# The Final Rule

The 2007 hospital in-patient prospective payment system final rule.

**BY ROSEANNE R. WHOLEY**

On August 1, 2006, the Centers for Medicare & Medicaid (CMS) issued the Hospital Inpatient Prospective Payment System Final Rule for fiscal year (FY) 2007. The final payment rate and policy changes are now available in the August 18, 2006 Federal Register. I was especially interested in the impact that this Final Rule would have on carotid stenting, which includes the development of a new diagnosis-related group (DRG) for carotid stenting procedures. Contained within the document issued on this date were several typographical errors including, strangely enough, the incorrect reporting of this new carotid stent DRG code. Below is a brief summary of some of the key issues from this document and the CMS Web site's news releases and fact sheets.

## IMPACT

In the Final Rule, CMS announced payment reforms for in-patient hospital services in 2007 beginning the shift from charge-based payment to cost-based weight. The changes will go into effect for discharges on or after October 1, 2006, and will be phased in over a 3-year period. This is the most significant revision of Medicare's in-patient hospital rates since 1983. Payment to all hospitals will increase by an average of 3.5% in FY 2007, or by more than $3.4 billion. Only 2% of hospitals have a projected reduction in payment as a result of the overall rule and factors other than the DRG changes (eg, certain wage index changes) account for these reductions. Medicare payment to 98% of hospitals will increase in FY 2007. The proposed rule changes in the DRG relative weights are budget neutral, some will go up and others will go down. Therefore, over a 3-year period, there will be a gradual shift from payment based on charges to cost-based weight with the full shift of cost-based weight in effect by FY 2009.

## GOALS AND KEY POLICIES

The goals have been identified as:

- Making meaningful first steps in diagnosis-related groups with plans to continue reforms in FY 2008.
- Ensuring that Medicare does not overpay for some services while underpaying for more severely ill patients or those with complex illnesses.
- Correcting inappropriate hospital incentives for providing certain types of services and redirecting a portion from services that are currently overpaid to those that are underpaid.

Key policies have been described as:

- Implementing a 3-year transition for cost weights and assess potential for further improvements for FY 2008.
- Make meaningful refinements to increase recognition of severity of illness.
- Conduct an evaluation with public comments of alternative severity adjustments for implementation in FY 2008.

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## TAKING STEPS TOWARD MORE ACCURATE PAYMENTS

The main purpose of the reform is to begin to take measured steps toward more accurate payments and to promote quality care for all hospitalized patients. With recommendations from the Medicare Payment Advisory Commission (MedPAC), the changes will reduce incentives for hospitals to invest in certain service areas because the reimbursement rates significantly exceed costs. Biases in the current system arise from hospitals charging much more than their costs for some services. The practice of "charge compression," whereby a hospital applies a lower percentage markup to higher-cost services and a higher percent markup to lower-cost services, will be addressed. Hospitals can mark up charges over costs in many ways that bear little relation to cost. A concern is that some specialty hospitals provide a limited range of profitable services and are owned in whole or in part by physicians who act as referral sources. By correcting hospital incentives, hospitals will be encouraged to provide the best care for all patients, not for treatments that happen to be the most profitable.

CMS began an introduction of severity-based DRGs. Refinements to the DRG payments will include an increased recognition of severity of illness as 32 DRGs will be modified to better capture differences in severity and 20 new DRGs have been developed in 13 different clinical areas. No DRG will decrease more than 5.4% in FY 2007, and 19 DRG weights will increase by more than 5%.

Payment reform will consist of two major parts:

(1) A transition to use estimated hospital costs rather than list charges to set payments to eliminate the practice of having list charges that disproportionately exceed costs for some services; and

(2) The involvement of more accurate accounting for the severity of a patient's illness, which has a significant impact on costs of care. For FY 2008, CMS will conduct an evaluation with public comments as a prelude to making more comprehensive changes to better account for severity in the DRG system.

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## NEW HOSPITAL QUALITY DATA

Hospitals must now report on the 20 Hospital Quality Alliance approved measures, as well as an additional approved measure (influenza vaccination) that will be added to the reported set during 2007. The Final Rule implements a provision that requires hospitals to report additional quality measures to receive an update in rates equal to the full rate of increase. Hospitals that do not report quality data will receive 2.0 percentage points less than the final updated rate.

