NEW TECHNOLOGY ADD-ON PAYMENT

iFuse TORQ TNT® Implant System
2026 Coding Guide and FAQs



SI-BONE®
Sacropelvic Solutions®

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NEW TECHNOLOGY ADD-ON PAYMENT (NTAP)

iFuse TORQ TNT® Implant System

Coding & Reimbursement Guide | Frequently Asked Questions

The iFuse TORQ TNT Implant System (TNT) is the first 3D-printed, porous, threaded implant with lengths capable of spanning the posterior pelvis, passing through the ipsilateral ilium, sacrum, and through the contralateral ilium (through and through, "TNT"). TNT has been designated by the U.S. Food and Drug Administration (FDA) as a Breakthrough Device.[1] In designating TNT as a Breakthrough Device, the FDA has determined that TNT has the potential to provide more effective fixation of pelvic fragility fractures than the current standard of care, cannulated screws.

For FY 2026, the Centers for Medicare and Medicaid Services (CMS) has granted a New Technology Add-on Payment (NTAP) for TNT.[2] NTAP payment may be triggered when one or more of twelve unique "Section X" New Technology ICD-10-PCS codes specific to the use of TNT are submitted on a qualifying Medicare inpatient claim, provided the case meets CMS criteria for NTAP eligibility. These codes describe the use of TNT as a "***bone density-specific thread and porosity pattern internal fixation device***" for either fracture fixation of the pelvis or sacroiliac joint fusion.[3] NTAP provides additional Medicare fee-for-service payment to hospitals above the standard Medicare Severity Diagnosis-Related Group (MS-DRG) payment amount. The NTAP program recognizes new technologies that provide substantial clinical improvement over already available therapies, to support Medicare beneficiaries' timely access to new innovations. **TNT is currently the only device awarded NTAP for this indication. ICD-10-PCS coding noted within this guide is specific to the TNT implants.**

The iFuse TORQ TNT Implant System is indicated for:

- Fracture fixation of the pelvis, including acute, non-acute and non-traumatic fractures.
- Sacroiliac joint fusion for sacroiliac joint dysfunction including sacroiliac joint disruption and degenerative sacroiliitis.

About NTAP for TNT

The add-on payment for TNT is incremental to the DRG payment, based on calculations described in this guide and paid by Medicare up to a potential cap of $4,136 per case. The additional payment is based on the hospital's reported cost of each case. NTAP is meant to partially compensate hospitals for using new products that are not already reflected in Medicare's cost-based payments.

Additional Topics addressed in this guide:

- New Technology ICD-10-PCS codes
- Case Study of NTAP Calculations
- Possible Diagnosis Related Groups (DRGs)
- Commonly Reported CPT® Codes for TNT
- Frequently Asked Questions

ICD-10-PCS Codes for iFuse TORQ TNT Implant System

CMS created twelve "Section X" ICD-10-PCS codes applicable to TNT ("***bone density-specific thread and porosity pattern internal fixation device"*** in the new technology, group 11 ICD-10-PCS codes.

- **For use of TNT as a fusion or a fixation-and-fusion device:** *Internal Fixation Device, Bone-Density-Specific Thread and Porosity Pattern*, Sacroiliac Joint, Right and Sacroiliac Joint, Left, to identify sacroiliac joint fusion with a threaded implant system.

- **For use of TNT as a fixation-only device:** *Internal Fixation Device, Bone-Density-Specific Thread and Porosity Pattern*, applied to the body part values N Pelvic Bone, Right and Pelvic Bone, Left, to identify pelvic fracture fixation with a threaded implant system.

ICD-10-PCS Codes for TNT[3]

