CERAMENT® G
with Gentamicin

2025 INPATIENT CODING GUIDE

2025 Comprehensive Inpatient Coding & Billing Guide

CERAMENT® G with Gentamicin Synthetic Bone Void Filler

Device-drug matrix, absorbable, antimicrobial-eluting Bone Void Filler

BONESUPPORT Reimbursement Support Line Services:

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Reimbursement Disclaimer: This information is for educational/informational purposes only and should not be construed as authoritative. The information presented here is current as of January 1, 2025 and is based upon publicly available source information. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third-party payers is solely responsible for the accuracy of the codes assigned to the services or items in the medical record. When making coding decisions, we encourage you to seek input from the American Medical Association (AMA), relevant medical societies, Centers for Medicare & Medicaid Services (CMS), your local Medicare Administrative Contractor, (MAC) and other health plans to which you submit claims. Items and services that are billed to payers must be medically necessary and supported by appropriate documentation. It is important to remember that while a code may exist describing certain procedures and/or technologies, it does not guarantee payment by payers. The decision as to how to complete a reimbursement form, including the amount to bill, is exclusively the responsibility of the provider.

BONESUPPORT™

PRODUCT OVERVIEW

PRODUCT DESCRIPTION

CERAMENT® G is the first combination bone graft substitute and antibiotic indicated as part of the management of osteomyelitis and open fractures. Unlike other treatment options, CERAMENT® G is injectable and can be delivered in a more patient-friendly single-stage procedure because of its unique ability to simultaneously remodel into bone and elute an antibiotic to protect bone healing. With a 96% success rate in reducing chronic osteomyelitis, healthcare resources and costs are reduced while clinical outcomes are improved[1].

FDA INFORMATION ON CERAMENT® G[2]

CERAMENT® G received "breakthrough device designation" from the FDA in March 2020 for the indication of bone infection and in June 2021 for open fractures. This designation is reserved for therapies that provide effective treatment or diagnosis of life-threatening diseases or conditions (K090871).

INDICATIONS FOR USE[2]

CERAMENT® G is a resorbable, gentamicin-eluting ceramic bone void filler intended for use in defects in the extremities of skeletally mature patients as an adjunct to systemic antibiotic therapy and surgical debridement as part of the standard treatment approach to a bone infection and open fractures. By eluting gentamicin, CERAMENT® G can reduce the occurrence and recurrence of bone infection from gentamicin-sensitive microorganisms in order to protect bone healing. CERAMENT® G can augment provisional hardware to help support bone fragments during the surgical procedure. The cured paste acts only as a temporary support media and is not intended to provide structural support during the healing process. CERAMENT® G resorbs and is replaced by bone during the healing process.

CONTRAINDICATIONS[2]

- Hypersensitivity to any amino-glycoside antibiotics
- Myasthenia gravis
- Severe renal impairment
- Pre-existing calcium metabolism disorder
- Pregnancy
- Breastfeeding

1) Ferguson, J et al., 'Radiographic and Histological Analysis of a Synthetic Bone Graft Substitute Eluting Gentamicin in the Treatment of Chronic Osteomyelitis', Journal of Bone and Joint Infection, 4.2 (2019), 76-84 <https://doi.org/10.7150/jbji.31592>
2) For indications, contraindications, warnings and precautions see Instructions for Use

