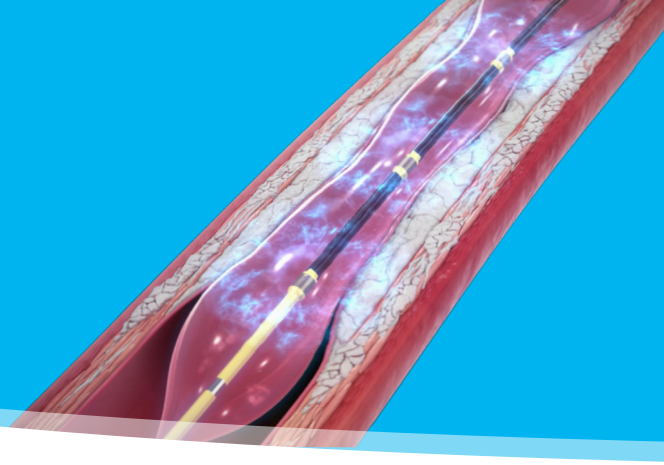
SHOCKWAVE | IVL

New Technology Add-on Payment (NTAP) for Coronary IVL



Overview

Effective October 1, 2021, percutaneous coronary intervention (PCI) cases utilizing Shockwave C^2 Coronary Intravascular Lithotripsy Catheter (IVL) performed in a hospital inpatient setting are eligible for an incremental payment from Medicare (in addition to the MS-DRG payment) to help cover the additional costs of using IVL[1]. In the inpatient setting, this incremental reimbursement is called the "New Technology Add-on Payment" or NTAP. The coronary IVL NTAP provides additional payment of up to $3,666 for FY 2022, based on the hospital's reported cost of each case. See below for more details regarding the NTAP, including an example of how the incremental NTAP payment is calculated and frequently asked questions.

The incremental NTAP is based on the total covered cost to hospitals for a coronary IVL case. If the total covered costs of a discharge (derived by multiplying the hospital's inpatient operating cost-to-charge ratio (CCR) to the total covered charges for the case) exceed the full MS-DRG payment (including payments for indirect medical education and disproportionate share hospitals, but excluding outlier payments), Medicare will provide the NTAP add-on payment equal to 65% of the difference between the full MS-DRG payment and hospital's reported cost for the discharge.

CMS has determined that the maximum NTAP incremental payment for a case involving IVL will be $3,666 for FY2022 (effective October 1, 2021).

Inpatient Coding for IVL Procedures

In the FY2022 Inpatient Final Rule, CMS finalized a set of new ICD-10-PCS codes approved for procedures involving IVL. Effective October 1, 2021, the complete list of procedure codes is provided below and describes the use of IVL in one or more coronary arteries. These codes must be billed in order to recieve an NTAP payment.

ICD-10-PCS Code	Descriptor
02F03ZZ	Fragmentation in coronary artery, one artery, percutaneous approach
02F13ZZ	Fragmentation in coronary artery, two arteries, percutaneous approach
02F23ZZ	Fragmentation in coronary artery, three arteries, percutaneous approach
02F33ZZ	Fragmentation in coronary artery, four or more arteries, percutaneous approach

1. https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page

Overview of the NTAP Calculation

1. Determine total covered charges for the entire hospital stay involving coronary IVL
2. Determine the Hospital-Specific Operating cost-to-charge ratio (CCR)[2]
3. Derive total covered costs of the case = Total charges * CCR
4. Determine the hospital specific MS-DRG payment[3]
5. Subtract the MS-DRG payment from the total covered costs of the case
6. If the difference is > $0, Medicare will make an add-on payment equal to the lesser of 65 percent of the difference or $3,666
7. Final NTAP Payment. Determine the lesser of Step 6 or $3,666
8. Total Case Payment. NTAP plus MS-DRG

Example of NTAP Calculation

The table below uses representative total covered charges, hosptial operating cost-to-charge ratios, and DRG payments to illustrate how NTAP payment is calculated along with the total payment for PCI procedures involving coronary IVL.

NTAP calculation for a Percutaneous Coronary Intervention (PCI) with a Drug Eluting Stent (DES) or Bare Metal Stent (BMS) admission including Coronary IVL

To Qualify for An NTAP, Total Covered Case Costs Must Be Greater Than The Assigned MS-DRG Payment for That Case														Determine The NTAP Payment						Total Payment		
	Example: Total Covered Charges†	x	Example: Hospital CCR[2]	=	Hospital Total Covered Cost	-	Example: Hospital MS-DRG Payment[1]	=	Covered Cost Minus Hospital DRG Payment	x .65	=	65% of Cost in Excess of MS-DRG	OR	Maximum Add-On Payment	=	New Tech Add-On Payment	+	Hospital MS-DRG Payment	=	Total
	1		2		3		4		5			6				7				8
MS-DRG 246: PERCUTANEOUS CARDIOVASCULAR PROCEDURES W DRUG-ELUTING STENT W MCC	$138,573	x	.258	=	$35,752	-	$20,603	=	$15,149	x .65	=	$9,847	OR	$3,666	=	$3,666	+	$20,603	=	$24,269
MS-DRG 247: PERC CARDIO-VASC PROC W DRUG-ELUTING STENT W/O MCC	$95,479	x	.258	=	$24,634	-	$13,012	=	$11,622	x .65	=	$7,554	OR	$3,666	=	$3,666	+	$13,012	=	$16,678
MS-DRG 248: PERCUTANEOUS CARDIOVASCULAR PROCEDURES W NON-DRUG-ELUTING STENT W MCC	$130,479	x	.258	=	$33,664	-	$20,853	=	$12,811	x .65	=	$8,327	OR	$3,666	=	$3,666	+	$20,853	=	$24,519
MS-DRG 249: PERC CARDIO-VASC PROC W NON-DRUG-ELUTING STENT W/O MCC	$87,946	x	.258	=	$22,690	-	$12,356	=	$10,334	x .65	=	$6,717	OR	$3,666	=	$3,666	+	$12,356	=	$16,022

