Ambu

Medicare Inpatient New Technology Add-on Payments for the aScope™ Duodeno

CODING AND PAYMENT GUIDE

Effective October 1, 2021, the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare program, has granted a New Technology Add-on Payment (NTAP) for a single-use duodenoscope such as the aScope™ Duodeno, which is used in performing endoscopic retrograde cholangiopancreatography (ERCP) procedures in the hospital inpatient setting. The NTAP status applies to the original Medicare program and can remain in effect for up to three years from the time of marketing authorization.[1]

HOW NTAP PAYMENTS WORK

Under the Inpatient Prospective Payment System, the Medicare program pays a hospital a fixed bundled payment for items and services furnished by the hospital, such as operating rooms, room and board, nursing services, and diagnostic tests. This fixed payment is known as a Medicare Severity Diagnosis-Related Group (MS-DRG). When a new technology is adopted for patient treatment, the Medicare program may authorize an additional payment to the hospital in addition to the MS-DRG payment to help cover the costs of that new technology if certain criteria are met.[2] This additional payment is called a New Technology Add-on Payment (NTAP).

The NTAP amount that a hospital receives is based on the cost of the new technology. In the final rule that approved NTAP reimbursement for the aScope™ Duodeno, the Medicare program set a value of $1,715.59, which is 65 percent of the weighted average cost of a disposable duodenoscope. In order to receive a NTAP payment, the hospital's costs for an inpatient discharge must exceed the applicable MS-DRG payment.

Under the Medicare regulations, if NTAP reimbursement is available, the amount that will be paid is the lesser of the following:

- 65% of the amount the cost of the case exceeds the MS-DRG payment
- 65% of the cost of the new technology ($1,715.59 for the aScope™ Duodeno)[3]

To illustrate how NTAP payments can be determined, suppose that a Medicare beneficiary is discharged and the applicable MS-DRG payment is $6,921. The NTAP payment would be determined as follows:

Example 1: If the hospital's costs are $6,000, then no NTAP payment would be made because the costs are below the MS-DRG payment that would be made. NTAP payments are made only when the hospital's total costs exceed the MS-DRG schedule amount.

Example 2: If the hospital's costs are $7,500, then a partial NTAP payment would be made by Medicare. In this scenario, the hospital incurred $579 in costs in excess of the MS-DRG payment.
Therefore, because the excess cost is less than 65% of the cost of the new technology ($1,715.59), the Medicare program would pay the hospital an additional $376.35, or 65% of the excess cost.

Example 3: If the hospital's costs were $10,000, then the hospital would receive the full NTAP payment. Its excess costs are $3,079, which is greater than the sum of the MS-DRG payment and the NTAP allowable amount. In this scenario, the Medicare program will compare (1) 65% of the costs above the MS-DRG rate ($2,001.35) with (2) 65% of the cost of the new technology ($1,715.59) and pay the lesser amount. Since 65% of the cost of the aScope™ Duodeno is less than 65% of the additional costs that exceed the MS-DRG payment, the hospital would receive the full NTAP payment of $1,715.59, and the total reimbursement to the hospital would be $8,636.59.

[1] FY 2022 Medicare Inpatient Prospective Payment System Final Rule; 86 Fed. Reg. 44774, 45133 (2021); available at: https://www.govinfo.gov/content/pkg/FR-2021-08-13/pdf/2021-16519.pdf
[2] Social Security Act, § 1886(d)(5)(K).
[3] 42 C.F.R. § 412.88(a)(2).

Coding for the aScope Duodeno

HCPCS Code for Reporting the aScope Duodeno

HCPCS Code	Descriptor
C1748	Endoscope, single-use (i.e. disposable), upper GI, imaging/illumination device (insertable)

Revenue Codes

Revenue Codes	Descriptor
272	Sterile supplies
278[4]	Medical/surgical supplies and implants; other implants

ICD-10-PCS Code[5]

All cases using the aScope™ Duodeno should be identified using one of the following two special ICD–10– PCS codes:

ICD-10PCS Codes	Descriptor
XFJB8A7	Inspection of hepatobiliary duct using single-use duodenoscope, new technology group 7
XFJD8A7	Inspection of pancreatic duct using single-use duodenoscope, new technology group

ICD-10PCS Codes	Descriptor
0FD48ZX	Extraction of gallbladder, via natural or artificial opening endoscopic, diagnostic
0FD58ZX	Extraction of right hepatic duct, via natural or artificial opening endoscopic, diagnostic
0FD68ZX	Extraction of left hepatic duct, via natural or artificial opening endoscopic, diagnostic
0FD78ZX	Extraction of common hepatic duct, via natural or artificial opening endoscopic, diagnostic
0FD88ZX	Extraction of cystic duct, via natural or artificial opening endoscopic, diagnostic
0FD98ZX	Extraction of common bile duct, via natural or artificial opening endoscopic, diagnostic
0FDC8ZX	Extraction of ampulla of vater, via natural or artificial opening endoscopic, diagnostic
0FDD8ZX	Extraction of pancreatic duct, via natural or artificial opening endoscopic, diagnostic
0FDF8ZX	Extraction of accessory pancreatic duct, via natural or artificial opening endoscopic, diagnostic
0FJ48ZZ	Inspection of gallbladder, via natural or artificial opening endoscopic

[4] Items that are insertable may be billed with revenue code 0278 per the National Uniform Billing Committee (NUBC)'s Updated Guidance on Other Implant Revenue Code (0278) effective July 1, 2020 available at https://www.nubc.org/system/files/media/file/2020/04/Guidance%20on%20Other%20Implant%20RC0278.pdf

[5] 86 Fed. Reg. at 45134-35.

