RevRx AI Consulting

MEDTECH MARKET ACCESS GUIDE

Reimbursement Strategy Guide

If sites can't get paid, they won't use your device. No matter how good it is.

For MedTech leaders who need coding, coverage, and payment answers before launch.

Code · Coverage · Payment · Evidence · Support · Track

Coding, Coverage, and Payment Are Not the Same

Most reimbursement problems start when teams treat these as one question. They are three, and each has a different answer.

Coding

THE QUESTION

Is there a code that describes the procedure or device?

WHO DECIDES

code-setting bodies, not payers.

Coverage

THE QUESTION

Will the payer pay for it, for this patient, in this setting?

WHO DECIDES

each payer, through its own policies.

Payment

THE QUESTION

How much is paid, and to whom?

WHO DECIDES

the payer's payment system, which depends on the site of care.

A code does not mean coverage. Coverage does not mean enough payment. The existence of a CPT code does not warrant coverage for a procedure.

COPY THIS PROMPT INTO YOUR AI TOOL. FILL IN THE BRACKETS.

Act as a reimbursement strategy advisor. For **[device]** used in **[procedure and site of care]**, list the coding, coverage, and payment questions we must answer. Separate what we have confirmed from what we need to verify. Do not state codes or payment rates as fact.

This guide is educational. It is not coding, billing, or legal advice. Confirm all codes and policies with payers and a qualified reimbursement expert.

Find the Code Before the First Case

Providers bill with codes. If no code fits, or the wrong one is used, the claim stalls.

CODE TYPE	WHAT IT DESCRIBES	WHO MAINTAINS IT
CPT Category I	Established procedures and services, mostly physician work	American Medical Association (AMA)
CPT Category III	Temporary tracking codes for new and emerging technology	AMA
HCPCS Level II	Supplies, devices, and some services, including codes for certain new outpatient devices	Centers for Medicare and Medicaid Services (CMS)
ICD-10-CM	Diagnoses	U.S. government (CDC and CMS)
ICD-10-PCS	Inpatient hospital procedures	CMS

About Category III codes

Category III CPT codes are a temporary set of tracking codes for new and emerging technologies. They are archived five years after publication unless converted to Category I or extended by the Editorial Panel, and it can be challenging to get payers to cover Category III services.

If no code fits:

1
Check whether an existing code accurately describes the procedure.

2
If not, ask an expert about using an unlisted code in the meantime.

3
Plan the path to a new code early. Code changes take time.

COPY THIS PROMPT INTO YOUR AI TOOL. FILL IN THE BRACKETS.

For **[device]** used in **[procedure]** at **[site of care]**, list the types of codes that may apply (procedure, device, and diagnosis) and the questions we must answer to confirm each one. Do not name specific codes as correct. Mark everything that a certified coder or reimbursement expert must verify.

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Know What Each Payer Will Pay For

Every payer decides coverage on its own. Check the payers your target patients use before you launch.

Medicare (national)

National coverage determinations apply across the country.

Medicare (local)

Medicare contractors set local coverage policies by region.

Commercial payers

Each plan has its own medical policies.

Medicaid

Coverage varies by state.

PAYER	POLICY FOUND?	COVERED, NOT COVERED, OR SILENT	PATIENT CRITERIA	EVIDENCE THE POLICY CITES	NEXT STEP

"Silent" is not the same as "covered." No policy often means case-by-case decisions and prior authorization.

COPY THIS PROMPT INTO YOUR AI TOOL. FILL IN THE BRACKETS.

Here are the payer policies I found for **[procedure or device]**: **[paste policy names and key text]**. For each, summarize whether it covers, excludes, or does not address our device, the patient criteria, and the evidence cited. Flag anything unclear that we should ask the payer about directly.

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Will the Facility Lose Money Using Your Device?

Payment depends on where the procedure happens. A facility that loses money on a case will hesitate, even if physicians want the device.

SITE OF CARE (MEDICARE EXAMPLES)

SITE OF CARE	HOW MEDICARE GENERALLY PAYS THE FACILITY	HOW THE PHYSICIAN IS PAID
Physician office	Physician Fee Schedule (covers the practice)	Physician Fee Schedule
Hospital outpatient	Outpatient Prospective Payment System (OPPS)	Physician Fee Schedule
Ambulatory surgery center	ASC payment system	Physician Fee Schedule
Hospital inpatient	Inpatient Prospective Payment System (IPPS), by MS-DRG	Physician Fee Schedule

New technology payment

Medicare has programs that can add temporary payment for some new technologies:

- **Inpatient:** New Technology Add-on Payment (NTAP).
- **Outpatient:** transitional pass-through payment for devices. Once the pass-through payment period expires, payment for the device is packaged into the OPPS payment rate for the associated procedure(s).