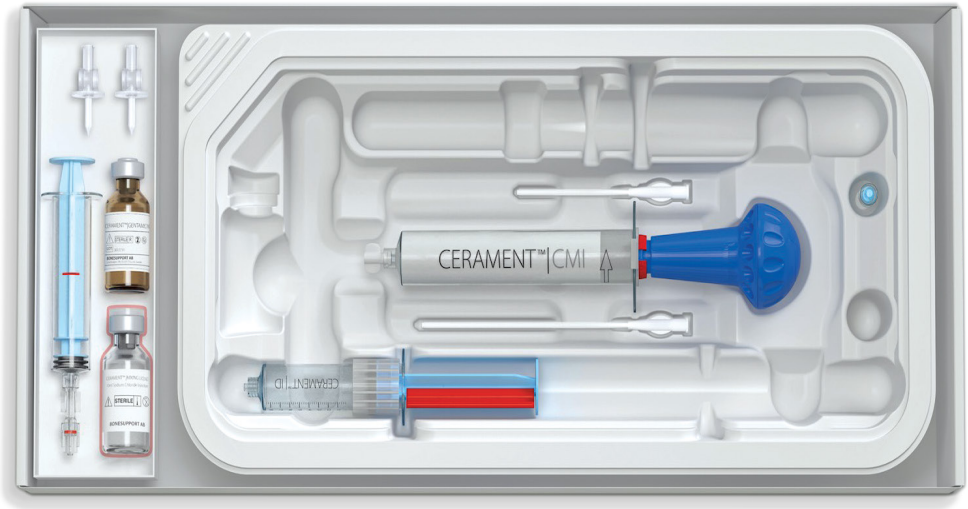
COVERAGE

MEDICARE COVERAGE DETERMINATIONS (NCD/LCD)

Currently, there is no National Coverage Determination (NCD) related to CERAMENT® G. Check with your local Medicare Administrative Contractor (MAC) regarding any Local Coverage Determinations (LCDs) related to CERAMENT® G. Medicare may cover CERAMENT® G on a case-by-case basis, with evidence of medical necessity. While traditional Medicare does not require or allow prior authorization or prior approval for procedures, Medicare Advantage plans are managed by commercial payers who may require prior authorization for Medicare Advantage patients. Check with your plan administrator for any prior authorization requirements.

COMMERICAL COVERAGE DETERMINATIONS

Commercial insurance coverage policies vary, and many require prior authorization for any procedure. We encourage health care professionals to contact payer(s) directly with questions regarding coverage policies or guidelines for CERAMENT® G.



2025 CURRENT PROCEDURAL TERMINOLOGY (CPT) CODING

The CPT codes listed in Table 1 represent some procedures that can be billed on a physician claim when performing procedures with CERAMENT® G in the hospital; it is not meant to be a complete list of procedure codes. CPT codes are not used by an inpatient facility on its UB-04 facility claim.

Physician services will be billed with CPT codes under Medicare Part B and be paid according to the Medicare physician fee schedule (MPFS).

	TABLE 1: 2025 Current Procedural Terminology (CPT) Coding
CPT CODE	**DESCRIPTION**
Subchondral Bone Injection	
Debridement	
11012	Debridement including removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement); skin, subcutaneous tissue, muscle fascia, muscle, and bone
11044	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
11047	Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
Shoulder/Clavicle	
23035	Incision, bone cortex (e.g., osteomyelitis or bone abscess), shoulder area
23170	Sequestrectomy (e.g., for osteomyelitis or bone abscess), clavicle
23172	Sequestrectomy (e.g., for osteomyelitis or bone abscess), scapula
23174	Sequestrectomy (e.g., for osteomyelitis or bone abscess), humeral head to surgical neck
23180	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), clavicle
23182	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), scapula
23184	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), proximal humerus
Arm/Elbow	
23935	Incision, deep, with opening of bone cortex (e.g., for osteomyelitis or bone abscess), humerus or elbow
24134	Sequestrectomy (e.g., for osteomyelitis or bone abscess), shaft or distal humerus
24136	Sequestrectomy (e.g., for osteomyelitis or bone abscess), radial head or neck
24138	Sequestrectomy (e.g., for osteomyelitis or bone abscess), olecranon process
24140	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), humerus
24147	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis), olecranon process
25035	Incision, deep, bone cortex, forearm and/or wrist (e.g., osteomyelitis or bone abscess)
25145	Sequestrectomy (e.g., for osteomyelitis or bone abscess), forearm and/or wrist
25150	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); ulna
25151	Partial excision (craterization, saucerization, or diaphysectomy) of bone (e.g., for osteomyelitis); radius
Partial Excision, Hand/Fingers	

	TABLE 1: 2025 Current Procedural Terminology (CPT) Coding
CPT CODE	**DESCRIPTION**
Arm/Elbow	
26236	Partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis); distal phalanx of finger
Hip/Pelvis	
26992	Incision, bone cortex, pelvis and/or hip joint (e.g., osteomyelitis or bone abscess)
27070	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); superficial
27071	Partial excision, wing of ilium, symphysis pubis, or greater trochanter of femur, (craterization, saucerization) (eg, osteomyelitis or bone abscess); deep (subfascial or intramuscular)
Knee/Leg	
27303	Incision, deep, with opening of bone cortex, femur or knee (e.g., osteomyelitis or bone abscess)
27360	Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)
27607	Incision (e.g., osteomyelitis or bone abscess), leg or ankle
27640	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia
27641	Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula
Foot/Toes	
28005	Incision, bone cortex (e.g., osteomyelitis or bone abscess), foot
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (e.g., osteomyelitis or bossing); talus or calcaneus
28122	Incision (e.g., osteomyelitis or bone abscess), leg or ankle
28124	Excision or curettage of bone cyst or benign tumor, tibia or fibula;
Manual Preparation and Insertion	
20700	Manual preparation and insertion of drug-delivery device(s), deep (e.g., subfascial) (List separately in addition to code for primary procedure)
20702	Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)
20704	Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)

