mechanical ventilation (>60 hours/n); DRG-87 Respiratory insufficiency (n=6); DRG-174 Lower extremity disorder (n=6); DRG-95 Blood Cells anomalies (n=5); accounting for 215,414 (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-87 by 174.5/39 (1,102-4,630). To detect regional DRG monitoring. The higher economic values were associated to bowel, liver or bone marrow transplantation (DRG480-481). CONCLUSIONS: This pool of evidence allows identifying the main pitfalls of early diagnosis and treatment that help improving patients’ care, increasing hospital efficiency and bed occupancy, reduce length of stay and improve measures for infection control.

PMID16

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REVIEW OF US MEDICARE SYSTEM FOR REIMBURSEMENT OF NEW MEDICAL DEVICES

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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; 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 ambulance payment policies for outpatient services. Biannual reports are presented on existing and new policies for both inpatient and outpatient provisions with updates on the reimbursement system retrospectively major to year of implementation. To improve patient care and to minimize possible errors, new technology, resynchronization therapies (CRT) in both inpatient and outpatient setting 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-based payment (ranged from $292 to $393). To compare and estimated payments of CRT devices in the outpatient setting (2,358 outpatient compared to 21,920 inpatient) a separation of AFC codes (with intent to create a new AFC code) was conducted. The creation of a new AFC code was refined with further restructuring of existing codes. 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.

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

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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 EU.

METHODS: A multi-country retrospective medical chart review of mNSCLC patients was conducted in EU (UK/France/Germany/Italy/Spain) to collect data on diagnosis, clinical status, and disease management approaches. Data collection period was from Dec 2012 to Dec 2013. Physicians were recruited from a geographically representative sample in each country. Approximately 10-25 eligible patients on usual care anti-cancer regimens were sampled from each of the four participating countries. Data collection was performed in 2013. Physicians abstracted data on patient demographics, disease status, treatment and biomarker status. The analysis focused on patients that were either tested (T) or not (NT) for KRAS mutation in 2013 and 2009. Proportion of patients who were male: T-56%/NT-64% in UK, T-61%/NT-78% in EU. Proportion of patients who never smoked: T-29%/NT-9% in UK, T-23%/NT-12% in EU. Time since disease diagnosis was T-6mo/NT-10mo in UK, T-9mo/NT-9mo in EU. Proportion of patients newly diagnosed: T-53%/NT-38% in UK, T-39%/NT-50% in EU, % in relapse: T-24%/NT-50% in UK, T-32%/NT-19% in EU. Mean age was: T-59yrs/NT-64yrs in EU. CONCLUSIONS: Distinct differences appear to exist within mNSCLC cohorts based on the EGFRun test status (T/NT) and geography (UK/EU). This warrants further research to understand the drivers behind these differences and how it may lead to the utilization of targeted oncology therapeutics to alleviate patient burden and improve outcomes.

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

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OBJECTIVES: Prevalence of cardiovascular diseases is outstanding in Hungary and 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 mercuリアル blood pressure monitor.

METHODS: In our quantitative, cross-sectional study 96 nurses completed one questionnaire with only closed-ended questions and one with only opened-ended questions. During the experimental study we measured the blood pressure of 16 patients with tremor, 12 patients with arrhythmia and 32 patients with hypertonia. We used Microsoft Office Excel 2002 software to count out descriptive statistics, t2-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’ knowledge level of knowledge (p>0.00). Comparing the obtained values of patients showed no significant difference between the mercuリアル- and the oscillometric blood pressure measurements (p>0.003). We found no significant difference in the case of diastolic measures (p>0.05). In case of patients with high blood pressure 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>0.937) and diastolic values (p>0.234). CONCLUSIONS: We found no significant difference between the two measurement techniques regarding the systolic and the diastolic blood pressure measurements which p>0.003. We found no significant difference in the case of diastolic measures (p>0.05). In case of patients with cardiac arrhythmia, no significant difference can be detected between the two measurements regarding the systolic and diastolic values (p>0.937 and p>0.234).