DEFENCATH®
Taurolidine and Heparin Catheter Lock Solution

Limited Population

NEW TECHNOLOGY ADD-ON PAYMENT (NTAP)

A Hospital In-Patient Guide

HOSPITAL INPATIENT BILLING AND CODING FOR DEFENCATH

The guide provides coding information for billing inpatient use of DefenCath to Medicare, including claims for New Technology Add-on Payments (NTAPs).

Effective October 1, 2024, Medicare provided an updated add-on payment for DefenCath of up to $3,656.10 per qualifying case to Inpatient Prospective Payment System (IPPS)-participating acute care hospitals. This add-on payment will be incremental to the Medicare Severity Diagnosis-Related Group (MS-DRG) reimbursement for qualifying Medicare inpatient cases.[1]

WHAT IS AN NTAP?[2]

- NTAPs are temporary payments made in addition to the 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.

CMS REQUIREMENTS FOR NTAP ELIGIBILITY[2]

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**

IDENTIFYING NTAP-ELIGIBLE CASES

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Traditional (fee-for-service) Medicare beneficiaries treated in an acute care hospital inpatient setting may qualify for the NTAP[1,3] if the cost of the case exceeds the MS-DRG payment for the case.[3]

A unique ICD-10-PCS code has been assigned for the use of DefenCath to submit for the NTAP on hospital inpatient Medicare claim forms.[1] Hospitals may report use of DefenCath by recording the ICD-10-PCS code in the same section of the claim as other ICD-10-PCS codes applicable to the discharge.[3]

NTAP ICD-10-PCS CODE	
XY0YX28	**Extracorporeal introduction of taurolidine anti-infective and heparin anticoagulant, new technology group 8**

NTAP DETAILS FOR DEFENCATH	
Eligible facilities	Acute care hospitals that are reimbursed under the IPPS. 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.[1]
Setting of care	Acute care hospital inpatient setting[1]
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 lesser of[1]: 1. 75% of the cost of DefenCath, or 2. 75% of the amount by which the total covered costs of the case exceed the MS-DRG payment The maximum payment is $3,656.10 *per admission.[1] *The current NTAP maximum payment of $3,656.10 was based on the WAC of $249.99 per 3mL vial. If the total covered costs of the case do not exceed the MS-DRG payment, then no additional payment is made for the admission.[3]
Effective date	October 1, 2024 through November 15, 2026

DEFENCATH BILLING CODES

THE FOLLOWING CODES MAY BE USED TO BILL INPATIENT USE OF DEFENCATH:	
Health care 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	XY0YX28
ICD-10-CM Codes	
Chronic kidney disease, stage 5	N18.5
End stage renal disease	N18.6

Disclaimer: Third-party payment for medical products and services is affected by numerous factors. It is always the provider's responsibility to determine and submit appropriate codes, charges, and modifiers for services that are rendered. The information provided here is for illustrative purposes only and represents no statement or guarantee by CorMedix Inc, that these codes will be appropriate, or that reimbursement will be made, in a particular situation. Providers should contact their third-party payers for specific information on their coding, coverage, and payment policies.

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

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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, 3.0mL 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)*

