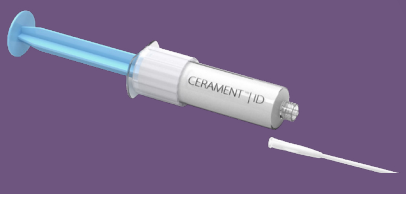

Frequently Asked Questions

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.

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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**
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 MCC	**$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**

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.

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

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.

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2025 DRGs https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software

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BONESUPPORT™

BONESUPPORT, INC.,
117 Fourth Ave, Suite 202
Needham, MA 02494

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

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