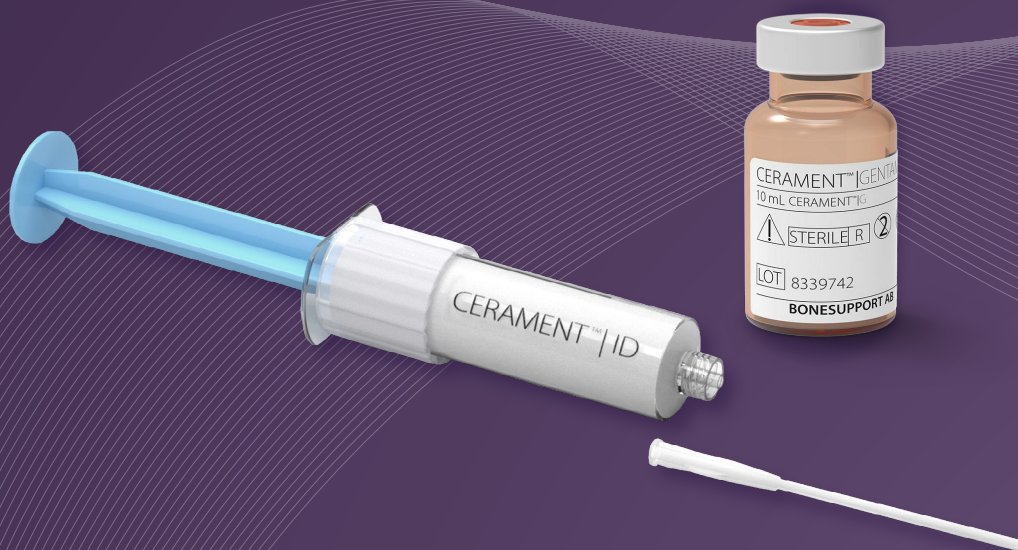


Inpatient Coding & Billing Guide

CERAMENT® G with Gentamicin Synthetic Bone Void Filler
Device-drug matrix, absorbable, antimicrobial-eluting Bone Void Filler



New technology
add-on payment
(NTAP) for open
fractures now
available

BONESUPPORT Reimbursement Support Line

Available Monday through Friday, from 8:30 AM to 5:00 PM EST

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Fax: 1-866-903-2663

*If a call is made outside of these hours, callers are welcome to leave a voicemail.
Alternatively, email inquiries to usreimbursement@bonesupport.com.*

REIMBURSEMENT PROGRAM

REIMBURSEMENT PROGRAM: NEW TECHNOLOGY ADD-ON PAYMENT (NTAP)

The New Technology Add-On Payment (NTAP) is an additional payment that can be made to the hospital if the costs of a case involving a Medicare beneficiary exceed the DRG payment. NTAP for devices are limited to the lesser of a maximum amount set by CMS (set at 65% of the average of the product used), or 65% of the amount by which the costs of the case exceed the standard DRG payment.

When a case is eligible, the NTAP is paid in addition to the 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.

ACTIVE NEW TECHNOLOGY ADD-ON PAYMENT (NTAP) FOR CERAMENT® G

Effective October 1, 2025, CMS determined that CERAMENT® G is eligible for an NTAP for the indication open fractures¹. The NTAP can be paid up to the maximum amount of \$5,687.50.

To qualify for this NTAP, the case must be coded with the ICD-10-PCS procedure XW0V0P7 (i.e., CERAMENT® G was used in the surgery), but **without** any of the ICD-10-CM diagnosis codes in the category **M86** (Osteomyelitis). Those cases with an M86 code do not qualify for this NTAP¹.

Please note: during FY 2023-FY 2025, CERAMENT® G had an active NTAP for the indication bone infection. This NTAP is now discontinued.

1) The Final Rule which documents the new NTAP is found here: <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ips-final-rule-home-page#CMS-1833-F>

Example scenarios

Here are three possible scenarios when NTAP applies to an open fracture case:

1. **Scenario A:** MS-DRG payment received is greater than hospital's reported costs
2. **Scenario B:** MS-DRG payment is less than hospital's reported costs
3. **Scenario C:** Hospital received significantly less MS-DRG payment than their reported costs. NTAP maximum payment is reached.

