mechanical ventilation = 96 hours (n = 7); DRG-87 Respiratory insufficiency (n = 6); DRG-176 Lymphatic bowel disease (n = 6); DRG-95 Blood Cells anomalies (n = 5), accounting for 214,414 (29%) of the total. The economic value associated to whole admissions was 738,258. The most significant fluctuation of income within the same DRG was in the more frequent one: DRG-572 (1,742 – 6,524); and in the DRG-571 by 30% (2,358 – 3,358). As expected, regional DRG monitoring. The higher economic values were associated to bowel, liver or bone marrow transplantation (DRG480-481). CONCLUSIONS: This pool of evidence allows to develop standardised pathways for early diagnosis and treatment that help improving patients’ care, increasing hospital efficiency and bed occupancy, leading to the reduction of stay and improving measures for infection control.

PMD116 REVIEW OF US MEDICARE SYSTEM FOR REIMBURSEMENT OF NEW MEDICAL DEVICES

Battaglia S1, Fattore G2, Busca B1
1Medtronic International Trading Sàrl, Tolochenaz, Switzerland; 2SIDA-Bocconi School of Management, Centre for Research in Healthcare Management (CERGAS), Milano, Italy

OBJECTIVES: The aim of this research is to assess US Medicare methodologies for the reimbursement of new medical devices in hospital inpatient and outpatient services.

METHODS: A comprehensive literature search was conducted on PubMed and US Department of Health and Human Services specific to Centers for Medicare and Medicaid Services (CMS). RESULTS: CMS reimbursement structure is shaped by coverage, coding and payment arrangements with reimbursement playing a major role for commercially available devices and coding and coverage for devices under clinical studies. The payment mechanisms applied are defined by diagnosis related groups (DRG in hospital inpatient) and ambulatory payment classification (APC in hospital outpatient) with an additional three separate short-term payment policies: new technology add on payments for in-patient services, transitional pass-through payments and new technology ambulatory payment policy for out-patient services. Biannual reports are presented on existing and new policies for both in-patient and outpatient provisions with updates on the reimbursement system retrospectively going up to year of implementation. An example of T-2 mutations in cardiac resynchronization therapies (CRT) in both inpatient and outpatient settings is used to illustrate the reimbursement mechanisms used by US Medicare. Medicare used a new technology add-on payment for 1 year (up to $16,262 supplemental funding) in addition to DRG payment (ranging from $81,950 to $104,092). To compare new technology add-on payments, the creation of a new APC code was refused with a new technology add-on payment for 1 year (up to $16,262 supplemental funding). To compare volume based on DRG payment (ranging from $81,950 to $104,092). To compare volume and systematic collection of data to revise tariffs each year act as the main feature for Medicare.

CONCLUSIONS: The results show regular and systematic collection of data to revise tariffs each year act as the main feature to allow for new medical technology to be accessible.

PMD117 PATTERNS OF USE OF TESTS TO MONITOR DISEASE ACTIVITY AMONG PATIENTS CURRENTLY RECEIVING TREATMENTS FOR RELAPSING REMITTING MULTIPLE SCLEROSIS (RRMS) IN EUROPE

Narayanan S1, O’Meara PA1, White J2, Chan JH1, Cooper RL1, Baynton EJ3
1Ipsos Healthcare, Washington, DC, USA; 2Ipsos Healthcare, New York, NY, USA; 3Ipsos Healthcare, New York, NY, USA

OBJECTIVES: To assess the patterns of use of tests to monitor disease activity/progression among patients currently treated with disease modifying treatments (DMTs) for RRMS in Europe. METHODS: A multi-country retrospective medical chart review of mNSCLC patient-charts (UK ~630/4 EU ~4170) were collected in 2013. 62/62% of patients newly diagnosed: T-53%/NT-38% in UK, T-42%/NT-49% in EU4. Physicians abstracted data on patient demographics, disease status, treatment patterns and biomarker status . The analysis focused on patients that were either tested (T) or not (NT) for KRAs in 2013. Proportion of patients who were male: T-56%/NT-64% in UK, T-61%/NT-78% in EU4. Proportion of patients who ‘never smoked’ was: T-99%/NT-9% in UK, T-73%/NT-12% in EU4. Time since disease diagnosis was T-6mo/NT-10mo in UK, T-9mo/NT-9mo in EU4. Proportion of patients newly diagnosed: T-53%/NT-38% in UK, T-39%/NT-50% in EU4, in 4 years: T-24%/NT-50% in UK, T-32%/NT-19% in EU4. CONCLUSIONS: The results show regular and systematic collection of data to revise tariffs each year act as the main feature to allow for new medical technology to be accessible.

