PEARLMATRIX® P-15 PEPTIDE ENHANCED BONE GRAFT

NEW TECHNOLOGY ADD-ON PAYMENT (NTAP) BILLING GUIDE FOR HOSPITALS

FY 2027 final rule update

CMS finalized FY 2027 NTAP approval for PearlMatrix® P-15 Peptide Enhanced Bone Graft. For eligible FY 2027 inpatient Medicare cases, the finalized maximum NTAP amount is $3,380, calculated as 65% of the $5,200 operating cost basis. NTAP remains case-specific and is limited to the lesser of 65% of the technology cost or 65% of the amount by which the case cost exceeds the MS-DRG payment.

Purpose of this guide

- Help hospital coding, revenue integrity, chargemaster, and billing teams identify the claim elements that may support Medicare NTAP payment for qualifying inpatient cases involving PearlMatrix.
- Provide a practical billing workflow, common claim-review checkpoints, and an illustrative FY 2027 payment example for internal hospital review.
- Reinforce that hospitals remain responsible for coding, documentation, charge capture, billing, and compliance decisions for each patient case.

At-a-glance: claim elements to verify before billing

Requirement	Hospital action	Why it matters	Owner
Inpatient claim	Confirm Medicare IPPS inpatient status and FY 2027 discharge date	NTAP is an inpatient add-on payment and is not an outpatient or ASC payment.	PFS
Eligible clinical context	Confirm PearlMatrix use is in conjunction with a single-level TLIF procedure for the Breakthrough Device-designated indication	CMS limited FY 2027 NTAP eligibility to the Breakthrough Device-designated TLIF use.	Surgeon / OR / HIM
Product use documented	Operative note and implant log show PearlMatrix product name, quantity, lot/label, and location	Supports coding, charge capture, and audit trail.	OR / HIM
NTAP code reported	Assign applicable ICD-10-PCS XW0U*XB code based on approach, when supported by documentation	CMS identifies PearlMatrix NTAP cases through claim coding.	Coding
Relevant TLIF fusion code present	Confirm applicable lumbar or lumbosacral fusion procedure code is present when supported	CMS identifies eligible cases using PearlMatrix NTAP code plus relevant TLIF procedure code.	Coding
Charge captured	Report appropriate implant/supply charge using facility policy	Case cost/charge data affects payment calculation.	Rev. Integrity
Payment reviewed	Check remittance for NTAP payment and variance	Confirms payment and supports rebill or appeal if appropriate.	PFS

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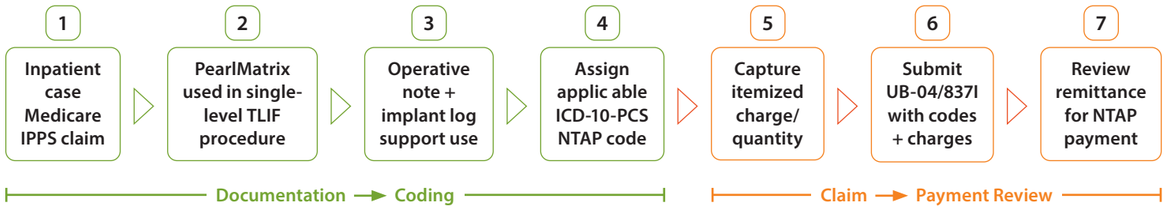
NTAP billing flow



Note: *NTAP payment is determined by Medicare based on claim data, case costs, and applicable CMS payment rules. This flow is an educational checklist, not patient-specific billing advice.*

PearlMatrix NTAP ICD-10-PCS codes

Use the applicable code only when supported by operative documentation and procedure approach. Hospitals should validate all code assignment through internal coding and compliance review and current CMS ICD-10-PCS files.

Code	Description	Approach	Use note
XW0U0XB	Introduction of Peptide Enhanced Bone Void Filler into Joints, Open Approach, New Technology Group 11	Open	Use when open approach is documented.
XW0U3XB	Introduction of Peptide Enhanced Bone Void Filler into Joints, Percutaneous Approach, New Technology Group 11	Percutaneous	Use when percutaneous approach is documented.
XW0U4XB	Introduction of Peptide Enhanced Bone Void Filler into Joints, Percutaneous Endoscopic Approach, New Technology Group 11	Perc. endoscopic	Use when percutaneous endoscopic approach is documented.

