

Minima Growth Stent System

New Technology Add-On Payment (NTAP)



The Minima Growth Stent System has been approved by Medicare for NTAP beginning October 1, 2025

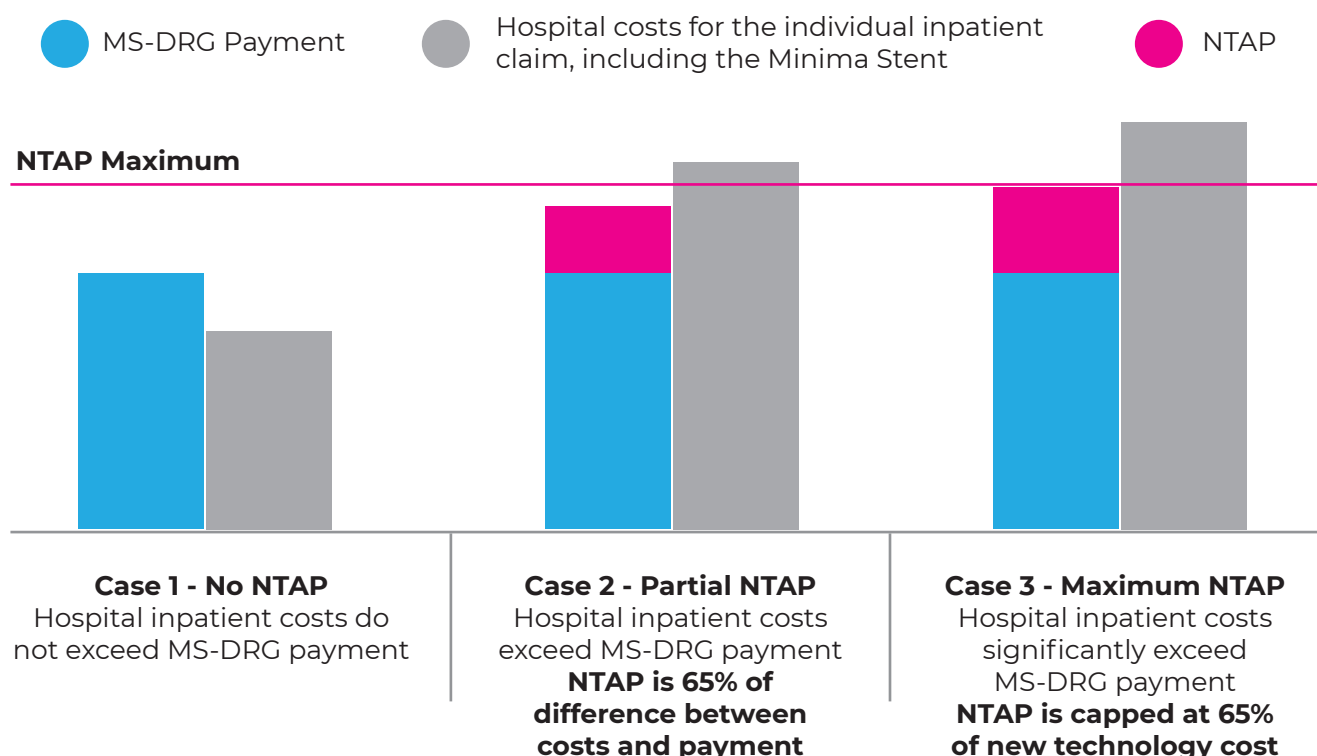
Overview

Effective October 1, 2025, Minima Stent System procedures are eligible for an incremental payment from Medicare. This incremental reimbursement is called the “New Technology Add-on Payment (NTAP)”. CMS has determined the Minima Stent NTAP maximum of \$22,685 for Fiscal Year 2026 (Effective October, 2025)¹. See below for more details regarding NTAP, including examples of how the NTAP payment is calculated and frequently asked questions.

NTAP Calculation

The NTAP amount is based on the total covered cost to hospitals for a Minima Stent case. If the total covered costs of a discharge (derived by multiplying the hospital's operating cost-to-charge ratio (CCR) by the total covered charges for the case) exceed the full MS-DRG payment, 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 discharge². Please note that total case reimbursement may vary based on different factors such as outlier payments, however, this guide is only focused on NTAP calculations.

NTAP Illustration



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Example NTAP Calculations

The three calculation examples below are for illustration purposes only. As you see in these examples, the NTAP eligibility depends on several factors such as hospital-specific MS-DRG payment rate, operating CCR, and estimated total cost per case.

