Regulatory committee insight

Reviewing ICD-10-PCS Section X

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There is a saying that “the only constant in life is change.” This can also be said about healthcare. New advances in medical technologies are constantly introduced allowing us to better care for our patients. Unfortunately, the cost of these new technologies can lead to an overwhelming financial burden to hospitals and patients. So, what can you, the CDI specialist, do to lessen the financial burden of new technology in your hospital? Let’s start with an overview of how Medicare pays for new technologies.

When certain criteria are met (fiscal year [FY] 2012 inpatient prospective payment system [IPPS] final rule), CMS may provide additional payment for new, high-cost technologies in the inpatient setting. New technology add-on payments (NTAPs) provides additional payment to hospitals above the standard MS-DRG payment amount. A given technology’s [NTAP](https://avalere.com/insights/the-inpatient-prospective-payment-systems-ipps-fy-2017-overview) designation lasts no more than three years for a specific indication. This means once a new technology add-on payment status is granted, hospitals are eligible to receive the NTAP for up to three years. In order for the new technology to qualify for NTAP, a technology must meet the following criteria:

* **Newness:** A technology is considered new until claims [data](https://avalere.com/webinars/data-driven-insights-the-future-of-performance-improvement) reflecting the use of that technology become available. The technology must also not be “substantially similar” to existing technologies.
* **Cost:** The technology is inadequately paid under the existing MS-DRG system as shown by the average standardized charge for inpatient cases receiving the technology exceed the cost threshold.
* **Clinical Improvement:** Use of the technology must significantly improve clinical outcomes for a patient population as compared to currently available treatments. Clinical data must be specific or generalizable to Medicare patient population.

An important note: devices that obtain breakthrough designation and drugs that obtain qualified infectious disease product (QIDP) designation from the FDA only need to show they meet the cost criteria. In those cases, CMS will assume the technology meets the newness and clinical improvement criteria.

So, when your hospital uses a Medicare approved new technology, it becomes eligible for a NTAP. This is in addition to the DRG payment for hospital inpatient care. For FY 2019, the calculation for add-on payments is based on cost to hospitals for the new medical service or technology. Specifically, Medicare makes an add-on payment equal to the lesser of the following:

* 50% of the costs of the new medical service or technology, or
* 50% of the amount by which the costs of the case exceed the standard DRG payment

In response to concerns from commenters and stakeholders, CMS agrees “that capping the add-on payment amount at 50 percent could, in some cases, no longer provide a sufficient incentive for the use of the technology.” As such, for discharges on or after October 1, 2019, CMS finalized their proposal to make the add-on payment be equal to the lesser of the following:

* 65% of the costs of the new medical service or technology, or
* 65% of the amount by which the costs of the case exceed the standard DRG payment.

As you can see, NTAP can result in a substantial additional payment to your hospital. So how do hospitals capture the use of approved NTAP for reimbursement?

The CMS ICD-10 Coordination and Maintenance committee created a new section in the ICD-10-PCS coding index. The ICD-10-PCS section X “New Technology” became active in 2015. This section provides a place for codes that identify procedures requested via the new technology application process, along with codes used to capture *other new technologies* not currently classified in ICD-10-PCS.

Section X codes are standalone codes which means no additional codes from other sections in ICD-10-PCS are necessary for reporting them as the specific procedure. Section X does not introduce any new coding concepts or unusual guidelines for correct coding. In fact, Section X codes maintain continuity with the other sections in ICD-10-PCS by using the same root operation and body part values as their closest counterparts in other sections of ICD-10-PCS.

For example, the two new codes for the infusion of ceftazidime-avibactam, a new technology antibiotic that requires unique procedure codes for October 1, 2015, use the same root operation (introduction) and body part values (central vein and peripheral vein) in Section X as the infusion codes in Section 3, Administration, which are their closest counterparts in the other sections of ICD-10-PCS.

But there is something different about coding in Section X. The seventh character in Section X is used only to indicate the year the new technology group code was added. For example, Section X codes added for the first year have the seventh character value 1, New Technology Group 1, and the next year that Section X codes are added have the seventh character value 2, New Technology Group 2, and so on. This is a much simpler use of the qualifier than in many other sections of ICD-10-PCS.