	Percutaneous	Open
Fixation	**XNSN3HB:** Reposition right pelvic bone with bone-density-specific thread and porosity pattern internal fixation device, percutaneous approach, new technology group 11 **XNSP3HB:** Reposition left pelvic bone with bone-density-specific thread and porosity pattern internal fixation device, percutaneous approach, new technology group 11 **XNH63HB:** Insertion of bone-density-specific thread and porosity pattern internal fixation device into right pelvic bone, percutaneous approach, new technology group 11 **XNH73HB:** Insertion of bone-density-specific thread and porosity pattern internal fixation device into left pelvic bone, percutaneous approach, new technology group 11	**XNSN0HB:** Reposition right pelvic bone with bone-density-specific thread and porosity pattern internal fixation device, open approach, new technology group 11 **XNSP0HB:** Reposition left pelvic bone with bone-density-specific thread and porosity pattern internal fixation device, open approach, new technology group 11 **XNH60HB:** Insertion of bone-density-specific thread and porosity pattern internal fixation device into right pelvic bone, open approach, new technology group 11 **XNH70HB:** Insertion of bone-density-specific thread and porosity pattern internal fixation device into left pelvic bone, open approach, new technology group 11
Fusion	**XRGE3HB:** Fusion of right sacroiliac joint using bone-density-specific thread and porosity pattern internal fixation device, percutaneous approach, new technology group 11 **XRGF3HB:** Fusion of left sacroiliac joint using bone-density-specific thread and porosity pattern internal fixation device, percutaneous approach, new technology group 11	**XRGE0HB:** Fusion of right sacroiliac joint using bone-density-specific thread and porosity pattern internal fixation device, open approach, new technology group 11 **XRGF0HB:** Fusion of left sacroiliac joint using bone-density-specific thread and porosity pattern internal fixation device, open approach, new technology group 11

CASE STUDY EXAMPLES

NTAP Calculations for iFuse TORQ TNT Cases Performed at 3 Different Fictitious Hospitals (Hospital A, B, and C)[4]

Description		Calculation	Hosp. A	Hosp. B	Hosp. C
Hospital Case Charges	A		$80,000	$80,000	$80,000
Hospital Cost-to-Charge Ratio (CCR)	B		0.30	0.25	0.15
Hospital Reported Cost of Case	C	A x B	$24,000	$20,000	$12,000
Hospital MS-DRG 516 Payment	D		$15,000	$17,000	$13,000
Difference between Reported Cost and Payment	E	C – D	$9,000	$3,000	n/a
65% of the Difference	F	E x 65%	$5,005	$1,950	n/a
NTAP Amount	G	Lesser of F or NTAP cap	$4,136	$1,950	$0
Total Payment (MS-DRG + NTAP)		D + G	$19,136	$18,950	$13,000

The above case charges, CCRs, case costs, and DRG payments are fictitious and used solely to demonstrate the NTAP calculation method.

Hospital A – "Full NTAP" Scenario

Hospital A charged $80,000 for a pelvic trauma case which included TNT implants. With a Medicare cost-to-charge ratio (CCR) of 0.30, its reported cost for the case is $24,000. The applicable MS-DRG 516 payment from Medicare is $15,000, creating a cost shortfall of $9,000. Because the NTAP program covers 65% of the cost shortfall, Hospital A qualifies for an NTAP payment of $5,005. However, the approved NTAP cap for TNT is $4,136, so Hospital A receives the full capped NTAP amount of $4,136, in addition to the DRG payment.

Total Medicare Payment = $15,000 (DRG) + $4,136 (NTAP) = $19,136

Hospital B – "Partial NTAP" Scenario

Hospital A charged $80,000 for a pelvic trauma case which included TNT implants. With a Medicare cost-to-charge ratio (CCR) of 0.25, its reported cost for the case is $20,000. The applicable MS-DRG 516 payment from Medicare is $17,000, creating a cost shortfall of $3,000. Because the NTAP program covers 65% of the cost shortfall, Hospital A qualifies for an NTAP payment of $1,950. Since this amount is below the NTAP cap, Hospital B qualifies for the full 65% of the cost shortfall.

Total Medicare Payment = $17,000 (DRG) + $1,950 (NTAP) = $18,950

Hospital C – "No NTAP" Scenario

Hospital A charged $80,000 for a pelvic trauma case which included TNT implants. With a Medicare cost-to-charge ratio (CCR) of 0.15, its reported cost for the case is $12,000. The applicable MS-DRG 516 payment from Medicare is $13,000, which is greater than the reported costs. Because the reported cost does not exceed the DRG payment, there is no cost shortfall. As a result, no NTAP payment is made, and Hospital C receives only the base DRG amount.

Total Medicare Payment = $13,000 (DRG only with no incremental NTAP)

Medicare Severity Diagnosis-Related Groups (MS-DRGs)

The following table presents the MS-DRGs associated with pelvic trauma and/or adjunctive sacroiliac joint fusion procedures. Hospitals and physicians should use independent judgment when selecting codes that most appropriately describe the services or supplies provided to a patient.