PMD118 COMPARISON OF KRAS TESTED AND NOT-TESTED METASTATIC COLORECTAL CANCER (mCRC) PATIENT COHORTS IN EUROPE

Narayanan S1, Gallo F1
1Ipsos Healthcare, Washington, DC, USA; 2Ipsos Healthcare, New York, NY, USA

OBJECTIVES: To compare the characteristics of mCRC patients either tested or not for KRAs mutations in Europe in 2009 and 2013. METHODS: A multi-country retrospective medical chart review of mNSCLC patient-charts (UK ~630/4 EU ~4170) were collected in 2013. Proportion of patients newly diagnosed: T-53%/NT-38% in UK, T-42%/NT-49% in EU4. Physicians abstracted data on patient demographics, disease status, treatment patterns and biomarker status . The analysis focused on patients that were either tested (T) or not (NT) for KRAs in 2013. Proportion of patients who were male: T-56%/NT-64% in UK, T-61%/NT-78% in EU4. Proportion of patients who ‘never smoked’ was: T-99%/NT-9% in UK, T-73%/NT-12% in EU4. Time since disease diagnosis was T-6mo/NT-10mo in UK, T-9mo/NT-9mo in EU4. Proportion of patients newly diagnosed: T-53%/NT-38% in UK, T-39%/NT-50% in EU4, in 4 years: T-24%/NT-50% in UK, T-32%/NT-19% in EU4. CONCLUSIONS: The results show regular and systematic collection of data to revise tariffs each year act as the main feature to allow for new medical technology to be accessible.

PMD120 KNOWLEDGE ON THE APPROPRIATE TECHNIQUE OF BLOOD PRESSURE MEASUREMENT AND MONITORING AND LIMITS OF THE OSCILLOMETRIC BLOOD PRESSURE MEASUREMENT

Oláh A1, Horváth A1, Pakai A2, Boncz I1, Fullér N1, Knisz J1, Müller Á1, Szebeni-Kovács G1
1University of Pécs, Pécs, Hungary, 2University of Pécs, Zalaegerszeg, Hungary

OBJECTIVES: Prevalence of cardiovascular diseases is outstanding in Hungary. Incorrect data due to the inappropriate measurement of blood pressure and the inappropriate choice of the measurement tool cause a huge problem during clinical decision making. The aim of our examination was to evaluate the nurses’ knowledge on blood pressure measurement and analyse the precision of oscillometric blood pressure measurement compared to the mercurial blood pressure monitor.

METHODS: In our quantitative, cross-sectional study 96 nurses completed one questionnaire with only closed-ended questions and one with only open-ended questions. During the experimental study we measured the blood pressure of 16 patients with tremor, 12 patients with arthrythmia and 32 patients with hypertension. We used Microsoft Office Excel 2002 software to carry out descriptive statistics, X2-test and two-sample t-test (p < 0.05).

RESULTS: We found no significant difference between the two questionnaire types (p = 0.261), but we did find significant difference in the participating nurses’ level of knowledge (p < 0.001). Comparing the two questionnaire types of patients showed no significant difference between the mercurial- and the oscillometric blood pressure measurements (p = 0.003).

We found no significant difference in the case of the diastolic measures (p < 0.05). In case of systolic measures with high blood patients we found no significant difference between systolic values (p = 0.067), but we did find significant difference regarding the diastolic values (p = 0.044). In case of patients with cardiac arrhythmia, no significant difference can be detected between the two measurements regarding the systolic (p = 0.725) and the diastolic values (p = 0.997).

CONCLUSIONS: The results show regular and systematic collection of data to revise tariffs each year act as the main feature to allow for new medical technology to be accessible.