

The FY2019 Reimbursement Impact in the Cath Lab



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Healthcare is an ever-changing entity — and with so many regulatory and financial updates, it is no wonder hospital leaders can face difficulties keeping up. Hospitals as a whole, and specialty service lines specifically, must be continually aware of changing regulations, quality standards, outcomes metrics, profit margins, and the list goes on. All of these aspects of care have a direct impact to the overall viability of a hospital, which makes preparation for what is to come a key strategic move well in advance of the effective date of any changes.

The following summary provides a high-level look at the upcoming fiscal year (FY) 2019 changes in terms of financial and quality standards. Understanding these updates can help hospital and cardiovascular program leaders, along with cath lab staff, to be aware of new criteria and how the changes, either major or minor, impact the hospital's bottom line.

Payment Updates

Inpatient Payments

Under the Centers for Medicare and Medicaid Services (CMS) FY2019 hospital inpatient final rule, the market basket update is 2.9% for the 3,300 acute care hospitals; however, hospitals will see a net increase of 1.85% in overall operating

payment rates due to adjustments. These adjustments include the following:

1. Productivity Adjustment = 0.8% 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 Affordable Care Act (ACA) and healthcare cost savings. This is the last year CMS plans to continue this adjustment.
3. Documentation and Coding = 0.5% increase. FY18 was the last year hospitals saw a negative documentation and coding adjustment in order to recover billions of dollars due to overpayments related to the conversion to MS-DRGs in FY08. This adjustment is back in FY19, but as a permanent, positive adjustment.

Even though hospitals lost 1.05% 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 FY2018 to FY2019 for the most common inpatient cath lab procedures. With the exception of Diagnostic Caths, Carotid Stents, and ICD Generator or Lead Procedures, the majority of cath lab procedures will receive an increase for inpatient payments.

Outpatient Payments

Since close to half of the cath lab procedures are paid as outpatients, payments for this population must also be critically reviewed. Especially since some of this payment transition has resulted in the need for operational transitions that many hospitals have yet to fully implement. With certain procedures moving to the outpatient setting, and being paid as such, program leaders and care givers must understand the difference and make sure that procedures being paid as outpatient are also being cared for as such.

Table 1. FY2019 Inpatient Reimbursement Changes.

MS-DRGs	Description	FY19 Average CMS Payment	% Change FY18-FY19
Interventional Cardiology			
286-287	Diagnostic Cath	\$10,140	- 1.2%
246-247	PCI with DES	\$16,238	+ 1.2%
248-249	PCI without DES	\$15,770	+ 4.5%
250-251	PCI without Stent	\$13,027	+ 3.7%
Vascular			
034-036	Carotid Stent	\$15,367	- 4.2%
252-254	Peripheral Vascular	\$15,607	+ 2.4%
Electrophysiology			
273, 274	Ablation	\$20,255	+ 5.9%
245, 265	ICD Generator & Lead Proc.	\$24,830	- 6.3%
222-227	ICD System	\$40,497	+ 0.4%
242-244	Pacemaker System	\$17,110	+ 0.7%
258-262	Pacemaker Revise/Replace	\$15,063	+ 1.2%

In the outpatient proposed rule released by CMS in July 2018, CMS continues to aggressively shift outpatient payments to a true prospective payment system. Table 2 illustrates the payment difference for endovascular procedures which include Diagnostic Cath, PCI, and Peripheral Interventions.

Surprisingly, reimbursement is proposed to decrease for the outpatient coronary and peripheral interventional procedures; this is the converse of what is occurring for inpatient reimbursement for the same procedures. Regardless of patient 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, particularly since the margins for outpatient cases is projected to get smaller. 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 FY2019 increases in reimbursement for cath-lab based procedures will easily be overshadowed by penalties.

Readmissions

The Hospital Readmissions Reduction Program (HRRP) requires a reduction to a hospital's base operating DRG payment up to 3%, to account for excess readmissions of selected applicable conditions. The following six conditions are used to determine potential penalties:

- Acute myocardial infarction;
- Heart failure;
- Pneumonia;
- Chronic obstructive pulmonary disease;
- Total hip and knee arthroplasty;

- Coronary artery bypass grafting (CABG).

CMS is implementing changes to the payment adjustment factor in accordance with the 21st Century Cures Act and further clarifying the definitions related to dual eligibility. Lastly, the final FY19 HRRP results have not been made available yet, since CMS wanted to give providers time to review and correct their calculations. Regardless, all payment adjustments will be applicable to discharges occurring on or after October 1, 2018.

Value-Based Purchasing (VBP)

The estimated base operating DRG payment amount reductions for FY2019 (2% reduction) is the same amount available for value-based incentive payments. Although the measures for FY2019 were finalized in previous rulings, CMS has made final and proposed rulings for the future VBP program, which includes the removal of four measures effective for FY2021, all of which are still included in the Hospital IQR Program. Any other proposals such as the removal of six patient safety measures, removal of the safety domain, and revised weighting of the VBP Program domains, were not finalized.

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 25%. CMS has made a few changes to the HAC program that includes adoption of a new scoring methodology which will weight all measures equally. No new measures were added/removed/edited in the final rule.