2026 change

In the FY 2027 IPPS final rule, CMS repealed the alternative pathway for both NTAP and outpatient device pass-through payments, beginning with FY 2028 applications. That means Breakthrough Devices will need to show substantial clinical improvement to qualify. Limited exceptions apply for devices already in process. Confirm your status with an expert.

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For [device] used in [procedure], compare how the facility and physician are likely paid in [sites of care]. List what we need to confirm, whether the device cost could be a burden for the facility, and which questions to bring to a reimbursement expert. Do not state payment rates as fact.

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Build the Evidence Payers Will Read

Payers want to know that your device helps their members compared with what they pay for today. Plan your evidence with that question in mind.

What payers look for

- [ ] Clinical outcomes compared with current care
- [ ] Study patients who look like the payer's members (for Medicare, older adults)
- [ ] Peer-reviewed publications
- [ ] Real-world data after launch
- [ ] Economic data, such as total cost of care
- [ ] Support from medical society guidelines

PAYER QUESTION	EVIDENCE WE HAVE	GAP	PLAN TO CLOSE IT	OWNER
Does it improve outcomes?				
Is it safe for our members?				
Does it lower total cost?				
Do physician societies support it?				

Medicare coverage pathways

CMS has proposed the RAPID coverage pathway to speed national Medicare coverage for certain Breakthrough Devices. Public comments closed October 13, 2026. CMS paused the Transitional Coverage for Emerging Technologies (TCET) pathway for new candidates while it works on RAPID. Ask an expert which applies to you.

COPY THIS PROMPT INTO YOUR AI TOOL. FILL IN THE BRACKETS.

Here is the evidence we have for **[device]**: **[list studies, outcomes, and data]**. Compare it to what payers typically ask for: outcomes versus current care, patient fit, peer-reviewed data, real-world data, and economic data. List the gaps and suggest how to close each one. Do not overstate what our data shows.

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Help Sites Get Paid

Your customers' billing teams are busy. Make it easy for them to bill correctly and fight denials.

Billing guide
codes that may apply, with a clear note that providers are responsible for their own coding.

Prior authorization help
templates and a checklist of what payers ask for.

Appeal letter templates
for common denial reasons.

Reimbursement contact
one person or line sites can call.

Payer policy updates
a simple way to tell sites when policies change.

DENIAL TRACKER

PAYER	DENIAL REASON	NUMBER THIS MONTH	FIX	OWNER

Never promise payment. Never tell a site which code to bill. Give them the information and let their coders decide.

COPY THIS PROMPT INTO YOUR AI TOOL. FILL IN THE BRACKETS.

Draft an outline for a provider billing guide for [device] used in [procedure]. Include sections for possible codes, documentation tips, prior authorization, appeals, and contacts. Add a clear statement that providers are responsible for their own coding and billing. Leave placeholders for codes instead of naming them.

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Know When to Call for Help

Reimbursement is specialized work. Bring in an expert early when any of these are true.

- [ ] No existing code fits your procedure or device
- [ ] Payer policies are silent or negative
- [ ] The device could make the facility lose money on the case
- [ ] You plan to apply for NTAP, pass-through payment, or a Medicare coverage pathway
- [ ] Denials are rising, and you can't find the cause
- [ ] Most of your patients are on Medicare

Readiness timeline

Before the FDA submission

coding review, payer landscape, and an evidence plan that includes payer needs.

Before launch

coverage review, billing guide, site support plan, and payment program applications if they apply.