Using hypothetical figures, we illustrate the reimbursement received in each scenario on Table 5 below. Follow the steps to see what NTAP payment and total payment would be received.

Table 5: NTAP Calculation Scenarios

Calculation Steps	Scenario A	Scenario B	Scenario C
1. Total Charges of the Entire Hospital Discharge	\$85,000	\$100,000	\$98,000
2. Hospital-Specific Cost-to-Charge Ratio (CCR)	X 0.2064	X 0.2609	X 0.3500
3. Hospital-Specific Reported Cost of the Hospital Discharge	\$17,544	\$26,090	\$34,300
4. Hospital-Specific MS-DRG Payment Amount	\$19,000	\$21,200	\$24,400
5. Difference in DRG Payment and Hospital Reported Costs	+\$1,456	-\$4,890	-\$9,900
6. 65% of the Difference (of the underpayment)	N/A	\$3,178.50	\$6,435
7. NTAP Cap: Average Cost of the New Technology X65%	\$5,687.50	\$5,687.50	\$5,687.50
8. Incremental NTAP Payment = The Lesser of Calculation Step 5 or 6	\$0	\$3,178.50	\$5,687.50
9. Total Payment = MS-DRG Payment + NTAP Payment	\$19,000	\$24,378.50	\$30,087.50

PRODUCT OVERVIEW

PRODUCT DESCRIPTION²

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 surgical 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 could be reduced while clinical outcomes are improved³. CERAMENT® G received breakthrough device designation from the FDA for the indications of bone infection and open fractures.

INDICATIONS FOR USE²

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.

CONTRAINDICATIONS²

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



²) For detailed information on indications, contraindications, warnings and precautions see [Instructions for Use](#).

³) 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.