Relevant TLIF fusion procedure codes CMS identified for eligible PearlMatrix NTAP cases

Procedure code	Description
0SG00AJ	Fusion of lumbar vertebral joint with interbody fusion device, posterior approach, anterior column, open approach
0SG03AJ	Fusion of lumbar vertebral joint with interbody fusion device, posterior approach, anterior column, percutaneous approach
0SG04AJ	Fusion of lumbar vertebral joint with interbody fusion device, posterior approach, anterior column, percutaneous endoscopic approach
0SG30AJ	Fusion of lumbosacral vertebral joint with interbody fusion device, posterior approach, anterior column, open approach
0SG33AJ	Fusion of lumbosacral vertebral joint with interbody fusion device, posterior approach, anterior column, percutaneous approach
0SG34AJ	Fusion of lumbosacral vertebral joint with interbody fusion device, posterior approach, anterior column, percutaneous endoscopic approach

Top 5 billing mistakes that may prevent NTAP payment

Mistake	Why it matters	Pre-bill check
Omitting the NTAP ICD-10-PCS code	If the applicable XW0U*XB code is not reported, the claim may not be recognized as involving the qualifying technology.	Confirm XW0U0XB, XW0U3XB, or XW0U4XB when supported.
Reporting PearlMatrix outside the eligible final-rule context	CMS stated only use in conjunction with a single-level TLIF procedure for the Breakthrough Device-designated indication is relevant for FY 2027 NTAP.	Confirm operative note supports the eligible TLIF context.
Generic OR documentation	"Bone graft used" without product name, location, quantity, and implant record may not support coding or claim review.	Confirm product name, quantity, lot/label, and location.
Missing or miscoded approach	The NTAP code varies by open, percutaneous, or percutaneous endoscopic approach.	Match code approach to documentation.
No payment/remittance review	Hospitals should validate that expected NTAP payment appears and reconcile underpayments promptly.	Review remittance and variance.

Sample UB-04 / 837I claim review screenshot

Sample UB-04 / CMS=1450 Claim Review Elements

Illustrative only — not a completed claim and not patient-specific billing advice.

FL	Claim element	Illustrative entry	Why it matters	Review
4	Type of bill	**111 / inpatient**	Confirms IPPS inpatient claim context	☐
42–47	Revenue/charge lines	**Implant/supply line + charge**	Supports cost reporting for device/technology	☐
43	Description	**PearlMatrix P-15 Bone Graft**	Avoids generic implant descriptions where feasible	☐
74 / 74a–e	Procedure codes	**Primary fusion code + applicable XW0U*XB code**	Procedure coding identifies technology use	☐
80	Remarks, if used	**Use per facility policy only**	May support internal routing / claim review	☐

Claim review checkpoint: confirm the applicable PearlMatrix NTAP code (XW0U0XB, XW0U3XB, or XW0U4XB) is reported when supported by documentation and approach.

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Illustrative FY 2027 payment example

Education-only example using a sample Medicare inpatient case that groups to MS-DRG 451 and an assumed hospital cost of $30,000. Actual payment depends on the hospital, claim, cost-to-charge ratio, case mix, wage index, MAC processing, and applicable CMS rules.

Payment component	Illustrative amount	Explanation
MS-DRG 451 payment	$24,085	FY 2027 national unadjusted example for single-level spinal fusion except cervical without MCC.
Hospital cost assumption	$30,000	Illustrative case cost for calculation purposes only.
Excess cost over MS-DRG	$5,915	$30,000 minus $24,085.
65% of excess cost	$3,844.75	65% multiplied by $5,915.
Maximum PearlMatrix NTAP	$3,380	Final FY 2027 maximum NTAP amount.
Illustrative NTAP payment	$3,380	Lesser of 65% of excess cost or maximum NTAP.
Illustrative total Medicare payment	$27,465	$24,085 MS-DRG plus $3,380 NTAP.

Suggested hospital workflow

Timing	Recommended action
Before go-live	Add PearlMatrix to chargemaster/item master; educate OR supply, HIM coding, revenue integrity, and PFS teams; build claim-review edits if feasible.
At procedure	Capture product name, quantity, lot/label, anatomical location, approach, and TLIF fusion context; ensure operative documentation supports PearlMatrix use.
Prior to billing	Assign primary fusion code(s) and applicable PearlMatrix NTAP ICD-10-PCS code; validate charges; review claim against checklist.
After payment	Check remittance for NTAP payment; reconcile variance; correct and resubmit or appeal per hospital policy if appropriate.

Important information

This material is provided for general informational purposes only and is not coding, coverage, payment, medical treatment, or legal advice. Hospitals and providers are solely responsible for selecting the codes that accurately describe the services furnished to each patient and complying with applicable payer requirements. Cerapedics does not guarantee coverage or payment. Reimbursement support: reimbursement@cerapedics.com | (303) 974-6275, option 7 | info.cerapedics.com/reimbursement

Source notes for internal review

- CMS FY 2027 IPPS Final Rule, pages 489-493: PearlMatrix Breakthrough Device-designated indication, cost criterion, newness date, final NTAP approval, cost basis, maximum NTAP amount, and eligible ICD-10-PCS coding combination.
- CMS New Medical Services and New Technologies page: NTAP is an inpatient add-on payment program; NTAP payments are limited to the lesser of 65% of technology cost or 65% of excess case cost for non-QIDP/LPAD products.
- Internal FY 2027 IPPS payment-rate table: MS-DRG 451 FY 2027 national unadjusted example rate of $24,085 used solely for the illustrative payment scenario.

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