New Technology Add-on Payment (NTAP)

A Hospital Inpatient Guide

CorMedix

What are NTAPs?

NTAPs are temporary, 2-3 year payments made in addition to Medicare Severity Diagnosis-Related Group (MS-DRG) payments normally made to participating hospitals. They are designed to support the use of new medical services and technologies before their cost has been calculated into the MS-DRG bundled payment.[1]

CMS requirements for NTAP eligibility[1]

The medical service or technology must:

- ☑ Be new (ie, FDA-approved or marketed for less than 2 to 3 years)
- ☑ Provide substantial clinical improvement over existing medical services or technologies
- ☑ Be inadequately covered in the current MS-DRG payment bundle

Alternative NTAP pathways exist for certain antimicrobial products[2]

Qualified Infectious Disease Product (QIDP)

Antibacterial or antifungal drug for human use intended to treat serious or life-threatening infections

Limited Population Pathway for Antimicrobial and Antifungal Drugs (LPAD)

FDA approval pathway for drugs intended to treat a serious or life-threatening infection in a limited population of patients with unmet needs

Alternative NTAP pathway criteria

- Not required to have FDA approval at the time of NTAP application, and may qualify for NTAP payments following FDA approval
- Considered not substantially similar to an existing technology
- Does not need to represent an advance that substantially improves diagnosis or treatment

For more information on NTAP, scan the QR code or visit www.cms.gov

IDENTIFYING CASES ELIGIBLE FOR AN NTAP

Eligible facilities

- Acute care hospitals that are reimbursed under the IPPS are eligible[2]
- Hospitals not reimbursed under the IPPS, including but not limited to, inpatient rehabilitation facility hospitals, long-term care hospitals, and cancer hospitals, are not eligible to receive the add-on payment[2]

Setting of care

- Acute care hospital inpatient setting[2]

Qualified patients

- Traditional (fee-for-service) Medicare beneficiaries where the cost of the case exceeds the MS-DRG payment for the case[3]

Amount of the NTAP payment

- The maximum payment is dependent on the technology, calculated by CMS, per admission[4]
- If the total covered costs of the case do not exceed the MS-DRG payment, then no additional payment is made for the admission[5]

Unique ICD-10-PCS codes

» NTAP-eligible products are assigned a unique ICD-10-PCS code to submit for an NTAP on hospital inpatient Medicare claim forms[3]

» Hospitals may report use of an NTAP-eligible product by recording the ICD-10-PCS code in the same section of the claim as other ICD-10-PCS codes applicable to the discharge[4]

The following codes may be used to bill inpatient use of DefenCath:

Healthcare Common Procedure Coding System (HCPCS) code, also known as J-code	J0911
HCPCS Modifier	AX
National Drug Code (NDC) for 3 mL single-dose vial	72990-103-03
NTAP unique ICD-10-PCS code	XYOYX28

SAMPLE UB-04 FORM (ALSO KNOWN AS CMS 1450)

The following serves as an example guide for completing the UB-04 form (also known as CMS 1450) to bill inpatient use of DefenCath.

Disclaimer: The sample form provided is for informational purposes only. The accurate completion of this form is the responsibility of the healthcare provider and/or health system. CorMedix makes no guarantee regarding reimbursement for any service or item.

A Field 42 – Revenue Code*

- Enter code 0636 to indicate drugs requiring detailed coding

B Field 43 – Description

- Enter "N4" (product ID qualifier used to identify the NDC) followed by the 11-digit NDC in positions 01-13
- Enter the quantity qualifier (mL) followed by the quantity administered starting in position 14. In the example below, 3.0 mL was administered
- Example: N472990010303ML3