0FJB8ZZ	Inspection of hepatobiliary duct, via natural or artificial opening endoscopic
0FJD8ZZ	Inspection of pancreatic duct, via natural or artificial opening endoscopic
0FB48ZX	Excision of gallbladder, via natural or artificial opening endoscopic, diagnostic
0FB58ZX	Excision of right hepatic duct, via natural or artificial opening endoscopic, diagnostic
0FB68ZX	Excision of left hepatic duct, via natural or artificial opening endoscopic, diagnostic
0FB78ZX	Excision of common hepatic duct, via natural or artificial opening endoscopic, diagnostic
0FB88ZX	Excision of cystic duct, via natural or artificial opening endoscopic, diagnostic
0FB98ZX	Excision of common bile duct, via natural or artificial opening endoscopic, diagnostic
0FBC8ZX	Excision of ampulla of vater, via natural or artificial opening endoscopic, diagnostic
0FBD8ZX	Excision of pancreatic duct, via natural or artificial opening endoscopic, diagnostic
0FBF8ZX	Excision of accessory pancreatic duct, via natural or artificial opening endoscopic, diagnostic
0FN98ZZ	Release common bile duct, via natural or artificial opening endoscopic
0FNC8ZZ	Release ampulla of vater, via natural or artificial opening endoscopic
0FND8ZZ	Release pancreatic duct, via natural or artificial opening endoscopic
0FNF8ZZ	Release accessory pancreatic duct, via natural or artificial opening endoscopic
4A0C8BZ	Measurement of biliary pressure, via natural or artificial opening endoscopic
0FF78ZZ	Fragmentation in common hepatic duct, via natural or artificial opening endoscopic
0FF98ZZ	Fragmentation in common bile duct, via natural or artificial opening endoscopic

MEDICARE HOSPITAL INPATIENT PAYMENT

The information in this guide is based on some typical MS-DRG assignments for inpatient hospitalizations that may include the use of a disposable duodenoscope. The assignment of a MS-DRG to a given discharge is based on a wide range of diagnoses and services, and as a result Ambu cannot guarantee that this list is exhaustive, or that coverage will be guaranteed for any MS-DRG assignment in a reimbursement claim.

MS-DRG Description Hospital Inpatient Medicare National Average Payment

DRG	Descriptor	Average Medicare Payment[6]
435	Malignancy of hepatobiliary system or pancreas with Major Complication or Comorbidity (MCC)	$10,733.81
436	Malignancy of hepatobiliary system or pancreas with Complication or Comorbidity (CC)	$6,865.50
437	Malignancy of hepatobiliary system or pancreas without CC/MCC	$5,484.44
438	Disorders of pancreas except malignancy with MCC	$9,781.27
439	Disorders of pancreas except malignancy with CC	$5,174.07
440	Disorders of pancreas except malignancy without CC/MCC	$3,711.59
441	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with MCC	$11,505.75
442	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC	$5,693.19
443	Disorders of liver except malignancy, cirrhosis, alcoholic hepatitis with CC	$4,059.92
444	Disorders of the biliary tract with MCC	$10,233.05
445	Disorders of the biliary tract with CC	$6,596.14
446	Disorders of the biliary tract without CC/MCC	$4,998.99

[6] The Inpatient PPS standardized rate for FY 2022 is $6,121.71 for hospitals that participate in the Inpatient Quality Reporting program and are meaningful electronic health record users.

ABOUT THE ASCOPE DUODENO

The aScope Duodeno is a single-use sterile duodenoscope that seamlessly integrates into existing hospital systems and offers an intuitive, lightweight design with similar functionality to reusable duodenoscopes. The aScope Duodeno is part of a system includes a reusable process unit, the Ambu® aBox™ Duodeno. Duodenoscopes are used for visual examination of the duodenum and play a key role in diagnosis and treatment of conditions like gallstones, pancreatitis, and tumors or cancer in the bile duct and pancreas.

INDICATIONS FOR USE

The aScope Duodeno is designed to be used with the aBox Duodeno, endoscopic accessories (e.g. biopsy forceps) and other ancillary equipment (e.g. video monitor) for endoscopy and endoscopic surgery within the duodenum.

The aBox Duodeno is designed to be used with the aScope Duodeno, endoscopic accessories (e.g. biopsy forceps) and other ancillary equipment (e.g. medical grade video monitor) for endoscopy and endoscopic surgery within the duodenum.

DISCLAIMER

The reimbursement information provided in this Guide was obtained from third-party sources and information that is publicly available on the internet. The reported Medicare national average payments are subject to change and may vary based on geographic location and other individual factors. Information in this Guide is not legal advice, nor is it advice about how to code or complete claims for payment. It is the provider's responsibility to report the appropriate codes based on the procedures furnished to a specific patient and the patient's medical condition. Providers are also responsible for submitting claims for these services consistent with the specific payer billing requirements.

Payer billing, coding, and coverage requirements vary from payer to payer and are updated and change over time. Ambu encourages providers to verify current billing, coding and coverage policies and requirements with the specific payer if the provider has questions. Providers may also contact the American Gastroenterology Association (AGA), the American Society for Gastrointestinal Endoscopy (ASGE) and/or the American Medical Association (AMA).

Ambu does not promote the use of its products outside of the approved FDA approved indications for use and labeling.

For more information, please contact the Ambu Reimbursement Support Team
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