Table 1. Calculation examples for no NTAP (1), partial NTAP (2), and full NTAP (3)

DESCRIPTION	CALCULATION	CASE 1	CASE 2	CASE 3
Hospital Charges <i>(Entire hospital stay, including device)</i>	A	\$50,000	\$75,000	\$100,000
Hospital-Specific Inpatient CCR <i>(published by Medicare)</i>	B	0.85	0.8	0.85
Hospital Total Case Cost	C A x B	\$42,500	\$60,000	\$85,000
Hospital-Specific MS-DRG Payment	D	\$49,000	\$49,000	\$49,000
Hospital Case Cost Minus hospital-specific MS-DRG Reimbursement	E C - D	-\$6,500	\$11,000	\$36,000
65% of Hospital Case Cost Minus hospital-specific MS-DRG Payment	F E x 0.65	N/A	\$7,150	\$23,400
NTAP Cap (determined by CMS)	G	\$22,685	\$22,685	\$22,685
NTAP Payment Amount	H Lesser of F and G	\$0	\$7,150	\$22,685
Estimated Total Hospital Reimbursement [NTAP + hospital-specific MS-DRG payment]	D + H	\$49,000	\$56,150	\$71,685

NTAP Identifiable ICD-10-PCS Codes

Cases involving the use of the Minima Stent System that are eligible for new technology add-on payments (NTAP) will be identified by the following ICD-10-PCS procedure codes.

ICD-10-PCS Code	Descriptor
X27339B	Dilation of right pulmonary artery with expandable intraluminal device, percutaneous approach, new technology group 11
X27439B	Dilation of left pulmonary artery with expandable intraluminal device, percutaneous approach, new technology group 11
X27W39B	Dilation of thoracic aorta, descending with expandable intraluminal device, percutaneous approach, new technology group 11
X27X39B	Dilation of thoracic aorta, ascending/arch with expandable intraluminal device, percutaneous approach, new technology group 11

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Frequently Asked Questions

When does the Minima Stent NTAP go into effect?

The Minima Stent NTAP goes into effect for discharges on or after **October 1, 2025**.

How long will the Minima NTAP be effective?

The Minima NTAP will be effective for three years (Oct 1, 2025, to Sep 30, 2028)

Is NTAP payment for each Minima procedure the same?

No, the NTAP is not a fixed amount and varies for each case. Each Minima Stent case will be assessed for NTAP eligibility and payment individually. The maximum NTAP amount that a hospital can receive is \$22,685 per discharge. Please note that the NTAP amount is paid once per discharge, not per the number of devices used in a procedure.

How should a Minima case be billed in the hospital inpatient setting?

The appropriate ICD-10-PCS code (X27339B, X27439B, X27W39B, or X27X39B) should be included on inpatient hospital claims to describe the use of the Minima Stent. Otherwise, there are no special billing requirements for processing the NTAP payment.

What DRG will Minima be assigned to?

The actual DRG assignment for an individual case will vary according to other services included in the claim. By including the ICD-10-PCS codes listed above, NTAP payment will be initiated if applicable. Please reference the Minima Reimbursement Guide for DRG guidance.

Where can you access the hospital inpatient operating cost-to-charge-ratio (CCR) used in the NTAP payment calculation?

The 2026 CCRs sorted by provider are available at <https://www.cms.gov/files/zip/fy2026-ippes-fr-impact-file.zip>. Download the IPPS rule Impact File and search the Excel file by Medicare provider number to find your facility. You can locate the "Operating CCR" in the Excel's Column AG.

How is the total hospital reimbursement amount (with NTAP) calculated for each case?

As you see in the calculation examples above, the total hospital reimbursement amount will consist of the hospital-specific MS-DRG payment in addition to 65% of the difference between the cost of discharge for the hospital and the hospital-specific MS-DRG payment, up to a maximum of \$22,685 per case.

How does NTAP impact physician payment?

Physician professional payments are not impacted by NTAP in the inpatient setting.

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Please visit our Minima Stent Reimbursement Homepage for more information.

If you need assistance understanding NTAP or have other questions, please contact the Renata Medical health economics and reimbursement experts at: info@renatamedical.com.

References:

1. IPPS Final Rule Home Page. cms.gov
<https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipp-final-rule-home-page>
Updated August 1, 2025. Accessed August 2, 2025
2. New Medical Services and New Technologies. cms.gov,
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/newtech>.
Accessed 2 Aug. 2025.

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