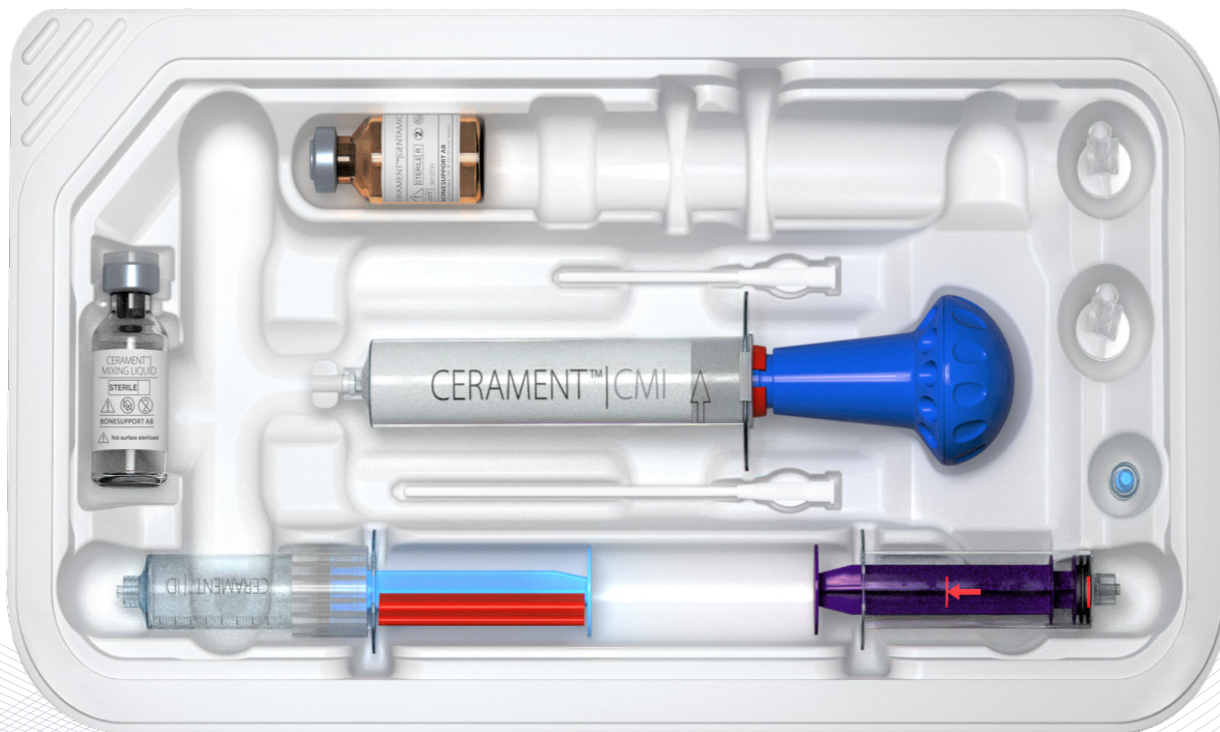
COVERAGE

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.

COMMERCIAL 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.



PHYSICIAN CODING AND PAYMENT

CURRENT PROCEDURAL TERMINOLOGY (CPT) CODING⁴

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.

Physician services will be billed with CPT codes under Medicare Part B and be paid according to the Medicare physician fee schedule (MPFS). CPT codes are not used by acute-care inpatient facilities on the UB-04 facility claim. (Please see section on ICD-10-PCS Procedure codes for codes.)

Table 1: 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

⁴ CPT 2025 Professional Edition, ©2025 American Medical Association (AMA); CPT is a trademark of the AMA.

CPT CODE	Description
Partial Excision, Hand/Fingers	
26034	Incision, bone cortex, hand or finger (e.g., osteomyelitis or bone abscess)
26230	Partial excision (craterization, saucerization, or diaphysectomy) bone (e.g., osteomyelitis); metacarpal
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)

HOSPITAL CODING AND PAYMENT

CODING IN THE INPATIENT SETTING

In the inpatient setting, the hospital will bill using a combination of ICD-10-CM (diagnosis) and ICD-10-PCS (procedure) codes. Based on the codes submitted, the hospital will be paid one fixed payment based on the assigned Medicare Severity Diagnosis Related Group (MS- DRG) that the case best fits in. This payment is called 'DRG payment'. 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.

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. These lists show possible codes that represent the typical diagnoses associated with the procedure and are not intended to be complete lists. No actual patient condition is represented by the examples provided.

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

Table 2: ICD-10 Clinical Modification Codes for Bone Infection/Osteomyelitis

ICD-10-CM Code	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

The following diagnosis codes may be appropriate when using CERAMENT® G in the FDA approved indication of open fracture.

Table 3: ICD-10 Clinical Modification Codes for Open Fracture

ICD-10-CM* Code	Diagnosis Description
S42.***B	Fracture of shoulder and upper arm
S52.***B	Fracture of forearm
S52.***C	Fracture of forearm
S63.***B	Dislocation and sprain of joints and ligaments at wrist & hand level
S72.***B	Fracture of femur
S72.***C	Fracture of femur
S82.***B	Fracture of lower leg including ankle
S82.***C	Fracture of lower leg including ankle
S92.***B	Fracture of foot and toe, except ankle
S99.***B	Other and unspecified injuries of ankle and foot

**The seventh character being 'B' or 'C' indicates that the fracture is an open fracture, where 'B' is defined as 'initial encounter for open fracture type I or II' and 'C' is defined as 'initial encounter for open fracture type IIIA, IIIB, or IIIC'*

ICD-10-PCS CODE FOR CERAMENT® G

CERAMENT® G has a unique ICD-10-PCS code used for billing, which is described in Table 4. Use of this code should be included on all claims for treating patients that use CERAMENT G - independent of the diagnosis. The tracking of claims is important to generate the data used by CMS for setting Medicare policy going forward. Use of this PCS code is also necessary to trigger the additional NTAP Payment for those cases that qualify for the additional payment.

Table 4: 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

FREQUENTLY ASKED QUESTIONS



NEW TECHNOLOGY
ADD-ON PAYMENT

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

The CERAMENT® G NTAP for the indication of open fractures became effective on October 1, 2025. CMS allows for an NTAP to last for a maximum of 3 years.