Commonly Reported MS-DRGs for Pelvic Trauma and Sacroiliac Joint Fusion[2]			
MS-DRG	**Description**	**Severity**	**2026 Medicare Unadjusted Rate[2]**
450	Single Level Spinal Fusion Except Cervical	with MCC	$38,782
451		Without CC/MCC	$23,507
447	Multiple Level Spinal Fusion Except Cervical	With MCC	$48,620
448		Without CC/MCC	$30,859
515	Other Musculoskeletal System and Connective Tissue O.R. Procedures	With MCC	$23,190
516		With CC	$15,122
517		Without CC/MCC	$11,182
907	Other O.R. Procedures for Injuries	With MCC	$27,938
908		With CC	$14,519
909		Without CC/MCC	$9,552
957	Other O.R. Procedures for Multiple Significant Trauma	With MCC	$55,448
958		With CC	$30,664
959		Without CC/MCC	$21,424

PELVIC BONE FRACTURE REPAIR AND SACROILIAC JOINT FUSION

Procedure: The iFuse TORQ TNT Implant System is intended for both fracture fixation of the pelvis, including acute, non-acute and non-traumatic fractures and for sacroiliac joint fusion. Please see TNT's Indications for Use (IFU) statement. The code(s) selected by the physician to describe the procedure(s) performed will depend on surgical approach, fracture reduction and stabilization technique, patient diagnosis and other case specifics. Providers must use independent judgment and report codes that most accurately describe the services provided.

Commonly Reported CPT Codes When Performing Pelvic Fracture Repair			
CPT Code[5]	**Description[5]**	**Total RVUs[6]**	**2026 Medicare PFS Unadjusted Rate[6]**
27215	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral, for pelvic bone fracture patterns that do not disrupt the pelvic ring, includes internal fixation, when performed.	18.17 *(wRVUs = 10.45)*	$544
27216	Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral (includes ipsilateral ilium, sacroiliac joint and/or sacrum) *[For bilateral procedure report 27216 with modifier -50]*	26.84 *(wRVUs = 15.73)*	$801
27217	Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes pubic symphysis and/or ipsilateral superior/inferior rami) *[For bilateral procedure report 27217 with modifier -50]*	25.24 *(wRVUs = 14.65)*	$754
27218	Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns that disrupt the pelvic ring, unilateral, includes internal fixation, when performed (includes ipsilateral ilium, sacroiliac joint and/or sacrum) *[For bilateral procedure report 27218 with modifier -50]*	34.59 *(wRVUs = 20.93)*	$1,027
G0412[7]	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fracture(s), unilateral or bilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring, includes internal fixation, when performed.	22.09 *(wRVUs = 10.45)*	$672
G0413[7]	Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, (includes ilium, sacroiliac joint and/or sacrum)	32.37 *(wRVUs = 15.73)*	$983
G0414[7]	Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation when performed (includes pubic symphysis and/or superior/inferior rami)	30.58 *(wRVUs = 14.65)*	$928
G0415[7]	Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation, when performed (includes ilium, sacroiliac joint and/or sacrum)	41.65 *(wRVUs = 20.93)*	$1,245
27299	Unlisted procedure, pelvis, or hip joint	N/A	N/A

Commonly Reported CPT Codes When Performing Sacroiliac Joint Fusion			
CPT Code[5]	**Description**[5]	**Total RVUs**[6]	**2026 Medicare PFS Unadjusted Rate**[6]
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, with image guidance, includes obtaining bone graft when performed, unilateral; placement of transarticular device(s) and/or intra-articular device(s) piercing the lateral or medial cortices of the ilium and the lateral cortex of the sacrum *[For bilateral procedure report 27279 with modifier -50]*	24.43 *(wRVUs = 12.13)*	$762
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed. *[For bilateral procedure report 27280 with modifier -50]*	41.52 *(wRVUs = 20.00)*	$1,290
22899	Unlisted procedure, spine	N/A	N/A
27299	Unlisted procedure, pelvis, or hip joint	N/A	N/A

Physician Coding Considerations

- AMA CPT Assistant September 2013, Volume 23, Issue 9. 27280 is reported for a sacroiliac joint fusion using an open approach requiring direct visualization.
- Typically, 27216 and 27279 procedures are not billed on the same date of service but are allowed when each is medically necessary and when appropriate modifier(s) detail that separate services and diagnoses are present. No National Correct Coding Initiative (NCCI) bundling edits or AMA guidance exists which prohibit billing them together.
- When multiple surgeries or procedures are performed by a single physician or physicians in the same group practice on the same patient at the same operative session, reduction in reimbursement for secondary and subsequent procedures may occur. Appropriate use of modifiers will facilitate claims processing. Modifier -51 is reported for secondary procedures, in accordance with CPT guidelines. Both CPT code 27279 and CPT 27280 are unilateral procedures. If performed bilaterally, some payors require that the service be reported twice with modifier -50 appended to the second code while others require identification of the service only once with modifier -50 appended. Check with individual payors.

