HEALTH ECONOMICS & REIMBURSEMENT

New Technology Add-on Payment (NTAP) Resource for Esprit™ BTK Everolimus Eluting Resorbable Scaffold System

Overview

Effective **October 1, 2025,** Esprit™ BTK Everolimus-Eluting Resorbable Scaffold procedures are eligible for an incremental payment from Medicare (Fee for Service cases)[1]. This incremental reimbursement is called the "New Technology Add-on Payment (NTAP)". CMS has determined the **Esprit™ BTK System NTAP maximum of $6,922.50** for Fiscal Year 2026 (Effective October 1, 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 an Esprit™ BTK System 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 discharge[2]. 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.

Illustrative NTAP Calculations

The two 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.

1. Calculation example for an NTAP-eligible case (total covered cost exceeds MS-DRG)

DESCRIPTION		CALCULATION	AMOUNT
Hospital Charges per Case *(Entire hospital stay, including device)*	A		$150,000
Hospital-Specific Inpatient Operating CCR (*published by Medicare*)	B		0.30
Hospital Estimated Cost Per Case	C	A X B	$45,000
Hospital-Specific MS-DRG Payment	D		$28,000
Hospital Case Cost Minus MS-DRG Reimbursement *(Hospital case cost must exceed MS-DRG payment)*	E	C – D	$17,000
65% of Hospital Case Cost Minus MS-DRG Payment	F	E x 0.65	$11,050
NTAP Cap (determined by CMS)	G		$6,922.50
NTAP Payment Amount	H	Lesser of F and G	$6,922.50
Estimated Total Hospital Reimbursement [NTAP + MS-DRG payment]		D + H	**$34,922.50**

See Important Safety Information referenced within.
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2. Calculation example for an NTAP-ineligible case (total covered cost does not exceed MS-DRG)

DESCRIPTION		CALCULATION	AMOUNT
Hospital Charges *(Entire hospital stay, including device)*	A		$120,000
Hospital-Specific Inpatient Operating CCR (*published by Medicare*)	B		0.25
Hospital Total Case Cost	C	A X B	$30,000
Hospital-Specific MS-DRG Payment	D		$31,000
Hospital Case Cost Minus MS-DRG Reimbursement *(Hospital case cost must exceed MS-DRG payment)*	E	C – D	($1,000)
65% of Hospital Case Cost Minus MS-DRG Payment	F	E x 0.65	N/A
NTAP Cap (determined by CMS)	G		$6,922.50
NTAP Payment Amount	H	Lesser of F and G	$0
Estimated Total Hospital Reimbursement [NTAP + MS-DRG payment]		D + H	**$31,000**

CMS Resource for IPPS and NTAP calculation

CMS provides a tool that may be used to estimate IPPS payment, including NTAP amount.
The tool can be accessed via the link Inpatient PPS Web Pricer | CMS

- Enter the provider number
- Enter claim information: date of service, billed charges, covered days, DRG, transfer status, procedure code (ICD-10-PCS code for everolimus-eluting resorbable scaffold)
- Click on “Estimate” to calculate estimated IPPS payment amount
- The estimated NTAP amount is located under the Operating amounts, labeled “New technology”

Frequently Asked Questions

1. When does the Esprit™ BTK System NTAP effectiveness period start?

The Esprit™ BTK System NTAP goes into effect for discharges on or after **October 1, 2025** (Federal Fiscal Year 2026).

2. How long would Esprit™ BTK System NTAP be effective?

The Esprit™ BTK System NTAP will be effective for two years [from Oct. 1, 2025, to Sept. 30, 2027].

3. Will the case qualify for NTAP if the date of service begins before NTAP eligibility date?

If the patient is discharged on or after NTAP eligible date, the case will qualify for NTAP.

4. Is NTAP payment the same for each Esprit™ BTK System procedure?

No, the NTAP is not a fixed amount and varies for each case. Each Esprit™ BTK System case will be assessed for NTAP eligibility and payment individually. The maximum NTAP amount that a hospital can receive is **$6,922.50** per discharge. Please note that the NTAP amount is **paid once per discharge**, not per the number of devices used in a procedure.