During FY 2023 – FY 2025, CERAMENT® G had an active NTAP for the indication bone infection. This NTAP was discontinued after three years' duration (ended September 30, 2025).

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 a potential NTAP payment is to include the appropriate ICD-10-PCS X-code that was created to describe the use of CERAMENT® G.

XW0V0P7	Introduction of Antibiotic-Eluting Bone Void Filler into Bones, Open Approach, New Technology Group 7
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Hospital claims should include this code for any case using CERAMENT® G so that tracking data is accurate. For open fracture cases that may qualify for NTAP, the code will trigger a calculation of the NTAP payment by your MAC and the Medicare claims processing system.

As always, the hospital should bill the appropriate ICD-10 codes to reflect all of the procedures performed and patient diagnoses, as documented by the treating physician. The claim should accurately reflect charges and revenue codes for all components of the care provided.

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 \$5,687.50 per discharge for FY 2026. The exact NTAP amount per case depends on the total reported costs of the discharge as well as the DRG payment to the hospital for that case.

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 NTAP payment amount is the amount added to the MS-DRG payment. 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 \$5,687.50 per case.

6. Will the NTAP amount be less than the allowed \$5,687.50?

Most likely yes, the \$5,687.50 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 NTAP payment equal to 65% of the difference — up to \$5,687.50.

7. 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 reported costs by removing the markup that hospitals apply to their costs.

8. 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 charges, converted to reported costs, and the actual Medicare DRG payment amount.

Here are three possible scenarios when NTAP applies to an open fracture case:

1. **Scenario A:** MS-DRG payment received is greater than hospital's reported costs
2. **Scenario B:** MS-DRG payment is less than hospital's reported costs
3. **Scenario C:** Hospital received significantly less MS-DRG payment than their reported costs. NTAP maximum payment is reached.

Using hypothetical figures, we illustrate the reimbursement received in each scenario on Table 5 below. Follow the steps to see what NTAP payment and total payment would be received.

Table 5: NTAP Calculation Scenarios

Calculation Steps	Scenario A	Scenario B	Scenario C
1. Total Charges of the Entire Hospital Discharge	\$85,000	\$100,000	\$98,000
2. Hospital-Specific Cost-to-Charge Ratio (CCR)	x0.2064	x0.2609	x0.3500
3. Hospital-Specific Reported Cost of the Hospital Discharge	\$17,544	\$26,090	\$34,300
4. Hospital-Specific MS-DRG Payment Amount	\$19,000	\$21,200	\$24,400
5. Difference in DRG Payment and Hospital Reported Costs	+\$1,456	-\$4,890	-\$9,900
6. 65% of the Difference (of the underpayment)	N/A	\$3,178.50	\$6,435
7. NTAP Cap: Average Cost of the New Technology x65%	\$5,687.50	\$5,687.50	\$5,687.50
8. Incremental NTAP Payment = The Lesser of Calculation Step 5 or 6	\$0	\$3,178.50	\$5,687.50
9. Total Payment = MS-DRG Payment + NTAP Payment	\$19,000	\$24,378.50	\$30,087.50

9. 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 relevant CCR. Appropriate hospital charges are important because CMS uses the Medicare charge data from current claims to determine future DRG payments.

10. 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.

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.

For further information

- 2026 ICD-10 diagnosis (CM) and procedure (PCS) codes <https://www.cms.gov/medicare/coding-billing/icd-10-codes2026>
- 2026 Physician Fee Schedule (PFS) <https://www.cms.gov/medicare/payment/fee-schedules/physician>
- 2026 Diagnosis-related groups (DRGs) <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/ms-drg-classifications-and-software>
- CPT 2025 Professional Edition, ©2025 American Medical Association (AMA); CPT is a trademark of the AMA.
- FY2026 Inpatient Prospective Payment System (IPPS) Final Ruling <https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipp-final-rule-home-page#CMS-1833-F>

CERAMENT® G

with Gentamicin

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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

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 October 1st, 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.

