Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-02-124 **Date: DECEMBER 13, 2002**

CHANGE REQUEST 2301

SUBJECT: Necessary Changes to Implement Special Add-On Payments for New Technologies

SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES

Section 533(b) of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA) amended section 1886(d)(5) of the Act to add subparagraphs (K) and (L) and establish a process of identifying and ensuring adequate payment for new medical services and technologies under Medicare. In the September 7, 200l, final rule (66 FR 46902), we established that cases using approved new technology would be appropriate candidates for an additional payment when: the technology represents an advance in medical technology that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries; the payment for such cases can be demonstrated to be inadequately paid otherwise under the diagnosis-related group (DRG) system; and data reflecting the costs of the technology would be unavailable to use to recalibrate the DRG weights.

Under 42 CFR 412.88 of the regulations, an add-on payment is made for discharges involving approved new technologies, **if the total covered costs of the discharge exceed the DRG payment for the case** (including adjustments for indirect medical education (IME) and disproportionate share hospitals (DSH) but excluding outlier payments). PRICER will calculate the total covered costs for this purpose by applying the cost-to-charge ratio (that is used for inpatient outlier purposes) to the total covered costs of the discharge. Payment for eligible cases will be equal to:

- The full DRG payment (see example 1 that follows); plus
- The lesser of
    1. 50 percent of the costs of the new medical service or technology (see example 2); or
    2. 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment (see example 3); plus
- Any applicable outlier payments if the costs of the case exceed the DRG, plus adjustments for IME and DSH, and any approved new technology payment for the case plus the fixed loss outlier threshold. The costs of the new technology are included in the determination of whether a case qualifies for outliers.

This Program Memorandum (PM) implements the above payment mechanism into the claims processing systems.

Below are three illustrative examples of this policy for cases involving an eligible technology estimated to cost $3,000 in a DRG that pays $20,000.

Example One: Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $19,000. Medicare would pay $20,000, the full DRG payment. Even though the case involved a new technology eligible for add-on payments, the total covered costs of the case did not exceed the DRG payment, therefore, no additional payment is made.

Example Two: Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $25,000. Because, in this case, 50 percent of the costs of the new medical service or technology is less than 50 percent of the amount by which the total covered costs (as determined above) of the case exceed the DRG payment, Medicare would pay 50 percent of the costs of the new technology (in addition to the DRG payment). Therefore, for this case, Medicare would pay $21,500 (the DRG payment of $20,000 plus one-half of $3,000, the estimated cost of the new technology).

Example Three: Applying the hospital's cost-to-charge ratio to the total covered charges for the case, it is determined the total cost for the case is $22,000. Medicare would pay one-half of the amount by which the costs of the case exceed the DRG payment, up to the estimated cost of the new technology. Therefore, for this case, Medicare would pay $21,000 (the DRG payment of $20,000 plus one-half of the costs above that amount).

Identifying Claims Eligible for the Add-On Payment for New Technology

Technologies eligible for add-on payments will be identified based on the applicable codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Claims submitted with an ICD-9-CM code indicating that a new technology was involved in the treatment of the patient is then eligible for add-on payments as described above.

The system maintainers must pass (if present) the "principal" and up to five "other procedure" codes to PRICER. If an eligible code is present, PRICER will calculate an add-on payment if appropriate.

It is expected that this will add six new fields (7 positions each) to the end of the claim data record sent to PRICER by the system maintainer.

Additionally, the National Uniform Billing Committee has approved value code 77 (FL 39-41 of the UB-92 or electronic equivalent) for FI use only, defined as "New Technology Add-On Payment." This value code must be passed to CWF and the PS&R. The amount shown in this value code will need to be paid to PIP providers on a claim-by-claim basis the same as outlier payments are paid to PIP providers.

Remittance Advice Impact

In order to process this special add-on payment for new technologies, and report in the Remittance Advice (electronic and paper):

- Use reason code 94 with group code OA in the CAS segment
- Use code ZL in the AMT segment.
- Code ZL should be reported in the Flat File for reporting with X12 code CS in the composite data element of the 835 PLB segment.

For PIP payment, include only the add-on payment on a claim-by-claim basis.

Processing Claims Between October 1, 2002 and June 2, 2003

In the August 1, 2002, **Federal Register**, we approved Xigris™ (identified by ICD-9-CM code 00.11) for new technology pass-through payments for discharges on or after October 1, 2002. During the interim period before a new PRICER becomes available, providers will bill claims as usual and you will make the appropriate payment without the new technology add-on payment. For any payment adjustment on these claims, if deemed an originally clean claim, applicable interest will apply.

You will mass adjust claims with ICD-9-CM code 00.11 and Type of Bill 11X for claims between October 1, 2002, and June 2, 2003, and process through the new PRICER. You will complete the mass adjustment as soon as possible, but no later than July 1, 2003.

The *effective date* for this PM is October 1, 2002.

The *implementation date* for this PM is June 2, 2003.

The instructions contained in this PM should be implemented within your current operating budget.

This PM may be discarded after September 30, 2003.

If you have any questions pertaining to special add-on payments for new technologies contact Meredith Walz (410-786-4548).