2025 INPATIENT AND MEDICARE PAYMENT

In the inpatient setting, the hospital will bill using a combination of ICD-10-CM and ICD-10-PCS codes. Based on these codes submitted, the hospital will be paid one fixed payment based on the assigned Medicare Severity Diagnosis Related Group (MS– DRG). In the inpatient setting, all costs other than physician services are considered part of the facility expenses and would be reported by the facility using the appropriate revenue codes.

Effective October 1, 2022, CERAMENT® G has been eligible under Medicare for a New Technology Add-on Payment (NTAP) to help mitigate the additional costs a hospital might incur when using the technology under the Medicare Inpatient Prospective Payment System. The NTAP will be described in greater detail below.

ICD-10-PCS CODING

Reporting ICD-10-PCS codes for the procedures performed is required for Medicare and most other payers to determine the appropriate DRG. Table 3 provides a guide that may help determine appropriate PCS codes for the primary procedures.

For billing CERAMENT® G, there is a unique ICD-PCS-X-code (Table 2). Section X (new tech) PCS codes are standalone codes created for CMS that, when used appropriately, can trigger the additional NTAP payment to the hospital in addition to the MS-DRG payment.

TABLE 2. ICD-10 PROCEDURE CODE FOR CERAMENT® G

ICD-10-PCS Code	***New Technology PCS Description***
XW0V0P7	Introduction of Antibiotic-Eluting Bone Void Filler into Bones, Open Approach, New Technology Group 7

TABLE 3. ICD-10 PROCEDURE CODING DESCRIPTION

ICD-10-PCS[iv] Procedure Code and Description
Please note: not all Root Operation/Device code combinations may be available.

0 Medical and Surgical
P Upper Bones / **Q** Lower Bones
9 Drainage/ **B** Excision/ **C** Extirpation/ **D** Extraction/ **H** Insertion/ **P** Removal/ **Q** Repair/ **T** Resection

Body Part	Approach	Device	Qualifier
Select the appropriate body part	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**4** Internal Fixation Device **5** External Fixation Device **7** Autologous Tissue Substitute **J** Synthetic Substitute **K** Nonautologous Tissue Substitute **Z** No Device	**Z** No Qualifier

2025 MS-DRG PAYMENTS

Table 4 shows relevant MS-DRG assignments along with the FY2025 Medicare national unadjusted payment rates.

TABLE 4. MS-DRG PAYMENTS

MS-DRG	*MS-DRG DESCRIPTION*	*FY2025 MEDICARE NATIONAL UNADJUSTED PAYMENT*
463	Wound Debridement and Skin Graft Except Hand for Musculoskeletal System and Connective Tissue Disorders with MCC	$38,437.00
464	Wound Debridement and Skin Graft Except Hand for Musculoskeletal System and Connective Tissue Disorders with CC	$20,985.00
492	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with MCC	$25,273.00
493	Lower Extremity and Humerus Procedures Except Hip, Foot and Femur with CC	$17,088.00
495	Local Excision and Removal of Internal Fixation Devices Except Hip and Femur with MCC	$25,054.00
496	Local Excision and Removal of Internal Fixation Devices Except Hip and Femur with CC	$14,041.00
498	Local Excision and Removal Internal Fixation Devices of Hip and Femur with CC/MCC	$17,968.00
503	Foot Procedures with MCC	$18,835.00
504	Foot Procedures with CC	$12,495.00
510	Shoulder, Elbow or Forearm Procedures, Except Major Joint Procedures with MCC	$20,340.00
511	Shoulder, Elbow or Forearm Procedures, Except Major Joint Procedures with CC	$13,959.00
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures with MCC	$22,007.00
516	Other Musculoskeletal System and Connective Tissue O.R. Procedures with CC	$14,317.00

MEDICARE NTAP PAYMENT

NTAP is part of the CMS Inpatient Prospective Payment System (IPPS), and it offers Medicare reimbursement to assist acute care hospitals when they adopt new technology. NTAP is an additional payment that can be made to the hospital if costs of a hospital case exceed the DRG payment. Add-on payments for devices are limited to the lesser of 65% of the average cost of the product, or 65% of the amount by which the costs of the case exceed the standard MS–DRG payment. NTAP designation lasts no more than three years for a specific indication.

