Reimbursement - Frequently Asked Questions
AeroPace® System
Temporary Transvenous Diaphragm Neurostimulation (TTDN)

Inpatient Hospital Reporting - New Technology Add-On Payment (NTAP) and Documentation

For further detailed information, refer to the NTAP Calculation Model document that contains illustrative examples of the CMS allowance, the AeroPace® System Chargemaster Guide, and the Coding and Reimbursement Guide. For medical record documentation refer to the Documentation Reference Guide.

A. What is NTAP?

- NTAP designation enables additional payment to hospitals for medical device technologies that meet specified CMS criteria to allow a payment amount above the standard Medicare Severity Diagnosis-Related Group (MS-DRG).

B. When is the NTAP for the AeroPace® System effective and for how long?

- NTAP began October 1, 2025, and is effective for at least 2 years and up to 3 years.

C. What is the NTAP amount paid per patient case for the AeroPace System?

- The NTAP amount is up to $23,650.90, which represents 65% of the cost of the single-use components of the AeroPace System. It is paid once per discharge. CMS established the rate with the assumption that in some cases, more than one AeroPace® Neurostimulation Catheter may be needed.
- The hospital is eligible to receive NTAP payment when the costs of the inpatient stay exceed the Medicare MS-DRG payment including adjustments but excluding outlier payments. Payment is the lesser of the 65% of the device cost or 65% of the cost of the inpatient stay over the MS-DRG payment. The NTAP amount can vary for each case and is added to the MS-DRG payment.

D. Is it necessary to report revenue codes since TTDN is an inpatient procedure typically performed in critical or in intensive care at bedside?

- Yes. Revenue codes are standardized to indicate broad categories of products and procedures performed and classify the area in which the service was performed. These codes identify cost centers within a hospital for purposes of billing and tracking costs.
- Revenue codes are typically designated and assigned charges by departments that are part of revenue management such as hospital billing, finance, or purchasing.
- When considering revenue code assignment, the AeroPace System includes a sterile single use AeroPace Neurostimulator Catheter and a single patient use Airway Sensor.

E. As the AeroPace System is a NTAP designated technology, what should a hospital consider for identifying the use of the technology for each patient case during the inpatient stay?

- Ensure required ICD-10-PCS codes are included in the chargemaster and recorded for the claim:
  - *X2H13XB Insertion of Temporary Phrenic Nerve/Diaphragm Stimulation Electrodes, Superior Vena Cava, Percutaneous Approach, New Technology Group* is coded for procedures and services
  - *5A1955Z Respiratory ventilation, greater than 96 consecutive hours*
- Add *X2H13XB* in the Electronic Health Record ICD-10-PCS procedure pull down menu.
- Train physicians, allied health personnel, and coders about the key words for the insertion procedure (AeroPace® Neurostimulation Catheter) and the mapping, programming and therapy for the medical record.
- Establish charges and select revenue codes that reflect single use device costs and other relevant supply costs.

F. Do all payers recognize NTAP payments?

- In general, NTAP is only recognized by Medicare. Private payers, Medicare Advantage plans, and other payers pay according to the terms of their contracts.

G. Are all facilities eligible for NTAP?

- Only Acute Care Facilities/Hospitals are eligible for NTAP payments associated with Medicare inpatient hospitalizations. Other facilities, such as Long-Term Care Hospitals, Rehabilitation Hospitals, and Skilled Nursing Facilities, cannot receive payments under the NTAP program.

Physician Reporting

For further detailed information about physician reporting, refer to the AeroPace® System Coding and Reimbursement Guide and the Documentation Reference Guide.

A. What CPT codes may be reported to describe the physician services associated with Temporary Transvenous Diaphragm Neurostimulation (TTDN) using the AeroPace® System?

- Until July 2026, physicians can report an unlisted CPT code to identify that TTDN was provided which includes the insertion of the AeroPace® Neurostimulation Catheter with capture of the left phrenic nerve, mapping and programming, and TTDN therapy.
- Effective July 1, 2026, new specific Category III CPT Codes will be available to report the various elements of TTDN therapy.

B. How can charges and payments be established for physician work since national RVUs are not assigned to CPT Unlisted codes?

- Charges and RVUs may be 'crosswalked' to procedures and services that represent similar work complexity and activities.
- Payments may also be established with a payer typically based on the charge from the provider either on a case-by-case basis or through contracting.
- While it may take time for payers to recognize the clinical benefits and medical necessity for provision of TTDN therapy with an unlisted CPT code, the submission of claims raises awareness to payers, which supports a need for payment. If claims are denied, submit the medical record documentation to establish medical necessity and ensure the record reflects a description of the procedure and service.
- A sample Letter of Medical Necessity to manage claim denials is available from Lungpacer.

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