5. Is there a specific coding guidance to become eligible for NTAP?

The only coding requirement placed on the hospital for processing the NTAP payment is using the appropriate ICD-10-PCS code that describes the use of the Esprit™ BTK System:

Code	Description
X27P3TA	Dilation of *right anterior tibial artery* with intraluminal device, everolimus-eluting resorbable scaffold(s), percutaneous approach, new technology group 10)
X27Q3TA	Dilation of *left anterior tibial artery* with intraluminal device, everolimus-eluting resorbable scaffold(s), percutaneous approach, new technology group 10)
X27R3TA	Dilation of *right posterior tibial artery* with intraluminal device, everolimus-eluting resorbable scaffold(s), percutaneous approach, new technology group 10)
X27S3TA	Dilation of *left posterior tibial artery* with intraluminal device, everolimus-eluting resorbable scaffold(s), percutaneous approach, new technology group 10)
X27T3TA	Dilation of *right peroneal artery* with intraluminal device, everolimus-eluting resorbable scaffold(s), percutaneous approach, new technology group 10)
X27U3TA	Dilation of *left peroneal artery* with intraluminal device, everolimus-eluting resorbable scaffold(s), percutaneous approach, new technology group 10)

The proper code utilization will trigger a calculation of the NTAP payment by your Medicare Administrator Contractor's claims processing system. For a comprehensive coding guidance, please download the Esprit™ BTK System coding guide from the Abbott customer-facing website: Vascular Coding and Coverage Resources | Abbott

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

The Operating CCRs sorted by provider are available at:

https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps

Operating CCR is updated annually. Select the corresponding fiscal year, download the IPPS rule Impact File and Supporting Data Files, search the Excel file by Medicare provider number to find your facility. You can locate the "Operating CCR" in the Excel's Column AG.

7. What is the total hospital reimbursement amount for the case that qualifies for NTAP?

The total hospital reimbursement amount will consist of:

1. The hospital-specific MS-DRG payment, and
2. The lesser of 65% of the difference between the cost of discharge and the MS-DRG payment, or $6,922.50

8. Can the NTAP amount received by a hospital be less than the maximum $6,922.50 allowed for an Esprit™ BTK System case?

Yes, if the hospital-specific calculation of 65% of the hospital costs minus the DRG payment is less than $6,922.50, the lower amount is paid.

9. Are Medicare Advantage claims eligible for NTAP payments?

NTAP is applicable to claims paid by traditional Medicare (Fee-for-Service Medicare). Certain Medicare Advantage claims may qualify for NTAP, depending on the terms of the contracts with hospitals. Contracts that follow Medicare reimbursement methodology may receive NTAP.

For additional questions, please contact Abbott's Reimbursement Hotline at 855-569-6430 (Monday - Friday, 8 am – 5 pm Central Time) or AbbottEconomics@abbott.com

IMPORTANT SAFETY INFORMATION

Esprit™ BTK Everolimus Eluting Resorbable Scaffold System

INDICATIONS

The Esprit™ BTK Everolimus Eluting Resorbable Scaffold is indicated for improving luminal diameter in infrapopliteal lesions in patients with chronic limb-threatening ischemia (CLTI) and total scaffolding length up to 170 mm with a reference vessel diameter of ≥ 2.5 mm and ≤ 4.00 mm.

CONTRAINDICATIONS

The Esprit™ BTK Everolimus Eluting Resorbable Scaffold System is contraindicated for use in:

- Patients who cannot tolerate, including allergy or hypersensitivity to, procedural anticoagulation or the post-procedural antiplatelet regimen.
- Patients with hypersensitivity or contraindication to everolimus or structurally related compounds or known hypersensitivity to scaffold components poly(L-lactide), poly(D, L-lactide), and platinum.

WARNINGS

- **This device is intended for single use only.** Do not reuse, reprocess, or re-sterilize. Note the product "Use-by" date on the package. Reuse, reprocessing, or re-sterilization may compromise the structural integrity of the device and / or delivery system and / or lead to device failure, which may result in patient injury, illness, or death. Reuse, reprocessing, or re-sterilization may also create a risk of contamination of the device and / or cause patient infection or cross-infection, including, but not limited to, the transmission of infectious disease(s) from one patient to another. Contamination of the device and / or delivery system may lead to injury, illness, or death of the patient.
- The Esprit™ BTK System is intended to perform as a system. The scaffold should not be removed for use with other dilatation catheters.
- The Esprit™ BTK System should not be used in conjunction with other non-everolimus drug eluting devices in the same vessel as the Esprit™ BTK Scaffold.
- It is not recommended to use this scaffold to treat lesions located at any joint or other hinge points, such as the knee or ankle. The recommended region for below-the-knee (BTK) treatment with the Esprit™ BTK Scaffold is the infrapopliteal arteries at a location ≥ 10 cm above the proximal margin of the ankle mortise. The Esprit™ BTK Scaffold has not been tested for use outside the recommended implant locations.
- This product should not be used in patients with aneurysms immediately adjacent to the scaffold implantation site.
- Insertion of the Esprit™ BTK System and implantation of the scaffold should be performed only under fluoroscopic observation with radiographic equipment providing high resolution images.
- **Quantitative imaging is strongly recommended to accurately measure and confirm appropriate vessel sizing (reference vessel diameter ≥ 2.5 mm). If quantitative imaging determines a vessel size < 2.5 mm, do not implant the Esprit™ BTK Scaffold.**
- Adequate lesion preparation prior to scaffold implantation is required to ensure safe delivery of the scaffold across the target lesion. It is not recommended to treat patients having a lesion that prevents complete inflation of an angioplasty balloon.
- **Successful pre-dilatation with residual diameter stenosis of < 30% by visual estimation is required for treatment of the target lesion; < 20% by visual estimation is preferred.**