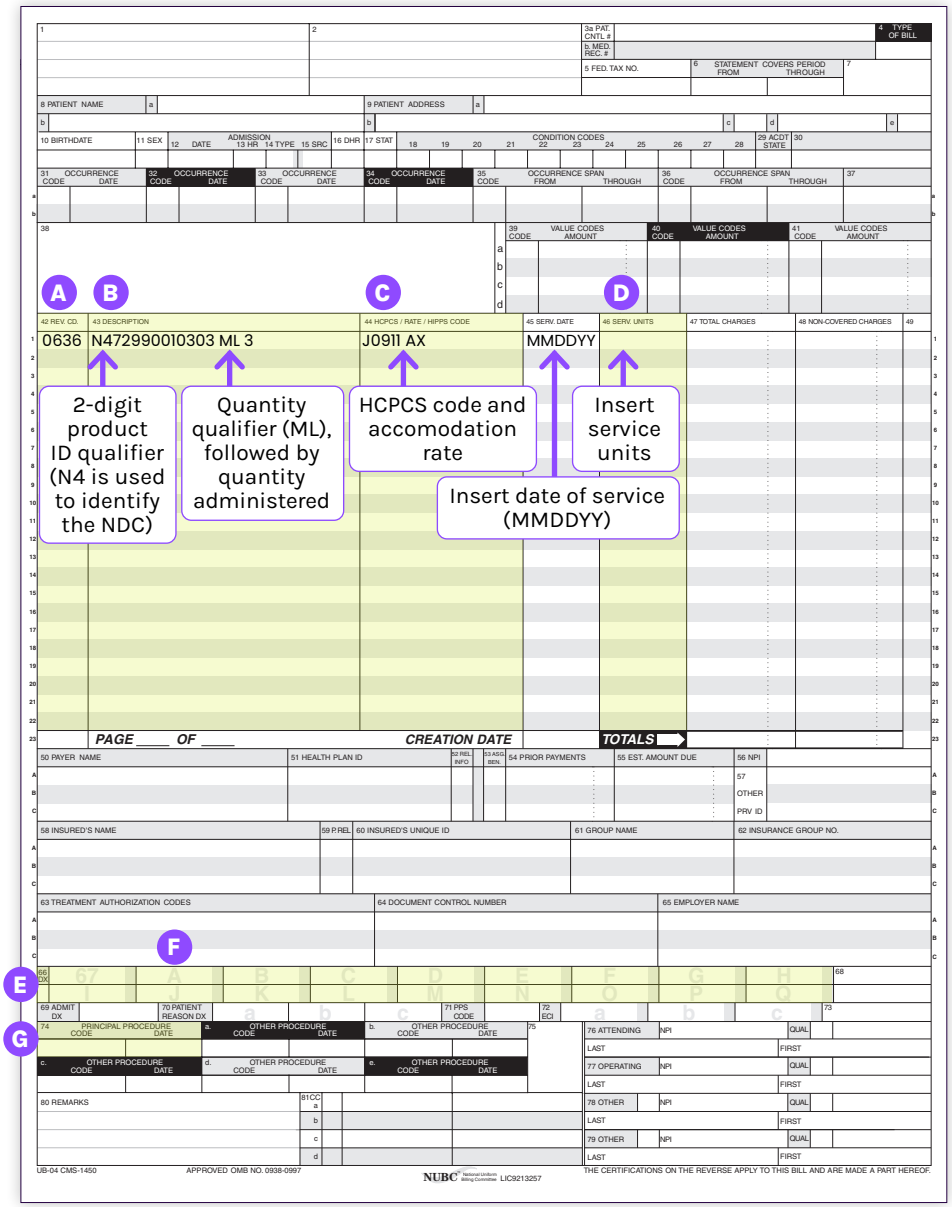
- Enter "0" to indicate that the Tenth Revision of the International Classification of Diseases (ICD-10) will be used for reporting diagnosis codes

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.

QUICK TIPS:

- Include all required information on forms to avoid delays in reimbursement
- Check with your payor for complete instructions when billing for DefenCath
- Coverage determinations are made based on individual patient conditions and can vary depending on local payor policies
- If you have questions, consult with the appropriate payor(s) regarding billing and coding, and follow their guidelines
- You can schedule an appointment with a Reimbursement Support Specialist by calling 1-877-331-5472 or emailing info@defencathsupport.com

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; WAC=wholesaler acquisition cost.

REFERENCES

1. Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs and the Children's Health Insurance 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 2025 Rates; Quality Programs Requirements; and Other Policy Changes. Federal Register. 2024;89(167):68986-70046 **2.** 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 **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

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