Frequently Asked Questions

1. When is New Technology Add- On Payment (NTAP) effective for CERAMENT® G and how long will it be in effect?

The CERAMENT® G NTAP became effective October 1, 2022. NTAP's are effective for a minimum of 2 years and up to a maximum of 3 years.

2. What are the billing requirements for a CERAMENT® G case in the hospital inpatient setting?

There are no special billing requirements placed on the hospital for processing the NTAP payment, other than using the appropriate ICD-10-PCS X-codes that describe the use of CERAMENT® G as part of the primary procedure, AND either the primary or secondary ICD-10-CM diagnosis codes that identify the qualifying diagnoses for the NTAP, as indicated by the treating physician.

A list of these codes is available in the CERAMENT® G Coding and Billing Guide. Note that primary codes must be shown in the primary diagnosis line on the UB-04 form, and secondary codes must be listed on the secondary line.

The procedure X-codes indicate a procedure involving the use of CERAMENT® G. The use of any one of these X-codes in combination with a qualifying ICD-10-CM diagnosis code will trigger a calculation of the NTAP payment by your Medicare Administrator Contractor's claims processing system.

3. Is NTAP a fixed amount for each inpatient CERAMENT® G case?

The NTAP amount is not a fixed amount and can vary for each case. It is calculated on a case-by-case basis. CMS has determined that the maximum incremental NTAP amount that a hospital can receive (in addition to the full DRG payment) is $4,918.55 per discharge for CY 2023. The exact payment amount per case is not fixed and depends on the total costs of the discharge.

4. Is the CERAMENT® G NTAP amount paid per device used, or once per discharge?

The NTAP amount is paid once per discharge and not per product unit of new technology used; however, the total costs of the new technology (including multiple units) are part of the total case charges that go into the calculation of both the eligibility for NTAP and the NTAP amount.

5. How is the total payment amount of the CERAMENT® G case calculated if it qualifies for an NTAP?

The total payment amount for a CERAMENT® G case that qualifies for an NTAP will consist of the full MS-DRG payment + 65% of the difference between the reported cost of the discharge and the MS-DRG payment, up to a maximum of $4,918.55 per case. The NTAP payment amount is then added to the MS-DRG payment.

6. Can the NTAP amount be less than the allowed $4,918.55?

Yes, the $4,918.55 is the maximum amount allowed for the NTAP portion of the hospital payment. Should the hospital-specific calculation of 65% of the hospital costs minus the DRG payment be less than $4,918.55, then the lower amount is paid.

7. What are the MS-DRGs to which cases involving CERAMENT® G are assigned?

MS-DRG	Description	FY2022 Payment
463	Wound Debridement and Skin Graft Except Hand for Musculoskeletal System and Connective Tissue Disorders with MCC	**$35,413.42**
464	Wound Debridement and Skin Graft Except Hand for Musculoskeletal System and Connective Tissue Disorders with CC	**$19,624.01**
492	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC	**$22,882.26**
493	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with CC	**$15,337.05**
495	Local Excision and Removal of Internal Fixation Devices Except Hip and Femur with MCC	**$24,015.82**
496	Local Excision and Removal of Internal Fixation Devices Except Hip and Femur with MCC	**$13,098.94**
498	Local Excision and Removal Internal Fixation Devices of Hip and Femur with CC/MCC	**$17,037.72**
503	Foot Procedures with MCC	**$17,412.93**
504	Foot Procedures with CC	**$11,704.90**
510	Shoulder, Elbow or Forearm Procedures, Except Major Joint Procedures with MCC	**$18,092.81**
511	Shoulder, Elbow or Forearm Procedures, Except Major Joint Procedures with CC	**$12,973.65**
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC	**$20,710.09**
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC	**$12,943.31**

8. How is the actual cost of the discharge determined?

CMS derives the total covered cost of the discharge based on the total covered hospital charges for each case and the hospital's inpatient operating cost-to-charge ratio determined from its cost report. Multiplying the hospital charges by the cost-to-charge ratio will convert the submitted charges to an estimate of the hospital's costs by removing the markup that hospitals apply to their costs.

Total covered charges	x	Hospital CCR	=	Hospital total covered costs	-	Hospital MS-DRG payment	=	**Covered costs minus hospital MS-DRG payment**
Covered costs minus hospital MS-DRG payment	x	.65	=	65% of costs in excess of MS-DRG	OR	Maximum add-on payment	=	**New Technology Add-On Payment**
New Technology Add-On Payment	+	**MS-DRG payment**	=	**Total hospital inpatient payment**				

9. Where can a hospital find the hospital inpatient operating cost-to-charge-ratio (CCR) used in the NTAP payment calculation?

Download the FY2022 Impact File and search the excel file by Medicare provider number. The CCR is listed in Column AG (Operating CCR). The CY 2022 CCRs by provider number are available at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page#Data

10. What action can be taken if your hospital encounters issues with claims using the ICD-10-PCS code involving CERAMENT® G?

The best source of information regarding claims processing issues is the payer, (i.e. the patient's private insurance company, the Medicare Administrative Contractor, or other government payer). Providers should contact the appropriate payer to report the problem and seek clarification.

11. Do commercial payers and Medicare Advantage provide NTAP payments?

Private payers and Medicare Advantage plans will pay according to the terms of their contracts with hospitals. Contracts may follow Medicare methodology, pay per diem, or pay a percentage of charges.

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BONESUPPORT™

BONESUPPORT, INC.,
60 William St, Suite 330
Wellesley, MA 02481

T: 1.877.719.6718
E: us.sales@bonesupport.com
W: bonesupport.com

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