VITEK® REVEAL™ AST SYSTEM

Medicare New Technology Add-on Payment (NTAP)
Acute Care Hospital Inpatient System (IPPS) – FY 2026

FY 2026 NTAP Payment Highlights

Currently Effective: Oct 1, 2025 – Sept 30, 2026

Maximum NTAP Add-on: Up to $81.25 per discharge

ICD-10-PCS Code: XXE5X4A

CMS Estimated Technology Cost Reference: $125 per patient case

OVERVIEW

This information is intended for acute care hospital coding and billing personnel regarding the CMS Approved New Technology Add-On Payment (NTAP) for the VITEK REVEAL AST System (FY 2026).

In general, to qualify for NTAP, a medical service or technology must meet several criteria, which include:

- **Newness:** It is available within 2 or 3 years from which data becomes available.
- **Cost:** The average charge per case is higher than the threshold set for NTAP.
- **Substantial Clinical Improvement:** The medical service or technology represents an advance that substantially improves, relative to technologies previously available, the diagnosis or treatment of Medicare beneficiaries.

CMS approved VITEK REVEAL AST System for Fiscal Year 2026 NTAP under the Alternative Pathway for Certain Transformative New Devices and following the Food and Drug Administration Breakthrough Device Designation. The NTAP provides additional Medicare inpatient reimbursement to help hospitals offset the cost of adopting advanced antimicrobial susceptibility testing technology for Medicare Fee for Service hospital admissions.

Why This Matters to Hospitals?

- NTAP payments can be a supplemental payment in addition to the MS-DRG payment.
- NTAP can offset certain early adoption costs of VITEK REVEAL.
- NTAP can provide near-term financial support while CMS evaluates future DRG recalibration.

How NTAP Payment Works for VITEK REVEAL

For eligible Medicare Fee-for-Service inpatient cases, CMS pays the lesser of:

- 65 percent of the amount by which the estimated costs of the case exceed the MS-DRG payment, or the CMS-established maximum NTAP payment of $81.25 for VITEK® REVEAL (i.e., 65 percent of the average cost of the technology).
- CMS estimated the VITEK® REVEAL technology cost at $125 per patient case. The maximum NTAP payment represents approximately 65 percent of this incremental cost.

Payment Example:

Example			DRG Payment*	Cost of Individual Case	Add-On Payment (Lesser of the Two)	Final Payment
Patient A	Primary Diagnosis of ICD-10-CM R65.21 (Severe sepsis without septic shock)	Assigned to DRG 871 (Septicemia or Severe Sepsis without MV >96 Hours with MCC)	$14,135.11	$14,535.11	65% over DRG = $325 65% of Technology = $81.25	$14,135.11 + $81.25
Patient B				$14,235.11	65% over DRG = $65 65% of Technology = $81.25	$14,135.11 + $65
Patient C				$13,635.11	Not Applicable	$14,135.11

*This is not an all-inclusive determination of payment at the individual hospital level and is for illustrative purposes only. The payment amount is based on FY 2026 IPPS Final Rule; Table 1A. National Adjusted Standardized Operating Amounts; Hospital Submitted Quality Data and is a Meaningful EHR User (Update 2.6 percent), Labor-related $4,456.72 + Nonlabor-related $2,295.89; Table 1D. Capital Standard Federal Payment Rate, $524.15; and Table 5. List of Medicare Severity Diagnosis-Related Groups, 1.9425 Relative Weight.

Hospital Revenue Considerations:

- NTAP payments can be additive to standard MS-DRG reimbursement when eligibility criteria are met.
- To qualify for NTAP payment, hospitals must notate the corresponding CMS-designated ICD-10-PCS procedure code XXE5X4A on eligible inpatient claims.
- Coordination between the microbiology laboratory, coding/CDI, and revenue integrity teams can support appropriate NTAP identification.
- NTAP applies only to Medicare Fee-for-Service inpatient discharges reimbursed under IPPS.

Frequently Asked Questions (FAQs)

1. When is NTAP available for VITEK® REVEAL™?
NTAP applies to qualifying inpatient discharges occurring October 1, 2025 through September 30, 2026, and is eligible for additional payment periods.

2. Is NTAP paid for every patient who receives a VITEK® REVEAL test?
No. NTAP is paid only when the total inpatient case cost exceeds the MS-DRG payment and all NTAP eligibility requirements are met.

3. Is the NTAP paid per test or per patient case?
NTAP is paid per case, for the VITEK® REVEAL test.

4. What is the maximum NTAP payment for VITEK® REVEAL?
The maximum NTAP payment is $81.25 per eligible discharge, which is 65 percent of CMS's estimated technology cost of $125.

5. What coding is required to receive NTAP for VITEK® REVEAL?
Hospitals must report ICD-10-PCS code XXE5X4A on the inpatient claim to identify use of the VITEK® REVEAL AST System.

6. Does NTAP cover the full cost of the VITEK® REVEAL test?
No. NTAP provides a partial cost offset intended to support early adoption and does not guarantee full reimbursement of the cost of the test.

7. Does NTAP apply to outpatient testing?
No. NTAP applies only to Medicare Fee-for-Service inpatient claims reimbursed under IPPS.

8. Does NTAP apply to Medicare Advantage or commercial payers?
No. NTAP is a Medicare Fee-for-Service payment methodology. Other payers may have different coverage and payment policies to account for the cost of new technologies.

9. What happens after NTAP expires
After NTAP expires, CMS expects the cost of VITEK® REVEAL to be incorporated into future MS-DRG rate-setting, rather than subject to an additional payment.

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References:
1. 42 CFR 412.87
2. Centers for Medicare & Medicaid Services. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System; Fiscal Year 2026 Final Rule. 90 Fed. Reg. 36536, 36826 (Aug. 4, 2025).
3. Centers for Medicare & Medicaid Services. New Medical Services and New Technologies Add-on Payment (NTAP) Program Overview, available at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/new-medical-services-and-new-technologies.