Possible HCPCS Codes[8]		
C1776	Joint device (implantable)	No separate payment under Medicare (Commercial contracts may vary)
C1889	Implantable/insertable device, not otherwise classified	
L8699	Prosthetic implant, not otherwise specified	

Frequently Asked Questions

1. What exactly is NTAP?

New Technology Add-On Payment (NTAP) is a Medicare program that provides additional reimbursement to support the use of innovative medical technologies in the hospital setting. NTAP helps bridge the gap while Medicare evaluates and incorporates costs of new devices into its standard payment systems. To qualify, a technology must demonstrate meaningful clinical improvement, or satisfy an alternative pathway established by CMS for Breakthrough technologies, and meet specific criteria set by CMS. This temporary payment helps expand patient access to breakthrough treatments during their early adoption phase.

2. Are there other SI joint fusion or pelvic fracture fixation implants eligible for NTAP?

No, TNT is the only implant indicated for SIJ fusion and/or pelvic fracture fixation that qualifies for NTAP. SI-BONE's application was reviewed and approved based on TNT's unique clinical use, cost profile, and coding. No other implant, whether from SI-BONE or any other manufacturer, is eligible for NTAP in this clinical context.

3. Are there ICD-10-PCS codes to report the use of TNT for purposes of NTAP?

CMS has created twelve unique ICD-10-PCS codes ("Section X" new technology codes) which hospitals must use to report the use of TNT for purposes of receiving NTAP. This guide outlines the twelve unique ICD-10-PCS codes to describe the insertion of the TNT device for fixation and/or fusion (see page 2).

4. Will NTAP apply when TORQ TNT is used in either pelvic fracture fixation or fixation and fusion cases?

NTAP will apply when TNT is used for fracture fixation of the pelvis, including acute, non-acute and non-traumatic fractures and sacroiliac joint fusion for sacroiliac joint dysfunction including sacroiliac joint disruption and degenerative sacroiliitis. These NTAP applications match the FDA labeling describing the use of TNT

5. How do hospitals report TORQ TNT with NTAP? How is NTAP paid?

Hospitals should report one or more of the ICD-10-PCS procedure codes noted in this guide. These codes will allow the Medicare Administrative Contractors (MACs) to calculate the new technology portion of the case's payment. See page 2 of this guide for a list of specific NTAP-related ICD-10-PCS codes to describe the use of TORQ TNT.

MACs processing such claims will perform all calculations to determine the value of the NTAP amount for each specific case. Hospitals are paid NTAP in the same manner in which they receive typical fee-for-service reimbursements.

6. How is NTAP Calculated?

CMS will reimburse hospitals an incremental amount in addition to the MS-DRG payment. Unless the discharge qualifies for an outlier payment, the additional Medicare payment is

limited to the full MS-DRG payment, plus 65 percent of the estimated costs of the new technology.[4] The add-on payment will be based on the calculations described below and paid up to a potential cap of **$4,136** per case. The additional payment is based on the hospital's reported cost of each case.

The final NTAP is the *lesser* of either:

- The NTAP 'cap' for the new technology assigned by CMS (*i.e.*, $4,136)
  OR
- 65% of the costs of the case that exceed the usual DRG payment

For an estimate of new technology payment for a given case, consult CMS' Inpatient PPS Web Pricer tool (https://webpricer.cms.gov/#/pricer/ipps) for illustrations of final payment estimates.

7. Which hospitals and patient cases will receive NTAP?

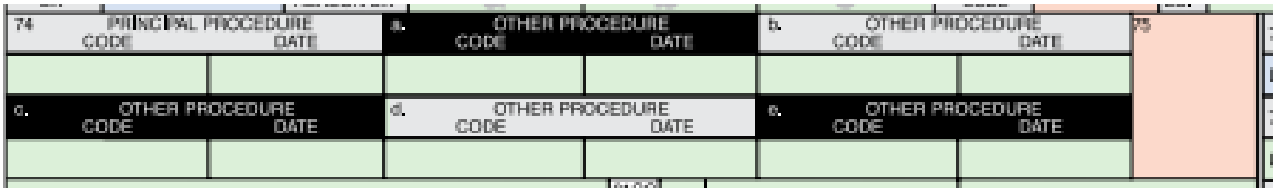
CMS determines whether a hospital choosing to use TORQ TNT will receive some additional reimbursement representing NTAP in addition to the typical DRG payment. NTAP is applicable to Medicare patients (*e.g.*, fee-for-service beneficiaries with or without a supplementary plan). Managed Medicare products, such as Medicare Advantage or HMO plans, will determine NTAP on a case-by-case basis. Additionally, NTAP will apply to TRICARE covered claims though NTAP calculation may vary from Medicare's calculation dependent on local carrier.