- Ensure the scaffold is not post-dilated beyond the allowable expansion limits.
- Use of appropriate anticoagulant and / or antiplatelet therapy per standard of care is recommended for use of this scaffold system.
- This product should not be used in patients who are not likely to comply with the recommended antiplatelet therapy.
- Judicious selection of patients is necessary, since the use of this device carries the associated risk of scaffold thrombosis, vascular complications, and / or bleeding events.

PRECAUTIONS

- Scaffold placement should not be performed in patients with known allergies to contrast agent that cannot be medically managed.
- It is not recommended to treat patients having a lesion with excessive tortuosity proximal to or within the lesion.
- When multiple scaffolds are required, only combinations of Esprit™ BTK Scaffolds must be used. Any potential interaction with other drug-eluting or coated devices has not been evaluated.
- The delivery system is intended for deployment of the scaffold only and should not be used to dilate other locations.
- Implantation of the scaffold should be performed **only** by physicians who have received appropriate training.
- As with all catheter-based procedures, scaffold placement should be performed at facilities where patient can be prepared for necessary intervention and / or surgical removal of the device and vessel repair as per facility protocol.
- Pre-dilatation should be performed with an angioplasty balloon. Cutting or scoring balloons can be used per physician discretion, if the lesion appears to be mildly calcified.
- Failure to pre-dilate the vessel may impair nominal / optimal scaffold delivery.
- Implanting a scaffold may lead to dissection of the vessel distal and / or proximal to the scaffold, requiring additional intervention.
  Note: In cases of bailouts, bailout treatment of the target lesion can be done using the Esprit™ BTK Scaffold of the appropriate length. If an appropriate length Esprit™ BTK Scaffold is not available, physicians should use standard of care.
- An unexpanded scaffold may be retracted into the introducer sheath **one time only**. An unexpanded scaffold should not be reintroduced into the artery once it has been pulled back into the introducer sheath.
- Post-dilatation is strongly recommended for optimal scaffold apposition. When performed, post-dilatation should be performed at high pressure (> 16 atm) with a non-compliant balloon up to 0.5 mm larger than the nominal scaffold diameter.
- Use an appropriately sized non-drug coated balloon to pre-dilate the lesion. When treating a long lesion, scaffold the distal portion of the lesion prior to scaffolding the proximal portion of the lesion.
- Ensure that the scaffolded area covers the entire lesion / dissection site and that no gaps exist between scaffolds.
- The extent of the patient's exposure to drug and polymer is directly related to the number of scaffolds implanted. The safety of everolimus, polymer, and polymer breakdown products was evaluated in pre-clinical studies and the biocompatibility assessment of the Esprit™ BTK Scaffold.
- The safety and effectiveness of the Esprit™ BTK Scaffold in patients with prior brachytherapy of the target lesion or the use of brachytherapy for treated-site restenosis in the Esprit™ BTK Scaffold have not been established. Both vascular brachytherapy and the Esprit™ BTK Scaffold alter arterial modeling. The potential combined effect on arterial remodeling by these two treatments is not known.
- The safety and effectiveness of the Esprit™ BTK System have not been established in clinical trials with the use of either mechanical atherectomy devices (directional atherectomy catheters, rotational atherectomy catheters) or laser atherectomy catheters.
- Formal drug interaction studies have not been performed with the Esprit™ BTK Scaffold because of limited exposure to everolimus eluted from the scaffold.
- Everolimus, the Esprit™ BTK Scaffold's active pharmaceutical ingredient, is an immunosuppressive agent. Therefore, consideration should be given to patients taking other immunosuppressive agents or who are at risk for immune suppression.
- Oral everolimus use in renal transplant and advanced renal cell carcinoma patients was associated with increased serum cholesterol and triglyceride levels, which in some cases required treatment.
- Non-clinical testing has demonstrated the Esprit™ BTK Scaffold is MR Conditional. A person with the Esprit™ BTK Scaffold may be safely scanned under the following conditions. Failure to follow these conditions may result in injury.
  - Static magnetic field strength of 7 Tesla or less
- The Esprit™ BTK Scaffold should not migrate in this MRI environment. MRI at 7 Tesla or less may be performed immediately following the implantation of the Esprit™ BTK Scaffold.