For a new technology to qualify for the NTAP program, it must meet the following eligibility requirements established by CMS:
• the medical service or technology must be new;
• the medical service or technology must be costly such that the DRG rate otherwise applicable to discharges involving the medical service or technology is determined to be inadequate; and
• the service or technology must demonstrate a substantial clinical improvement over existing services or technologies.

Effective October 1, 2022, CMS determined that CERAMENT® G is eligible for an NTAP. In FY 2025, the NTAP can be paid up to the maximum amount of $4,918.55.

The NTAP is paid in addition to the MS-DRG payment. The NTAP is calculated on a case-by-case basis and the amount can vary based on hospital-specific reported costs and the Medicare DRG payment amount. On Table 5, three possible NTAP outcomes are illustrated where:
Scenario A – Hospital received greater MS-DRG payment than their reported costs
Scenario B – Hospital received less MS-DRG payment than their reported costs
Scenario C – Hospital received significantly less MS-DRG payment than their reported costs. NTAP maximum payment is reached.

TABLE 5. NTAP CALCULATION EXAMPLES

NTAP CALCULATION SCENARIOS	SCENARIO A	SCENARIO B	SCENARIO C
Total Charges of the Entire Hospital Discharge	$85,000	$100,000	$98,000
Hospital-Specific Cost to Charge Ratio (CCR)	X 0.2064	x 0.2609	x 0.3500
Hospital-Specific Reported Cost of the Hospital Discharge	$17,544	$26,090	$34,300
Hospital-Specific MS-DRG 464 Payment Amount	- $19,000	- $21,200	- $24,400
Difference	$(1,456)	$4,890	$9,900
65% of the Difference	N/A	$3,178.50	$6,435
NTAP Cap: Average Cost of the New Technology x 65%	$4,918.55	$4,918.55	$4,918.55
Incremental NTAP Payment - Lesser 65% Difference or the Cap	**$0**	**$3,178.50**	**$4,918.55**
Total Payment - MS-DRG 464 + NTAP Payment	$19,000	$24,378.50	$29,318.55

2025 ICD-10-CM DIAGNOSIS CODING

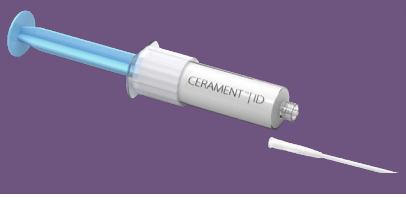
Diagnosis codes are assigned by the physician to accurately report the patient's condition as it relates to the procedure. Below are some examples of diagnosis codes that may be applicable for cases using CERAMENT® G. This is only a list of possible codes that represent the typical diagnoses associated with the procedure and is not intended to be a complete list. No actual patient condition is represented by the examples provided.

The following diagnosis codes when using CERAMENT® G in the FDA approved indication of bone infection/osteomyelitis.

TABLE 6. ICD-10 CLINICAL MODIFICATION CODES

ICD-10-CM Code	***ICD-10-CM Diagnosis Description***
M86.00 - M86.09	Acute hematogenous osteomyelitis
M86.10 - M86.19	Other acute osteomyelitis
M86.20 - M86.29	Subacute osteomyelitis
M86.30 - M86.39	Chronic multifocal osteomyelitis
M86.40 - M86.49	Chronic osteomyelitis with draining sinus
M86.50 - M86.59	Other chronic hematogenous osteomyelitis
M86.60 - M86.69	Other chronic osteomyelitis
M86.8X0 - M86.8X9	Other osteomyelitis
M86.9	Osteomyelitis, unspecified

In March 2024, CERAMENT® G received FDA clearance for an additional indication of open fractures. Currently, NTAP applies only to the bone infection indication.



Frequently Asked Questions

1. When is NTAP effective for CERAMENT® G and how long do NTAP's last?

The CERAMENT® G NTAP became effective October 1, 2022. CMS allows for an NTAP to last 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?