This unique coding of the seventh character allows CMS to collect information for three years for each of the new technologies. Once the three-year period is completed, CMS asks:

* Was the procedure code related to a NTAP application?
* If yes, was the technology approved for the NTAP?
* What is the frequency (total number of cases) of this procedure code as reported in the data for FYs over the three-year period?

That last question is where CDI and coding play an important role in determining the impact of NTAP. If the code is not captured when NTAP is used, then the data submitted to CMS will be inaccurate. This will have a significant impact on both the financial health of your hospital and the future of patient care.

Based on review of the data and the clinical aspects of each procedure code, CMS will propose one of the options below:

* Leave the code in Section X (e.g. procedure codes related to the administration of a specific medication).
* Reassign the code to the medical/surgical section of ICD-10-PCS and delete from Section X (e.g. NTAP has expired, data analysis and clinical review justifies incorporating this technology/procedure into the main medical/surgical section).
* Delete the Section X code (e.g. the procedure is not reported as anticipated in the data, therefore the absence of a unique code for this technology/procedure in the classification has minimal impact).

CMS just completed the first three-year review (FY 2016, 2017, 2018) of the new technology codes. These are their recommendations for ICD-10-PCS Section X new technologies after review:

* For FY 2020, CMS proposed to continue 10 of 13 technologies receiving NTAP in FY 2019.
* The remaining 3 of 13 technologies receiving NTAP in FY 2019 were no longer considered “new” and have been discontinued for FY 2020.
* There were 17 new applicants for new technology add-on payment for FY 2020.
* Eight of the 17 new applicants discussed in the proposed rule either withdrew their application, did not receive FDA approval by the deadline of July 1 or after evaluation CMS found they did not meet the criteria to be considered a new technology.
* Effective October 1, 2019, there will be 19 new technologies eligible for add-on payments.

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| Medical Service or Technology | Estimated Amount NTAP will Increase Overall 2020 Payments by | Estimated Number of Patients |
| KYMRIAH® & YESCARTA® | $93,585,700 | 386 |
| VYXEOS™ | $45,458,400 | 960 |
| VABOMERE™ (Meropenem-Vaborbactam) | $22,020,768 | 2,648 |
| Remedē® System | $1,794,000 | 80 |
| ZEMDRI™ (Plazomicin) | $10,209,375 | 2,500 |
| GIAPREZA™ | $11,173,500 | 5,730 |
| Sentinel® Cerebral Protection System | $11,830,000 | 6,500 |
| AQUABEAM System (Aquablation) | $677,625 | 417 |
| AndexXa™ (Andexanet alfa) | $98,755,313 | 5,402 |
| AZEDRA® (Ultratrace® iobenguane Iodine-131) Solution | $39,260,000 | 400 |
| CABLIVI® (caplacizumab-yhdp) | $4,351,165 | 131 |
| ELZONRIS™ (tagraxofusp, SL-401) | $30,985,668 | 247 |
| Balversa™ (Erdafitinib) | $178,162 | 50 |
| ERLEADA™ (Apalutamide) | $286,171 | 154 |
| SPRAVATO (Esketamine) | $6,494,656 | 6,400 |
| XOSPATA® (gilteritinib) | $13,710,938 | 1,875 |
| JAKAFI™ (Ruxolitinib) | $556,788 | 140 |
| T2Bacteria® Panel (T2 Bacteria Test Panel) | $3,669,803 | 37,639 |
| Data Source: [FY 2020 IPPS Final Rule, pp. 42669-42670](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2020-IPPS-Final-Rule-Home-Page.html) | | |

Unfortunately, Section X is not intuitive. Your computer-assisted coding software will not prompt you for the X codes. It is important that you familiarize yourself with these codes each year. Missing them could lead to losing the additional add on payment for your hospital. Now is the time for you to find out:

* Is your hospital providing any of these medical services or technology?
* Who needs to be aware of what the new technologies are? (e.g., physicians, pharmacy, coding professionals, CDI specialists, case managers)
* What process do you have in place to alert your coding staff of the need to code the new technologies?

Answering these questions will allow you to evaluate your hospital’s success at capturing NTAP codes and help you define your role in this process.

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