FEHB Program Carrier Letter
Fee-for-Service Carriers

Letter No. 2007-06   Date: February 28, 2007

Fee-for-service [4]   Experience-rated HMO [n/a]   Community-rated HMO [n/a]

SUBJECT: Omnibus Budget Reconciliation Act of 1990 (OBRA '90) IPPS Pricer Program Usage

Since the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) was enacted, we have issued several carrier letters to provide guidance on implementation of its provisions under the FEHB Program. OBRA '90 requires fee-for-service carriers to use Medicare Part A pricing limits in adjudicating claims for inpatient services provided to retirees and their spouses/survivors age 65 and over who were never eligible/enrolled in Medicare Part A. OPM's Office of Inspector General (OIG) audits have shown that some carriers are incorrectly pricing certain OBRA '90 claims. This carrier letter contains guidance on pricing these types of claims.

The Centers for Medicare and Medicaid Services (CMS) established the Inpatient Prospective Payment System (IPPS) Pricer program to price hospital inpatient services for Medicare Part A beneficiaries. Under IPPS, a hospital is paid a fixed amount for each patient discharged in a particular treatment category or Diagnosis Related Group (DRG). This fixed amount is intended to cover the cost of treating a typical patient for the particular DRG. CMS provides a separate IPPS Pricer software program and related hospital financial files for each federal government fiscal year. CMS releases the PC version of the IPPS Pricer software on its website (http://www.cms.hhs.gov/PCPricer/03_inpatient.asp#TopOfPage) every quarter. The Pricer release schedule is as follows:

- Initial Release of Pricer — October 1
- First Quarterly Release — On or about October 15
- Second Quarterly Release — On or about January 15
- Third Quarterly Release — On or about April 15
- Fourth Quarterly Release — On or about July 15

Each health insurance carrier should check the CMS website on or about the above dates to retrieve an updated version of that fiscal year's IPPS Pricer program. The latest release of the mainframe Pricer program is available from OPM.

To ensure that OBRA '90 claims are correctly priced, the "Transfer" and "Post Acute Transfer" questions on the Pricer program must be answered appropriately. A "Transfer" occurs when a patient is discharged from one acute care facility and is admitted to a similar facility on the same day. In contrast, a "Post Acute Transfer" takes place when a patient is discharged from an acute care facility and is taken to a facility that is exempt from prospective payment system pricing, such as a skilled nursing facility or home health agency. The Y (yes)/ N (no) responses to these questions are based on the "Patient Discharge Status Code" that appears on all hospital claim bills. The table below identifies when Y (yes) must be used for the Transfer and Post Acute Transfer questions on the IPPS Pricer program input screen.

		Discharge Status Code
Transfer	02	Discharged/Transferred to Another Short-Term General Hospital for Inpatient Care
Post Acute Transfer	03	Discharged/Transferred to Skilled Nursing Facility with Medicare Certification
	05	Discharged/Transferred to Another Type of Institution
	06	Discharged/Transferred to Home Under Care of Organized Home Health Service Organization
	62	Discharged/Transferred to an Inpatient Rehabilitation Facility Including Rehabilitation Distinct Part Units of a Hospital
	63	Discharged/Transferred to a Medicare Certified Long-term Care Hospital
	65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital (Effective April 1, 2004)

An additional set of questions on the IPPS Pricer program is related to new and emerging technologies in patient treatment. Periodically, CMS releases a transmittal that identifies a procedure or device as "new technology" and therefore eligible for additional payment. The transmittals define the procedure codes, procedure code combinations, or diagnosis related group (DRG) codes that qualify for the premium. When a claim has "new technology" procedure codes or DRG codes, carriers must select the Y (yes) response to the NEW TECH questions to ensure it is priced correctly.

Since October 1, 2002, CMS has authorized nine new technology add-on payments (see Attachment 1 for details and an example of the fiscal year 2007 Pricer screen that shows the current NEW TECH choices). Typically, a CMS transmittal is released at or near the beginning of each fiscal year in which changes to the IPPS program are announced. These transmittals also define "new" new technology add-on payments and can sometimes discontinue previously authorized additional payments. Therefore, carriers should periodically monitor the CMS website for new transmittals (http://www.cms.hhs.gov/Transmittals/01_Overview.asp). At this website, the CMS transmittals are grouped by year. Selecting a year links to a search engine that can be used to quickly locate transmittals related to new technology by using the keyword IPPS.