MCC - Major complicaitons and comoribidities

† Average hospital total charges specific to inpatient discharges for coronary interventions (MS-DRGs 246-249) assessed using FY2018 Medicare claims data

1. https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page#Data
2. See FAQ #9 for instructions on how to obtain the FY2022 Operating CCR for your hospital.
3. Hospital Specific DRG payments may be obtained by contacting the Shockwave Reimbursement Hotline at (877) 273-4628.

Frequently Asked Questions (FAQs)

New Technology Add-On Payment (NTAP)

1. When is the NTAP effective?

The NTAP payments for IVL go into effect for discharges on or after October 1, 2021 which coincides with the start of Federal Fiscal Year 2022. Coronary IVL procedures will be eligible for NTAP for two years from the effective date.

2. How should a IVL case be billed in the hospital inpatient setting?

There are no special billing requirements placed on the hospital for processing the NTAP payment, other than using the appropriate **ICD-10-PCS codes** that describe the use of IVL as part of the Coronary intervention procedure. The procedure codes listed above indicate a procedure involving the use of Coronary IVL. The use of any one of these codes will trigger a calculation of the NTAP payment by your Medicare Administrator Contractor's claims processing system.

3. Is there a fixed payment amount for each inpatient IVL case?

The NTAP amount is not a fixed amount and can vary for each case. It is calculated on a case-by-case basis. As explained in the example above, CMS has determined that the maximum incremental NTAP amount that a hospital can receive (in addition to the full DRG payment) is $3,666 **per discharge**. The exact payment amount per case is not fixed and depends on the total costs of the discharge.

4. Is the IVL NTAP amount paid per device (unit) 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 discharges that go into the calculation of both the eligibility for NTAP and the NTAP amount.

5. What is the total payment amount for the IVL case if it qualifies for an NTAP?

The total payment amount for a IVL 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 $3,666 per case. The NTAP payment amount is then added to the hospital assigned DRG payment.

6. Can the NTAP amount be less than the $3,666 allowed?

Yes, the $3,666 is the maximum amount allowed for the NTAP portion on the hospital payment. Should the hospital specific calculation of 65% of the hospital costs minus the DRG payment be less than $3,666, then the lower amount is paid.

FAQs (continued)

7. What are the DRGs to which cases involving IVL are assigned?

Most cases involving the use of IVL will fall into one of the four following MS DRGs: 246, 247, 248, or 249. The descriptions and payment amounts for FY2022 are shown below.

MS-DRG	Description	FY2022 National Unadjusted Payment
246	Percutaneous cardiovascular procedures with DES w/MCC	$20,603
247	Percutaneous cardiovascular procedures with DES w/o MCC	$13,012
248	Percutaneous cardiovascular procedures with non DES w/MCC	$20,853
249	Percutaneous cardiovascular procedures with non DES w/o MCC	$12,356

Source: CMS-1752-F

8. How is the actual cost of the discharge determined?

CMS derives the total covered cost of the discharge based on the total covered hospital charges for each case, and the hospital's inpatient operating cost to charge ratio determined from its cost report.

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

The CY 2022 CCRs by provider number are available at:
https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page#Data

Download the FY2022 Impact File and search the excel file by Medicare provider number. The CCR is listed in Column AG (Operating CCR). If you do not know your Medicare provider number, please contact us via email at reimbursement@shockwavemedical.com with the name and location of your hospital and we can look it up for you.

10. What should you do if your hospital encounters issues with claims using the ICD-10-PCS codes involving the use of IVL (including denial)?

The best source of information regarding claims processing issues is the payer – either the patient's private insurance company or, the Medicare Administrative Contractor (for traditional Medicare A/B patients). Providers should contact the appropriate payer to report the problem and seek clarification about the issue.

Please also contact us at the Shockwave Reimbursement Hotline (877-273-4628) or send us an email at reimbursement@shockwavemedical.com with the details of the issue for additional support and guidance.

FAQs (continued)

11. Is Coronary IVL reimbursed for PCIs performed as hospital outpatient procedures?

CMS also provides incremental payment in the hospital outpatient setting through the Transitional Pass-Through (TPT) Payment Status that was granted to Coronary IVL on July 1, 2021. For more information about TPT for IVL, visit Shockwave Medical's Reimbursement website at https://shockwavemedical.com/coronary-reimbursement

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