New Technology Add-On Payments (NTAP) for the Paradise® Ultrasound Renal Denervation System

Effective Date October 1, 2025[1]

Attention All Hospitals and Healthcare Providers,
Effective October 1, 2024, renal denervation cases utilizing the Paradise Ultrasound Renal Denervation System 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 performing uRDN procedures.

What is an NTAP?
New Technology Add-On Payments (NTAP) are additional payments by CMS for qualifying Inpatient Medicare Fee-For-Service procedures. They help hospitals adopt new technologies by covering the gap between the standard DRG payment and the actual cost of these new technologies and procedures. NTAPs are available for a limited time defined by CMS, typically 2 - 3 years.

What is the status/update?

- The Paradise System has been approved for NTAP, effective **October 1, 2024**
- Hospitals using our technology in the inpatient setting can receive up to **$14,950** in additional payment per case, above the standard DRG reimbursement available to the facility
- uRDN therapy received a unique inpatient procedure code **(X051329)** which links to the approved NTAP and the additional reimbursement for qualifying admissions

The incremental NTAP is based on the total covered cost to hospitals for a uRDN procedure. 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 up to $14,950. See below for an example calculation.[2]

Total Hospital Reimbursement if Charges/Covered Cost is more than the DRG Reimbursement but less than the NTAP amount

Hospital Charges for Admission	x	Hospital CCR	=	"Covered Cost"	-	MS-DRG 264 Reimbursement	=	Costs over DRG	NTAP Reimbursement (lesser of 65% of device costs = $14,950 or 65% of the cost over DRG)	+	MS-DRG 264 Payment	=	Total Payment
$120,000	x	.250	=	$30,000	-	$24,309	=	$5,691	$5,691 x 65% = $3,699	+	$24,309	=	$28,008

Total Hospital Reimbursement if Charges/Covered Cost is more than the DRG Reimbursement and more than the NTAP amount

Hospital Charges for Admission	x	Hospital CCR	=	"Covered Cost"	-	MS-DRG 264 Reimbursement	=	Costs over DRG	NTAP Reimbursement (lesser of 65% of device costs = $14,950 or 65% of the cost over DRG)	+	MS-DRG 264 Payment	=	Total Payment
$200,000	x	.250	=	$50,000	-	$24,309	=	$25,691	$14,950	+	$24,309	=	$39,259

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FAQs

When is the NTAP for the Paradise System effective?
CMS approved the NTAP for the Paradise System effective October 1st, 2024 (the start of Federal Fiscal Year 2025). Ultrasound Renal Denervation procedures will be eligible for NTAP for at least two years but up to three years from the effective date.

Are there any special coding or billing requirements related to the NTAP?
There are no special billing requirements placed on the hospital for processing the NTAP payment, other than using the appropriate uRDN ICD-10-PCS code, X051329. Using this code on your inpatient claim will trigger a calculation of the NTAP payment by your Medicare Administrator Contractor's (MAC) claims processing system.

What is the maximum additional reimbursement provided by the NTAP?
While the NTAP amount is not a fixed amount and can vary for each case, hospitals are eligible for up to $14,950 in additional reimbursement (plus the hospital's full DRG payment).

It is important to note that the NTAP payment is calculated on a case-by-case basis. The exact payment amount per case is not fixed and depends on the total cost of the admission. Should the hospital specific calculation of 65% of the hospital costs minus the DRG payment be less than $14,950, then the lower amount is paid.

Does the NTAP apply to Medicare Advantage or private insurance inpatient procedures?
No, NTAPs only apply to Medicare FFS discharges. Medicare Advantage plans and private insurance reimbursement is based on private contracts with these providers. If you would like more insight into what your contracted rates are with these providers, contact your contracting team for more information.

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.

Where can a hospital find the hospital inpatient operating CCR used in the NTAP payment calculation?
The CCRs by provider number are available at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page#DataFiles

Download the FY2026 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 us via email at reimbursement@recormedical.com with the name and location of your hospital and we can look it up for you.

1. FY 2026 IPPS Final Rule Home Page 1833-F: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page
2. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-F/subject-group-ECFR5703923263fedba/section-412.88

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