After launch

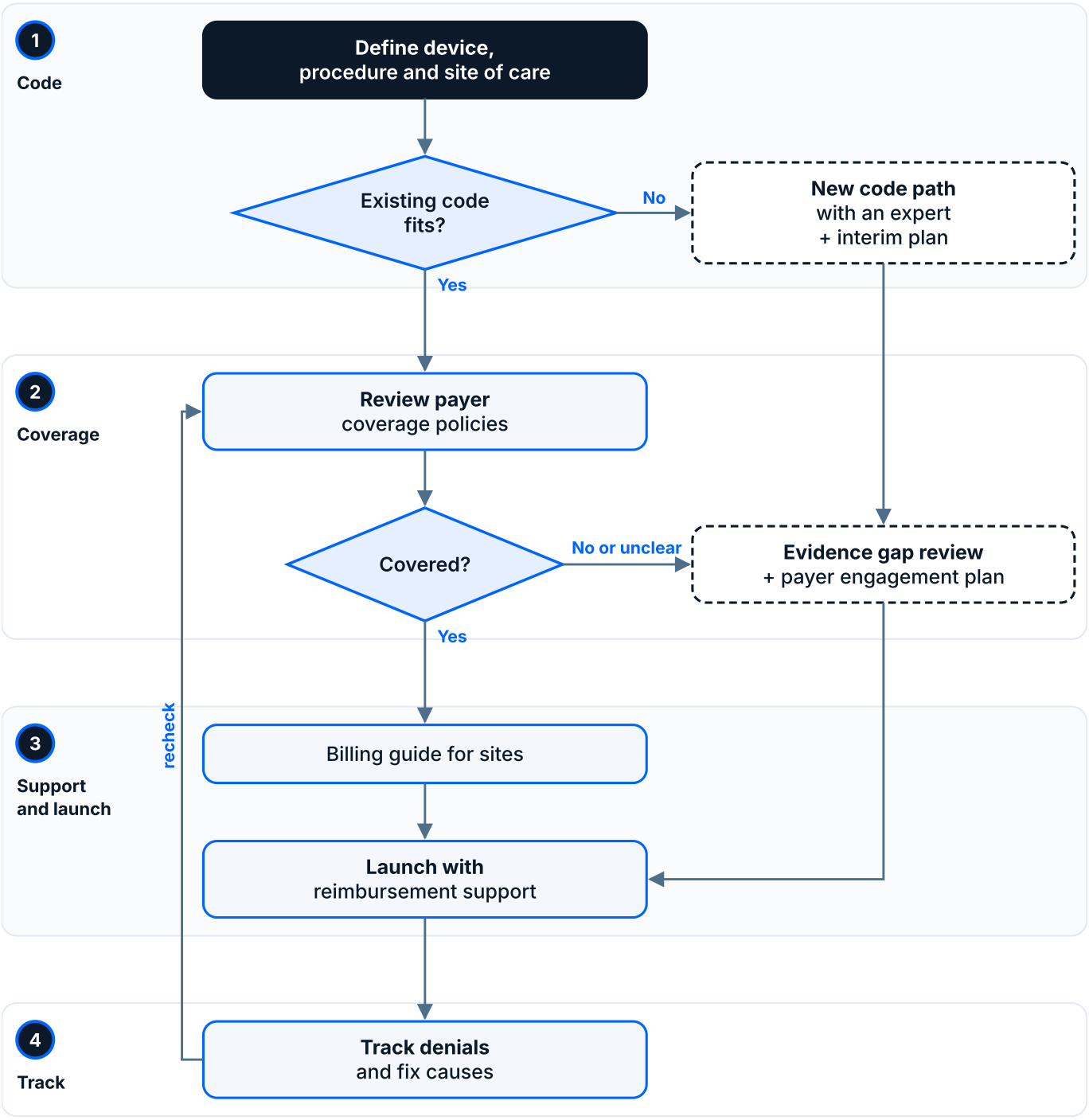
denial tracking, payer engagement, and policy monitoring.

COPY THIS PROMPT INTO YOUR AI TOOL. FILL IN THE BRACKETS.

Draft a reimbursement readiness workflow for **[device]** covering code review, payer policy review, evidence gaps, provider billing support, denial tracking, and when to escalate to a reimbursement expert.

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From Code to Paid Claim



Solid boxes are the main path. Dashed boxes are where you stop, get expert help, and fix before moving on.

09 | NEXT STEP

Find Where Payment Will Stall Your Launch

RevRx AI helps MedTech teams build the commercial system after authorization, including the path to getting paid.

STEP 1

Take the Revenue Friction Scorecard

Answer a few short questions and see where friction is slowing your revenue path.

Take the Revenue Friction Scorecard

revrxai.com/medtech-tools

STEP 2

Book a Discovery Call

A 30-minute call to walk through your reimbursement readiness and where it may stall.

Book a Discovery Call

https://api.revrxai.com/widget/bookings/30-minute-meeting-with-terryrovrku

RevRx AI Consulting

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