

the annual proposed rule, the Web site also lists the tracking forms completed by each applicant.

The new technology add-on payment policy provides additional payments for cases with high costs involving eligible new technologies while preserving some of the incentives under the average-based payment system. The payment mechanism is based on the cost to hospitals for the new technology. Under § 412.88, Medicare pays a marginal cost factor of 50 percent for the costs of the new technology in excess of the full DRG payment. If the actual costs of a new technology case exceed the DRG payment by more than the estimated costs of the new technology, Medicare payment is limited to the DRG payment plus 50 percent of the estimated costs of the new technology.

The report language accompanying section 533 of Pub. L. 106-554 indicated Congressional intent that the Secretary implement the new mechanism on a budget neutral basis (H.R. Conf. Rep. No. 106-1033, 106th Cong., 2nd Sess. at 897 (2000)). Section 1886(d)(4)(C)(iii) of the Act requires that the adjustments to annual DRG classifications and relative weights must be made in a manner that ensures that aggregate payments to hospitals are not affected. Therefore, we account for projected payments under the new technology provision during the upcoming fiscal year at the same time we estimate the payment effect of changes to the DRG classifications and recalibration. The impact of additional payments under this provision would then be included in the budget neutrality factor, which is applied to the standardized amounts and the hospital-specific amounts.

Because any additional payments directed toward new technology under this provision must be offset to ensure budget neutrality, it is important to consider carefully the extent of this provision and ensure that only technologies representing substantial advances are recognized for additional payments. In that regard, we indicated that we would discuss in the annual proposed and final rules those technologies that were considered under this provision; our determination as to whether a particular technology meets our criteria to be considered new; whether it is determined further that cases involving the new technology would be inadequately paid under the existing DRG payment; and any assumptions that went into the budget neutrality calculations related to additional payments for that new technology, including the expected number, distribution, and costs of these cases.

To balance appropriately the Congress' intent to increase Medicare's payments for eligible new technologies with concern that the total size of those payments not result in significantly reduced payments for other cases, we set a target limit for estimated add-on payments for new technology under the provisions of sections 1886(d)(5)(K) and (L) of the Act at 1.0 percent of estimated total operating prospective payments.

If the target limit is exceeded, we would reduce the level of payments for approved technologies across the board, to ensure estimated payments do not exceed the limit. Using this approach, all cases involving approved new technologies that would otherwise receive additional payments would still receive special payments, albeit at a reduced amount. Although the marginal payment rate for individual technologies would be reduced, this reduction would be offset by large overall payments to hospitals for new technologies under this provision.

Comment: Some commenters asked that CMS ensure that the necessary software changes be made to accommodate newly approved technologies so that hospitals experience no delay in receiving add-on payments for new technologies. Commenters noted that, at the time they prepared their comments, it was unclear whether hospitals were receiving any new technology add-on payments for FY 2003. Given that \$74.8 million was carved out of the FY 2003 standardized amount, it is critical that a reliable system be put in place to ensure that hospitals receive these add-on payments.

Response: We regret the delay any hospital may be experiencing in receiving add-on payments for FY 2003. On December 13, 2002, we issued Program Memorandum A-02-124 that requested fiscal intermediaries to implement the new technology payment mechanism into the claims processing system by April 1, 2003. The changes outlined in this program memorandum were delayed until July 16, 2003, in order to ensure that the claims processing system could properly process these add-on payments.

Comment: Several commenters pointed out that new ICD-9-CM codes are being created for procedures that were not typically captured and reported using ICD-9-CM coding. The commenters specifically mentioned the creation of new codes for types of drugs. Commenters are concerned about the types of medical record documentation that may be required for the administration of these drugs to be assigned an ICD-9-CM code. They

asked if a physician order for a drug and a notation on a medical sheet that a nurse had in fact injected the drug were sufficient documentation. The commenters indicated that further guidance is needed regarding documentation requirements for ICD-9-CM codes for new services and technologies that have not traditionally been reported through the use of ICD-9-CM coding.

One commenter recommended that the approval process for new technologies be revised to include a requirement that the applicant must barcode such item with appropriate detailed information. The commenter stated that the use of barcoding would reduce medical errors. The commenter also was concerned that the limit of 6 procedure codes that can be reported on the billing form may become problematic as more new technologies are approved in the future.

Response: We have asked the AHA to schedule this topic for discussion by the Cooperating Parties for ICD-9-CM and the Editorial Advisory Board for Coding Clinic for ICD-9-CM. AHA agrees that this is a timely topic and has scheduled it for discussion in one of its upcoming ICD-9-CM meetings.

We would like to explore further the commenter's suggestion to require applicants for new technology add-on payments to barcode the technology. We recognize the potential limitations of the current claims form, as well as the overall limitations of ICD-9-CM. As we have stated previously, we believe ICD-10-PCS offers great potential improvement for more specific coding that may limit the use of multiple ICD-9-CM codes to identify certain classes of patients.

Comment: Commenters asked that CMS present a full and clear accounting for estimated and actual new technology add-on payments and their impact on the DRG base rate in each proposed and final rule in order to ensure that hospitals receive these add-on payments in full. Another commenter recommended that, similar to outlier payments, CMS should report every year on the extent to which the actual add-on payments per case exceeded or were lower than the amount removed from the standardized amounts.

One commenter was concerned that additional payments might be carved out of the standardized amount for new technologies to ensure budget neutrality, and those payments might not be made because CMS' projection of spending for the add-on payments was too high or because hospitals failed to bill properly for add-on payments. The commenter recommended that CMS