8. What resources does SI-BONE have to address additional questions on NTAP?

SI-BONE has an experienced team of reimbursement professionals to help fully explain how NTAP works, and what the hospital can expect in terms of additional estimated payments. Contact us via email (**PICS@si-bone.com**) or call **1-800-710-8511**.

9. On a UB-04 (CMS 1450) form, where do I add the Principal Procedure Code for an Inpatient Claim?

On the UB-04 form applicable to inpatient claims, **Box 74** (see below) should be used to list the ICD-10-PCS coding related to the **Principal Procedure Code and Date**. In Boxes 74A-74E, enter the ICD-10-PCS code(s) that identify significant procedures performed other than the principal / primary procedure under **Other Procedure Code/Date**, such as the NTAP ICD-10-PCS codes describing either the open or percutaneous pelvic fracture fixation and / or SI joint fusion codes with the insertion of a ***bone-density-specific thread and porosity pattern internal fixation device*** (TNT). For a complete list of these NTAP codes, see page 2 of this guide.



References

1. U.S. Food and Drug Administration. Breakthrough Device Designation Letter for iFuse TORQ TNT Implant System, SI-BONE. August 19, 2024. Available from: https://www.fda.gov/
2. FY 2026 Medicare Hospital Inpatient Prospective Payment System, FY 2026 Final Rule, CMS-1883-F. The listed rates do not reflect all hospital-specific adjustments that may significantly alter a payment to a particular hospital.
3. CMS, 2026 ICD-10 Procedure Coding System (ICD-10-PCS).
4. CMS, MLN Matters Article SE20004, *Medicare Coverage of Innovative Technology (MCIT)*, January 2020. Available at: https://www.cms.gov/files/document/se20004.pdf
5. CPT© 2025. American Medical Association (AMA). All rights reserved.
6. CY 2026 Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program and Other Revisions to Part B for CY 2026, CMS-1832-F. The listed rates do not reflect all provider-specific adjustments that may significantly alter a payment to a particular provider.
7. G Codes: In 2009, CMS created HCPCS G-codes (G0412-G0415) which mirror the fracture/dislocation codes. These codes are used for either unilateral or bilateral procedures performed in Medicare beneficiaries in place of the CPT codes 27216-27218. Other payors (e.g., Medicaid) may also require the G codes to be reported, check with the specific payor to determine billing and coverage.
8. American Medical Association. *HCPCS Level II Professional 2026*. American Medical Association; 2025.

The iFuse TORQ TNT® Implant System is indicated for fracture fixation of the pelvis, including acute, non-acute, and non-traumatic fractures.

The iFuse TORQ TNT Implant System is indicated for sacroiliac joint fusion for sacroiliac joint dysfunction including sacroiliac joint disruption and degenerative sacroiliitis.

The iFuse TORQ TNT Navigation instruments are intended to be used with the iFuse TORQ TNT Implant System to assist the surgeon in precisely locating anatomical structures in iFuse TORQ TNT Implant System procedures, in which the use of stereotactic surgery may be appropriate, and where reference to a rigid anatomical structure, such as the pelvis or vertebra, can be identified relative to the acquired image (CT, MR, 2D fluoroscopic image or 3D fluoroscopic image reconstruction) and/or an image data based model of the anatomy. iFuse TORQ TNT Navigation instruments are intended to be used with the Medtronic® StealthStation® System.

Healthcare professionals should refer to the Instructions for Use for indications, contraindications, warnings, and precautions at https://si-bone.com/label.

There are potential risks associated with the iFuse procedures. They may not be appropriate for all patients, and all patients may not benefit. For indications, risk, and safety information about the risks visit https://si-bone.com/risks.

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Additional questions? Connect with our Area Reimbursement Management Team to learn more about NTAP for iFuse TORQ TNT Implant System.

Phone **1-800-710-8511**

Email **HealthPolicy@SI-BONE.com**

Website **https://si-bone.com/providers/reimbursement/**

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