The one specific billing requirement placed on the hospital for generating the NTAP payment is to include the appropriate ICD-10-PCS X-code that was created to describe the use of CERAMENT G. This will trigger a calculation of the NTAP payment by your MAC and the Medicare claims processing system.

XW0V0P7	Introduction of Antibiotic-Eluting Bone Void Filler into Bones, Open Approach, New Technology Group 7

As always, the hospital should bill the appropriate ICD-10 codes to reflect the procedures performed and patient diagnoses, as indicated by the treating physician. The claim should accurately reflect charges and revenue codes for all components of the care provided. NTAP is currently only available for the bone infection/osteomyelitis indication.

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

No. The NTAP amount is not a fixed amount and 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 FY 2025. 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 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 the amount 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. If the difference between the DRG payment and the total covered costs is greater than zero, Medicare will make an add-on payment equal to 65 percent of the difference up to $4,918.55.

7. Which MS-DRGs are most relevant to cases involving CERAMENT G? What are the corresponding national unadjusted payment amounts?

MS-DRG	Description	FY2025 Payment
463	Wound Debridement and Skin Graft Except Hand for Musculoskeletal System and Connective Tissue Disorders with MCC	**$38,437.00**
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8. How is the reported cost of the discharge determined?

CMS derives the total reported cost of the discharge based on the total covered hospital charges for each case and the hospital's inpatient operating cost-to-charge ratio (CCR) 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.

9. How is the NTAP amount calculated?

The NTAP is calculated on a case-by-case basis and the amount can vary based on hospital-specific reported costs and the actual Medicare DRG payment amount, as illustrated in Table 5 from the guide. Table 5 illustrates three possible NTAP outcomes: Scenario A – Hospital received greater MS-DRG pay-ment than their reported costs. Scenario B – Hospital received less MS-DRG payment than their reported costs. Scenario C – Hospital received significantly less MS-DRG payment than their reported costs and NTAP maximum payment is reached.

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Incremental NTAP Payment - Lesser 65% Difference or the Cap	**$0**	**$3,178.50**	**$4,918.55**
Total Payment - MS-DRG 464 + NTAP Payment	$19,000	$24,378.50	$29,318.55

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

The CY 2025 CCRs by provider number are available at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page. Download the FY2025 Impact File and search the excel file by Medicare provider number. The CCR is listed in Column AG (Operating CCR).

11. How much should a hospital charge for CERAMENT® G?

Only the hospital can determine what charges to list on its cost report, but it should be consistent with its billing in general. CMS will use reported charges to determine the reported costs by applying the CCR. Appropriate hospital charges are important because CMS uses the Medicare charge data from current claims to determine future DRG payments.

12. What should you do if your hospital encounters issues with claims using the ICD-10-PCS code involving the use of CERAMENT® G?

The best source of information regarding claims processing issues is the payer, for example 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.

13. 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.

REFERENCES

https://www.accessdata.fda.gov/cdrh_docs/pdf21/DEN210044.pdf
CPT 2025 Professional Edition, ©2025 American Medical Association (AMA); CPT is a trademark of the AMA.
2025 MPFS https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1807-f4) 2025 ICD-10-PCS https://www.cms.gov/medicare/coding-billing/icd-10-codes/2025-icd-10- pcs
2025 DRGs https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software

CERAMENT® G with Gentamicin

TO ORDER

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PRODUCT CODES

CERAMENT® G with Gentamicin 5ml	**A0450-11**
CERAMENT® G with Gentamicin 10ml	**A0450-10**
CERAMENT® G with Gentamicin 5ml (updated kit)	**A0535-06**
CERAMENT® G with Gentamicin 10ml (updated kit)	**A0535-05**
CERAMENT® BONE VOID FILLER 5ml	A0210-09
CERAMENT® BONE VOID FILLER 10ml	A0210-08
CERAMENT® BONE VOID FILLER 18ml	A0210-11
CERAMENT® Bead Tray	A0513
CERVOS Access/Delivery 8Ga x 250mm	CER-SUB-825
CERVOS Access/Delivery 15Ga x 60mm, Open Tip	CER-SUB-1560
CERVOS Access/Delivery 11Ga x 110mm, Open Tip	CER-SUB-1111-OT
BONESUPPORT Delivery Cannula 11Ga x 120mm, Closed Tip, Side Port Delivery	74389-01M
2-CAN Delivery Cannula 450mm	2CAN450B

BONESUPPORT™

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