Other Notable Updates

Price Transparency

As part of the Public Health Service Act, hospitals are currently required to make public a list of the hospital's standard charges for items and services

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Table 2. c-APCs for Endovascular Procedures.

c-APC	Description	Procedures	CY2018 CMS Payment	CY2019 CMS Proposed Payment	% Change CY18-CY19
c-APC 5191	Level 1 Endovascular Procedures	Dx Cath	\$2,813	\$2,830	+ 0.6%
c-APC 5192	Level 2 Endovascular Procedures	PCI & PV	\$5,085	\$4,756	- 6.5%
c-APC 5193	Level 3 Endovascular Procedures	PCI & PV	\$10,510	\$9,765	- 7.1%
c-APC 5194	Level 4 Endovascular Procedures	PCI & PV	\$16,019	\$15,504	- 3.2%

provided by the hospital. What is different about the FY19 final rule is that hospitals must make this information available online beginning January 2019. CMS clarified that the hospital's charge-master can be used to provide a list of charges, and to update the information each year at a minimum.

CMS is concerned that challenges continue to exist for patients due to insufficient price transparency and fully expect this ruling to expand in the future. Knowing that this will be a focus for CMS in the coming years, hospitals should act NOW to update their charge-masters to continually reflect current pricing. At a minimum, hospitals should update the chargemaster annually in order to avoid potentially costly errors that result from outdated or incorrect code

and pricing information. This is one relatively simple process that can assist in accurate documentation and as a result, accurate payments.

Promoting Interoperability Programs

Formerly known as the Electronic Health Record (EHR) Incentive Program, CMS has overhauled the Medicare and Medicaid Promoting Interoperability (PI) Program in order to better achieve program goals. A few key highlights of the changes include:

- Use of the 2015 Edition of the Certified EHR technology (CEHRT) next year in order to qualify for incentive payments and avoid cuts to Medicare payments.
- Finalizing the program scoring

method from a threshold-based method to a performance method that consists of a smaller set of objectives that will provide a more flexible, less burdensome structure, allowing eligible hospitals and critical access hospitals (CAHs) to place their focus back on patients.

- CMS is not finalizing its proposals to remove six patient safety measures until CY 2020.

Reduction of Reporting and Documentation Intensity

In response to providers' suggestions on ways to reduce the administrative burden of reporting and documenting, CMS decreased the amount of measures that hospitals are required to report, and eased documentation requirements. Beginning

in FY 2020, CMS will eliminate the 21 measures assessed through pay-for-performance (P4P) programs from the Hospital Inpatient Quality Reporting Program (IQR), along with an additional 18 measures deemed to be "topped out" or no longer worth the burden of reporting.

Additionally, in hopes to reduce the number of denied claims for clerical errors in documenting physician admission orders, CMS no longer requires that a written inpatient admission order be present in the medical record as a specific condition of Medicare Part A payment.

Conclusion

The final rulings go into effect October 1, 2018 for the inpatient payments system and January 1, 2019 for the outpatient payments 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 FY2019 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. ■

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The depth of prosthesis and larger size devices are implicated as a potential impetus for fistula development.⁶ In our case, debridement of the aortic valve leaflet via balloon dilation was performed pre-implantation, secondary to severe calcification. Serial post-implantation balloon dilations were required for a paravalvular leak. Either dilation mechanism had the potential to result in the fistula. Muñoz-García et al describe a case of a fistula formation following serial dilations with a 29 mm CoreValve to correct a paravalvular leak, which correlates with our case.⁶

Indication for aorto to RV fistula repair is contingent on the presence and severity of symptoms. Exertional dyspnea, pedal edema, and ascites are reflective of right ventricular volume, and pressure overload may improve with fistula repair. Shunt size has been associated with symptom severity.² A case series performed by Samuels et al describes 40 patients with post SAVR aorto-RV fistulas.⁸ Nearly all of the patients in this series required surgical correction of the fistula due to the development of symptoms of heart failure, with a mean interval of 1.5 years from fistula formation to repair. As an important note, 35% of the patients also had aortic valve regurgitation; therefore, it is unclear whether the postoperative symptoms were a result of the shunt or aortic regurgitation. In a review of case

reports of aorto-RV fistula post TAVR, two patients with symptomatic shunts did not undergo a surgical or percutaneous correction, and died from the progression of heart failure.^{2,4} One case was further complicated by accompanying complete heart block and ventricular septal defect.⁴

To date, there is no reported spontaneous closure of an aorto-RV fistula post TAVR. In asymptomatic patients, annual clinical evaluations and adjunctive echo imaging with a focus on the right ventricular and pulmonary artery pressures are crucial. In younger, symptomatic patients, correction of the fistula is prudent, given the risk of progression to heart failure.² Surgical repair remains the first-line treatment option. Percutaneous closure procedures utilizing TEE guidance have been reported for high surgical risk patients. Pilgrim et al described a case of successful shunt elimination of an aorto-RV fistula with an IMWC-5-PDA5 coil closure (MR eye Flipper Detachable Embolization Coil Delivery System, Cook Medical).⁵ A case series of 20 patients with ruptured sinus of Valsalva aneurysms demonstrated successful fistula closure using an Amplatzer Duct Occluder (Abbott).⁹ Variability in size, shape, and complexity of these defects must be kept in mind when using percutaneous devices not originally designed for aorto-RV fistula repair.⁷ Currently, there are no guidelines for percutaneous closure of aorto-RV fistulas. Our patient

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remained asymptomatic. At 30-day follow-up, TTE showed no significant change in fistula size or right ventricular dimensions, allowing for the continuation of conservative management. His symptoms and echocardiographic images remain stable and unchanged three years after TAVR. ■

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