C Field 44 – HCPCS/Rate/HIPPS Code*

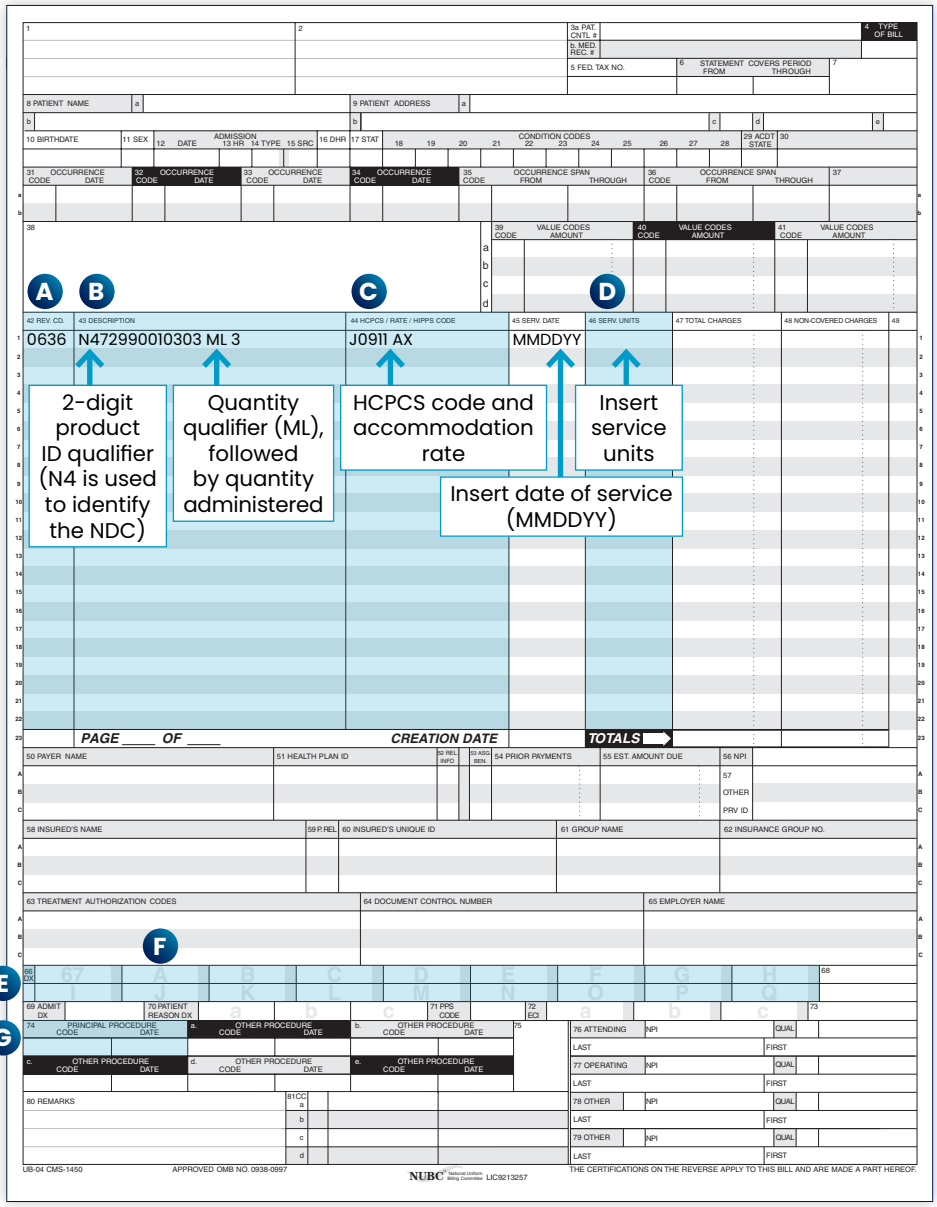
- Enter HCPCS code J0911 and the HCPCS code-modifier AX

D Field 46 – Service Units*

- The billing unit for DefenCath is 0.1 mL
- In this example, enter 30
- Bill discarded amount when applicable with JW modifier

E Field 66 – Diagnosis and Procedure Code Qualifier (ICD Version Indicator)*

- Enter "0" to indicate that the Tenth Revision of the International Classification of Diseases (ICD-10) will be used for reporting diagnosis codes



F Field 67 – Diagnosis Codes*

- Enter applicable ICD-10-CM diagnosis code(s)

G Field 74 – Procedure Codes

- Enter applicable ICD-10-PCS code, XYOYX28

*Required field.

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Disclaimer

The reimbursement information provided by CorMedix is intended to provide general information relevant to coding and reimbursement of CorMedix products only. CorMedix does not guarantee coverage or payment of its products.

CMS=Centers for Medicare and Medicaid Services; FDA=US Food and Drug Administration; HCPCS=Healthcare Common Procedure Coding System; HIPPS=Health Insurance Prospective Payment System; ICD=International Classification of Diseases; ICD-10-CM=International Classification of Diseases, Tenth Revision, Clinical Modification; ICD-10-PCS=International Classification of Diseases, Tenth Revision, Procedure Coding System; IPPS=inpatient prospective payment system; MS-DRG=Medicare Severity Diagnosis-Related Group; NDC=National Drug Code; NTAP=New Technology Add-on Payment.

REFERENCES

1. US Department of Health and Human Services. Title 42: Public Health. Chapter IV: Centers for Medicare & Medicaid Services, Department of Health and Human Services. Subchapter B: Medicare Program. 42 CFR 412.87. Updated February 27, 2024. Accessed March 6, 2024. https://www.ecfr.gov/current/title-42/section-412.87 **2.** Centers for Medicare & Medicaid Services. Medicare program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Final Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; changes to the New Technology Add-On Payment policy for certain antimicrobial products. Federal Register. 2020;85(182):58435-58436. **3.** Centers for Medicare and Medicaid Services. Medicare claims processing manual: Chapter 3 – Inpatient hospital billing. Updated October 19, 2023. Accessed March 6, 2024. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf **4.** US Department of Health and Human Services. Title 42: Public Health. Chapter IV: Centers for Medicare & Medicaid Services, Department of Health and Human Services. Subchapter B: Medicare Program. 42 CFR 412.88. Updated February 27, 2024. Accessed March 6, 2024. https://www.ecfr.gov/current/title-42/section-412.88 **5.** Centers for Medicare & Medicaid Services. Medicare program; hospital inpatient prospective payment systems for acute care hospitals and the long-term care hospital prospective payment system and policy changes and fiscal year 2024 rates; quality programs and Medicare promoting interoperability program requirements for eligible hospitals and critical access hospitals; rural emergency hospital and physician-owned hospital requirements; and provider and supplier disclosure of ownership; and Medicare disproportionate share hospital (DSH) payments: counting certain days associated with section 1115 demonstrations in the Medicaid fraction. Federal Register. 2023;88(165):58640-59438.

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