heart failure (I50.82), high output heart failure (I50.83), and end-stage heart failure (I50.84) for patients with an advanced form of the disease who no longer respond to medication.[1]

Table 2: c-APCs for Endovascular Procedures.

c-APC	Description	Procedures	CY2017 CMS Payment	CY2018 CMS Proposed Payment	% Change CY17-CY18
c-APC 5191	Level 1 Endovascular Procedures	Dx Cath	$2,832	$2,845	+ 0.5%
c-APC 5192	Level 2 Endovascular Procedures	PCI & PTA	$4,823	$4,999	+ 3.6%
c-APC 5193	Level 3 Endovascular Procedures	PCI & PTA	$9,748	$10,218	+ 4.8%
c-APC 5194	Level 4 Endovascular Procedures	PCI & PTA	$14,776	$15,573	+ 5.4%

c-APC-Comprehensive Ambulatory Payment Classification; CY-calendar year; Dx-diagnostic; PCI-percutaneous coronary intervention; PTA-percutaneous transluminal angioplasty

Outpatient Payments

Since close to half of the cath lab procedures are paid as outpatients, payments for this population must also be critically reviewed. In the outpatient proposed rule released by CMS in July 2017, CMS continues to aggressively shift outpatient payments to a true prospective payment system.

In the last three years, CMS focused on restructuring all high-cost, device-dependent and correlating procedures into Comprehensive Ambulatory Payment Classifications (c-APCs). After several years of revisions, there is no major classification or numbering changes for cardiovascular services in 2018. Table 2 illustrates the payment difference for endovascular procedures, which include Diagnostic Cath, PCI, and Peripheral Interventions.

Even though reimbursement has increased for outpatient coronary and peripheral procedures, the margin is still not as great as in the inpatient setting. On average, an inpatient PCI is reimbursed $6,000 more than an outpatient PCI. And regardless of admission status, the majority of cath lab costs (i.e., stents, other supplies, and pharmaceuticals) for these procedures are similar. When

evaluating the financial performance of the cath lab, Corazon recommends reviewing inpatient and outpatient procedures separately. This will help to monitor and manage patients differently in order to appropriately maximize profitability.

Quality Updates

In order to realize maximum reimbursement potential, hospitals must adhere to the three quality standards noted below or else receive a reduction in base payments. For hospitals with poor quality performance, the FY2018 increases in reimbursement for cath-lab based procedures will easily be overshadowed by penalties. Corazon recommends close operational attention to these areas, as any unintended or unexpected payment decrease due to quality missteps can compound quickly, equating to major financial losses for the overall bottom line. Indeed, ensuring that quality standards are in place is the best means for optimizing reimbursement margins, whether for these or other important quality measures.

Readmissions

The Hospital Readmissions Reduction Program requires a reduction to a hospital's base operating DRG payment to account for excess readmissions of selected applicable conditions. Data from 2013-2016 for the six following conditions are used to determine potential penalties: acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease, total hip and knee arthroplasty, and coronary artery bypass grafting (CABG). CMS is implementing changes to the payment adjustment factor in accordance with the 21st Century Cures Act. CMS will assess penalties based on a hospital's performance relative to other hospitals with a similar proportion of patients who are dually eligible for Medicare and full-benefit Medicaid.[2]

Value-Based Purchasing (VBP)

The estimated base operating DRG payment amount reductions for FY2018 (2% reduction) is the same amount available for value-based incentive payments. Although the measures for FY2018 were finalized in previous rulings, CMS has made final and proposed rulings for the future VBP program that includes the removal of one measure and the addition of two.

Hospital-Acquired Conditions (HAC)

As part of the Affordable Care Act, a 1% reduction in payment is made to hospitals whose ranking is in the lowest performing quartile. Last year, CMS shifted from a decile-based score to a continuous method called a Winsorized Z-score, which represents a hospital's distance from the national mean. No new measures were added in the final rule.

Conclusion

The final rulings go into effect October 1, 2017 for the inpatient payment system and January 1, 2018 for the outpatient payment system. Based on this summary, Corazon recommends all hospitals pay close attention to the financial and quality performance of the cardiovascular service line, and the cath lab in particular. Though many of the FY2018 changes are positive, Corazon strongly believes that all organizations must prepare by allocating appropriate resources, scheduling necessary training, and keeping clinical and financial teams apprised of required policy and/or procedure changes necessary to proactively tackle any issues and ultimately protect the profit margin of the cardiovascular specialty.

References

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