Questions regarding transfer, post acute transfer, new technology, or other issues related to the IPPS Pricer program should be directed to Lewis Parker, Chief, Information Systems Audits Group, on 202-606-4738 or at lewis.parker@opm.gov.

Sincerely,

Robert F. Danbeck
Associate Director
 for Human Resources Products and Services

Attachment 1
Pricing Procedures for "New Technology" Claims

1. NEW TECH 0011/XIGRIS (effective 10/1/2002 thru 9/30/2004):
   This field should be turned to "Y" when the claim has procedure code 00.11 on the hospital bill.
   [The maximum add-on is $3,400.]

2. NEW TECH INFUSION (effective 10/1/2003 thru 9/30/2004):
   This field should be turned to "Y" when the claim has procedure codes 84.51 **AND** 84.52 on the hospital bill **AND** DRG codes 497 or 498.
   [The maximum add-on is $8,900.]

3. NEW TECH INFUSION (effective 10/1/2004 thru 9/30/2005):
   This field should be turned to "Y" when the claim has procedure code 84.51 **AND** 84.52 **AND DOES NOT** have procedure code 81.05, 81.08, 81.35, or 81.38 on the hospital bill.
   [The maximum add-on is $1,955.]

4. NEW TECH OP-1 (effective 10/1/2004 thru 9/30/2005):
   This field should be turned to "Y" when the claim has procedure code 84.52 **AND** procedure code 81.05, 81.08, 81.35, or 81.38 on the hospital bill. [The maximum add-on is $1,955.]

5. NEW TECH CRT-D (effective 10/1/2004 thru 9/30/2005):
   This field should be turned to "Y" when the claim has procedure code 00.51 **OR** 00.54 on the hospital bill. [The maximum add-on is $16,262.50.]

6. NEW TECH NEURO (effective 10/1/2005)
   This field should be turned to "Y" when the claim has procedure code 86.98 on the hospital bill.
   [The maximum add-on is $9,320.00.]

7. NEW TECH GRAFT (effective 10/1/2005)
   This field should be turned to "Y" when the claim has procedure code 39.73 on the hospital bill.
   [The maximum add-on is $10,599.00.]

8. NEW TECH KINETRA (effective 10/1/2004 thru 9/30/2006):
   This field should be turned to "Y" when the claim has procedure codes 02.93 **AND** 86.95 on the hospital bill. [The maximum add-on is $8,285.00.]

9. NEW TECH X STOP (effective 10/1/2006)
   This field should be turned to "Y" when the claim has procedure code 84.58 on the hospital bill.
   [The maximum add-on is $4,400.00.]

Pricer Program for FY 2007

PRICER07.exe - COBOL Text Window

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            PRICER 2007.2 PSF 07/06R   (DISCHRGS 10/2006-9/2007)

   BILL PROV NUMBER ==>                PATIENT ID NUMBER==>     ■-■-

   BILL ADMIT DATE  ==>      ╱  ╱      BILL DISCHG DATE ==>     ╱  ╱
                           MM/DD/YY                           MM/DD/YY

                    BILL DRG          ==>      ■

                    COST OUTLR THRES  ==>   N   Y=YES OR N=NO
                    HMO PAID CLAIM    ==>   N   Y=YES OR N=NO
                    TRANSFER          ==>   N   Y=YES OR N=NO
                    POST ACUTE XFER   ==>   N   Y=YES OR N=NO
                    BILL CHARGES      ==>           .00

                    NEW TECH NEURO    ==>   N   Y=YES OR N=NO
                    NEW TECH GRAFT    ==>   N   Y=YES OR N=NO
                    NEW TECH X STOP   ==>   N   Y=YES OR N=NO

   NOTE: USE >TAB KEY< TO WALK THROUGH SCREEN
   NOTE: USE >SHT+TAB< TO BACK THROUGH SCREEN -   USE >END KEY<BOTTOM OF SCREEN

      <Y = CALCULATE> <V = VIEW A PROVIDER> <Q = QUIT>   ENTER ==> Y
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