IMPORTANT SAFETY INFORMATION (CONTINUED)

POTENTIAL ADVERSE EVENTS

Potential adverse events include, but are not limited to:

Allergic reaction or hypersensitivity to contrast agent, anesthesia, scaffold materials (poly[L-lactide] [PLLA], poly[D, L-lactide] [PDLLA], platinum, or everolimus), and drug reactions to anticoagulation or antiplatelet drugs.

- Vascular access complications which may require transfusion or vessel repair, including: Catheter site reactions • Bleeding (ecchymosis, oozing, hematoma, hemorrhage, retroperitoneal hemorrhage) • Arteriovenous fistula, pseudoaneurysm, aneurysm, dissection, perforation / rupture, and laceration • Embolism (air, tissue, plaque, thrombotic material, or device) • Peripheral ischemia
- Target artery complications which may require additional intervention, including: Total occlusion or abrupt closure • Arteriovenous fistula, pseudoaneurysm, aneurysm, dissection, perforation / rupture • Embolism (air, tissue, plaque, thrombotic material, or device) • Artery or scaffold thrombosis • Stenosis or restenosis • Vasospasm • Tissue prolapse / plaque shift

- Bleeding (non-access site)
- Additional surgery such as peripheral artery bypass graft surgery or amputation
- Peripheral nerve injury, neuropathy
- Compartment syndrome
- Tissue necrosis, gangrene, ulcer and acute limb ischemia
- Reperfusion injury
- New or worsening pain
- Intervention due to: Damaged scaffolds • Partial scaffold deployment • Scaffold migration / unintentional placement of scaffold
- Other general surgical risks, including: Cardiac arrhythmias (including conduction disorders, atrial and ventricular arrhythmias, and blocks) • Stroke / cerebrovascular accident (CVA) and transient ischemic attack (TIA) • Venous thromboembolism (including pulmonary embolism) • Nausea and vomiting • Hypotension / hypertension • Infection – local and systemic (including post-procedural) • Fever • Blood cell disorders including heparin-induced thrombocytopenia (HIT) and other coagulopathy • Death
- System organ failures: Cardiac Failure • Cardio-respiratory arrest (including pulmonary edema) • Respiratory failure • Renal failure • Shock

The risks described below include the anticipated adverse events referenced in the contraindications, warnings, and precautions sections of the everolimus labels / SmPCs and / or observed at incidences ≥ 10% in clinical trials with oral everolimus for different indications. Refer to the drug SmPCs and labels for more detailed information and less frequent adverse events.

• Abdominal pain • Anemia • Angioedema (increased risk with concomitant angiotensin-converting enzyme [ACE] inhibitor use) • Arterial thrombotic events • Bleeding and coagulopathy (including hemolytic uremic syndrome [HUS], thrombotic thrombocytopenic purpura [TTP], and thrombotic microangiopathy; increased risk with concomitant cyclosporine use) • Constipation • Cough • Diabetes mellitus • Diarrhea • Dyspnea • Embryo-fetal toxicity • Erythema • Erythroderma • Headache • Hepatic artery thrombosis (HAT) • Hepatic disorders (including hepatitis and jaundice) • Hypersensitivity to everolimus active substance, or to other rapamycin derivates • Hypertension • Infections (bacterial, viral, fungal, or protozoan infections, including infections with opportunistic pathogens). Polyoma virus-associated nephropathy (PVAN), JC virus associated progressive multiple leukoencephalopathy (PML), fatal infections and sepsis have been reported in patients treated with oral everolimus. • Kidney arterial and venous thrombosis • Laboratory test alterations (elevations of serum creatinine, proteinuria, hypokalemia, hyperkalemia; hyperglycemia, dyslipidemia including hypercholesterolemia and hypertriglyceridemia; abnormal liver function tests; decreases in hemoglobin, lymphocytes, neutrophils, and platelets) • Lymphoma and skin cancer • Male infertility • Menstrual irregularities • Nausea • Nephrotoxicity (in combination with cyclosporine) • Non-infectious pneumonitis (including interstitial lung disease) • Oral ulcerations • Pain • Pancreatitis • Pericardial effusion • Peripheral edema • Pleural effusion • Pneumonia • Pyrexia • Rash • Renal failure • Upper respiratory tract infection • Urinary tract infection • Venous thromboembolism • Vomiting • Wound healing complications (including wound infections and lymphocele)

There may be other potential adverse events that are unforeseen at this time.

References:

1. CMS final FY2026 IPPS rule: CMS-1833-F.
2. CMS claim submission requirements. Medicare Claims Processing Manual. Chapter 3 – Inpatient Hospital Billing. https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms018912

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