Hemospray Receives Additional Reimbursement

Hemospray Eligible for New Technology Add-on Payments (NTAP)

What is NTAP?

The Medicare New Technology Add-on Payment (NTAP) program used by the Centers for Medicare and Medicaid Services (CMS) was established to provide additional payment for new technologies/services in Medicare's hospital inpatient prospective payment system (IPPS). The intent of the additional payments is to provide a temporary payment mechanism for the use of new technologies in addition to the DRG payment amount the hospital would otherwise receive. The NTAPs are provided until CMS has an appropriate number of inpatient claims data for MS-DRG rate setting that reflected the added costs of the new technology.

To be eligible for NTAP, a technology must meet three criteria: 1) the technology must be considered new; 2) the technology must add significant cost to a hospital stay; 3) the technology must show substantial clinical improvement over current standards of care. In the fiscal year (FY) 2021 final rule published by CMS, it was determined that Hemospray meets all three criteria.

When does the payment go into effect?

Hospitals will be eligible to receive NTAP for Hemospray beginning October 1, 2020, for a period of up to three years.

ICD-10 Codes

One of the following ICD-10 codes MUST be reported on the claim for a hospital to be eligible for NTAP.

XW0G886 *(Introduction of mineral-based topical hemostatic agent into upper GI, via natural or artificial opening endoscopic, new technology group 6)*

XW0H886 *(Introduction of mineral-based topical hemostatic agent into lower GI, via natural or artificial opening endoscopic, new technology group 6)*

Payment Calculation

Each case where the total costs of the case are more than the MS-DRG payment, CMS will provide an add-on payment.

As stated in the FY2021 Hospital Inpatient Prospective Payment Final Rule from CMS, *"Under § 412.88(a)(2), we limit new technology add-on payments to the lesser of 65 percent of the average cost of the technology, or 65 percent of the costs in excess of the MS–DRG payment for the case. As a result,* ***the maximum new technology add-on payment for a case involving the use of Hemospray is $1,625.00 for FY 2021****."*

Hemospray Eligible for Transitional Pass-Through Payments

What is Transitional Pass-Through Payment (TPT)?

The Medicare Transitional Pass-through (TPT) payment program used by the Centers for Medicare and Medicaid Services (CMS) was established to provide additional payment for new technologies/services in Medicare's Hospital Outpatient Prospective Payment System (OPPS). The intent of the additional payments is to provide a temporary payment mechanism for the use of new technologies in addition to the procedural payment amount the hospital would otherwise receive. The TPT payments are provided until CMS has an appropriate number of claims data for rate setting that reflected the added costs of the new technology.

How does CMS decide which technologies receive TPT?

To be eligible for TPT, a technology must meet three criteria: 1) the technology must be considered new; 2) the technology must add significant cost to a procedure; 3) the technology must show substantial clinical improvement over current standards of care. In the calendar year (CY) 2021 final rule published by CMS, it was determined that Hemospray meets all three criteria.

Who is eligible for TPT payments?

Hospitals paid under the Medicare Outpatient Prospective Payment System (OPPS) and ambulatory surgery centers will be eligible for TPT payments.

When does the payment go into effect?

Hospitals will be eligible to receive TPT payments beginning January 1, 2021, for a period of up to 3 years.

HCPCS Code

The following HCPCS code **MUST** be reported on the claim for a hospital to be eligible for TPT.

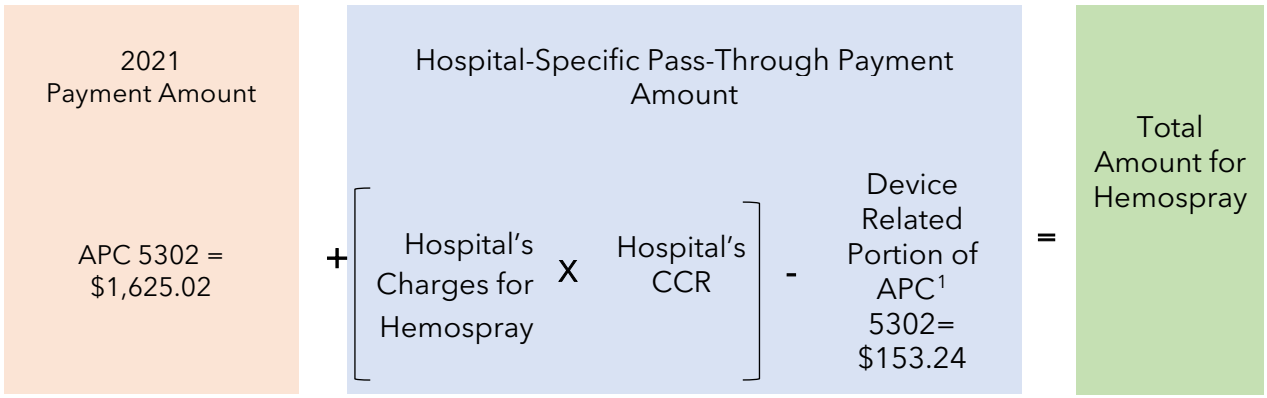
C1052 (Hemostatic agent, gastrointestinal, topical)

Payment Calculation

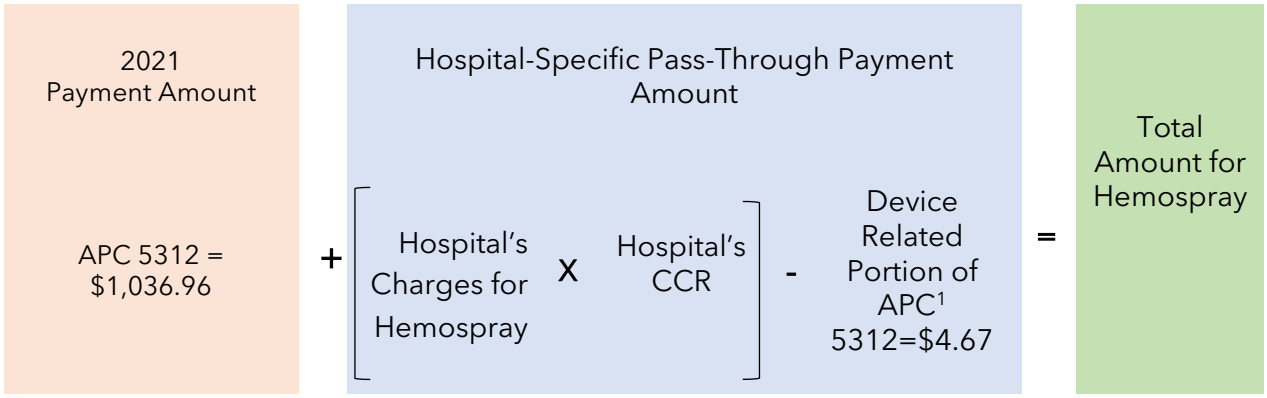
Medicare determines the TPT payment amount on a case-by-case basis for each hospital; it is not a standard amount. The TPT payment amount is calculated based on:

- *Hospital's charges* for the new technology, which includes a hospital's charge adjustment or markup to account for its operating and capital costs;
- *Hospital's cost-to-charge ratio (CCR)*, which Medicare applies to the charges submitted to determine the estimated costs of items and services on the claim form; and
- The *device related portion of the relevant APC* payment amount.

Example 1 – APC 5302 (Upper GI)



Example 2 – APC 5312 (Lower GI)



If you have further questions, please contact reimbursement@cookmedical.com

[1] 2021 OPPS APC Offset File. Available at: https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientppshospital-outpatient-regulations-and-notices/cms-1736-p.