AABB Frequently Asked Questions (FAQ) – Medicare Payment Policy for COVID-19 Convalescent Plasma (CCP)
Revised: July 25, 2022

Introduction

The Food and Drug Administration (FDA) issued an emergency use authorization (EUA) (on August 23, 2020, reissued on November 30, 2020, and revised on March 9, 2021 and on December 28, 2021) that permits providers to use COVID-19 convalescent plasma (CCP) to treat certain hospitalized patients with COVID-19.

AABB has prepared this FAQ to help the blood community understand the coverage and reimbursement policies in place for CCP provided in accordance with the EUA. This FAQ will be updated as new information becomes available.

Questions and Answers

Q1. How does the Medicare program reimburse hospitals for CCP provided to patients in the inpatient setting of care?

A1. For care provided in the hospital inpatient setting, a hospital receives a fixed bundled payment based on the patient's diagnosis. This bundled payment is intended to cover the cost of care, which includes but is not limited to CCP. In other words, a hospital does not receive a separate payment for CCP furnished to a hospital inpatient.

If the hospital's costs for a patient treated with CCP exceed the fixed payment amount, the hospital may qualify for a new COVID treatments add-on payment (NCTAP) if certain criteria are satisfied.

Q2. How does a hospital qualify for a new COVID treatments add-on payment (NCTAP)?

A2. The purpose of the NCTAP is to mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments by partially offsetting costs that exceed the Medicare payment. The NCTAP will be provided on top of the temporary adjustment that hospitals receive for treating individuals diagnosed with COVID-19 during the COVID-19 public health emergency. To be eligible for an NCTAP, the following criteria must be satisfied:

- The use of a drug or biological product authorized to treat COVID-19 [is] indicated in section "I. Criteria for Issuance of Authorization" of the current letter of authorization for the drug or biological product, or the drug or biological product must be approved by the FDA for treating COVID-19.
- The case must also be eligible for the 20 percent increase in the weighting factor for the assigned MS-DRG for an individual diagnosed with COVID-19 discharged during the period of the PHE for COVID-19.
- The operating cost of the case must exceed the operating Federal payment under the IPPS, including the 20 percent add-on payment described above.

CMS set the NCTAP amount equal to the lesser of: (1) 65 percent of the operating outlier threshold for the claim or (2) 65 percent of the amount by which the costs of the case exceed the standard DRG payment, including the payment adjustment established by the CARES Act.

For additional information on the NCTAP, please visit CMS' website.

Q3. How do I report the transfusion of CCP on a Medicare claim?

A3. The following ICD-10-PCS codes should be used on Medicare claims to identify cases involving the use of CCP for hospital discharges on or after November 2, 2020:

ICD-10-PCS Code	Description
XW13325	Transfusion of convalescent plasma (nonautologous) into peripheral vein, percutaneous approach, new technology group 5
XW14325	Transfusion of convalescent plasma (nonautologous) into central vein, percutaneous approach, new technology group 5

CMS indicates that hospitals **should report the ICD-10-PCS code(s) for all products administered during the stay,** regardless of whether the hospital received the product at no cost. However, hospitals should not report charges associated with a product received at no cost.

Q4. Why should I report the transfusion of CCP on a Medicare claim?

A4. All providers should report the transfusion of CCP on a Medicare claim to track the usage of CCP. Additionally, if a hospital receives CCP at a cost, it should report the charges associated with the product received on the Medicare claim since this information is needed to determine whether the hospital qualifies for an NCTAP.

Q5. How does the Medicare program reimburse hospitals for CCP furnished to patients in the hospital outpatient setting of care?

A5. The FDA revised the EUA on December 28, 2021, to allow for the use of CCP with high titers of anti-SARS-CoV-2 antibodies for treatment of COVID-19 for patients in the outpatient or inpatient setting. In response, CMS created HCPCS code C9507 (*Plasma, high titer COVID-19 convalescent, each unit*) for COVID-19 convalescent plasma for use in the outpatient setting, effective on or after December 28, 2021.

Outpatient facilities can use the following information when submitting claims for C9507:

- Ambulatory payment classification (APC): 1509 (New Technology – Level 9)
- Status indicator: S (Procedure or service, not discounted when multiple/Paid under OPPS; separate APC payment)
- Payment rate: $750.50

Similar to other blood components, CCP and the associated transfusion procedure are separately payable when furnished in the hospital outpatient setting of care.

Q6. Where can I find additional information on Medicare reimbursement policy for CCP?

A6. Please visit the following links for more information:

- COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing
- New COVID-19 Treatments Add-On Payment (NCTAP)
- CMS Interim Final Rule with Comment Period (IFC)
- CMS New HCPCS Code for CCP in Outpatient Setting