## NEW TECHNOLOGIES

To ensure that Medicare beneficiaries have rapid access to new technologies, CMS is providing temporary add-on payments for appropriate technologies. In order to be eligible for the additional reimbursement, a product must be:

- New (less than 2 years old)
- Expensive (meeting a defined cost threshold)
- A substantial clinical improvement for the Medicare population.

In section II.G. of the preamble to the final rule, there is a discussion regarding add-on payments for new medical services and technologies. There is no longer a requirement to ensure that any add-on payments for new technology under this section are budget neutral. An estimate of payment increases is described. Specifically, new technology add-on payments are limited to the lesser of 50% of the costs of the technology or 50% of the costs in excess of the DRG payment for the case. Because it is difficult to predict the actual new technology add-on payment for each case, the estimated increase in payment for FY 2007 is that every claim will receive the maximum add-on payment.

CMS approved new technology add-on payments for the X Stop Interspinous Process Decompression System (St. Francis Medical Technologies, Driebergen ,The Netherlands) and will continue to make add-on payments in FY 2007 for two technologies that were approved in FY 2006: Restore Rechargeable Implantable Neurostimulator (Medtronic, Santa Rosa, CA) and the Gore TAG (Gore & Associates, Flagstaff, AZ).

## CAROTID STENTING

CMS reviewed the current DRG codes that are used to report carotid artery stent procedures, DRG 533 (extracranial procedures with comorbidities or complications) and 534 (extracranial procedures without comorbidities or complications), and realized that these DRGs did not provide adequate payment for carotid stenting services. After reviewing all of the data, CMS believed it was compelling enough to warrant the creation of a new DRG for carotid stenting. Page 47,944 of the Final Rule currently identifies the new DRG as code 583. This is the typographical error that I mentioned previously. The correct new DRG code is actually code 577. This new code will contain two procedure codes. Code 00.61 (percutaneous angioplasty or atherectomy of precerebral vessel[s]; basilar, carotid, vertebral) will determine the DRG, and will be combined with code 00.63 (percutaneous insertion of carotid artery stent[s]). Both codes must be reported in order for cases to be assigned to this DRG.

The coverage of the carotid artery stent procedure is still limited to patients at risk for developing a stroke due to narrowing of the carotid artery and diagnosis code 433.10—occlusion and stenosis of carotid artery without mention of cerebral infarction—should be used to identify the procedure. If it is necessary to identify bilateral occlusion or stenosis, diagnosis code 433.30—occlusion and stenosis of multiple and bilateral arteries without mention of cerebral infarction—may also be used. These codes are to be used together. Reporting of code 433.30 alone will most likely cause the case to be denied. Also, the inclusion of the fifth digit "1" (with cerebral infarction) with either of these codes will cause the claim to be rejected.

The good news is that the National Base Payment (which

is adjusted based on geography) for DRG 577 is an increase of approximately 15% over the lowest-paying DRG for carotid endarterectomy. This is also a weighted average payment increase of 39% versus the DRGs 533 and 534 that carotid cases were previously grouped to in 2006.

## LEG PROCEDURES

DRG changes related to leg procedures include the following proposed and final DRGs for FY 2007:

479 (other vascular procedures without complications or comorbidities)

- proposed reduction 9.2%
- final increase 2.76%

553 (other vascular procedures with complications or comorbidities and major cardiovascular compromise)

- proposed reduction 5.6%
- final increase 0.10%

554 (other vascular procedures with complications or comorbidities)

- proposed reduction 3.1%
- final increase 3.23%

## DRUG-ELUTING STENTS

The impact on drug-eluting stent procedures are as follows:

557 (drug-eluting stent procedure with major cardiovascular condition)

- proposed reduction 23%
- final reduction 1%

558 (drug-eluting stent procedure without major cardiovascular condition)

- proposed reduction 33%
- final reduction 3.1%.

## SUMMARY

To improve the accuracy of Medicare payments for inpatient stays, the relationship between costs and charges is the important variable in setting Medicare reimbursement under this system. CMS is implementing the cost-based weighting methodology by gradually transitioning the cost and charge weights over a 3-year period to help minimize disruptions. The payment reforms will align hospital payments more closely with the costs of patient care by using costs rather than charges and by fully accounting for the severity of the patient's condition. ■

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