Advancing Transfusion and Cellular Therapies Worldwide

2017 Medicare Proposed Hospital Outpatient Payments
Solicitation of comments on HCPCS P-codes for Blood Products
07/27/16

On July 14, the Centers for Medicare and Medicaid Services (CMS) published in the *Federal Register* the hospital outpatient prospective payment system (OPPS) proposed rule for calendar year (CY) 2017. CMS proposed an overall increase in payment rates under OPPS by a factor of 1.55 percent, with differential adjustments to the payment rates for the blood and cellular therapy sectors. Additionally, CMS proposes to continue implementing a 2 percent payment reduction for hospitals that fail to meet outpatient quality reporting requirements.

Comments are due to CMS by September 6, 2016, and CMS will issue a final rule this fall. Provisions of the final rule will be effective January 1, 2017, unless stated otherwise. The following summary highlights key provisions of the proposed rule for the transfusion medicine and cellular therapy communities.

Blood HCPCS Descriptors

CMS is in the process of examining the HCPCS P-code set for blood products. These codes went into effect many years ago and may not represent the state of current technology and products in use. CMS is soliciting comments from the blood product stakeholder community on whether the HCPCS P-code set, specifically for red blood cells, platelets, and plasma, needs descriptor revisions, updating and/or consolidation. (See Table 1 Blood Products for the HCPCS descriptors.)

Impact of Rule on Blood and Stem Cell Providers

The tables below compare 2016 payments with the proposed 2017 rates for blood products (Table 1), procedural services (Table 2), and transfusion and blood processing (Table 3) codes. Unlike the physician fee schedule, it is not always obvious why payment for a particular service is increasing or decreasing under OPPS. Payment rates under OPPS are derived from hospital-billed charges from CY 2015, converted to estimated cost, and utilize a complex system of cost allocation for packaged services.

Blood Products (Table 1)

Proposed blood product reimbursements will receive a simple average increase of 5% for CY 2017, this is greater than the overall OPPS average payment rate increase of 1.55%. Payments for most high volume blood products – e.g., P9016 (Red blood cells leukocytes reduced), P9021

(Red blood cells unit), P9035 (Platelet pheresis leukoreduced), P9037 (Platelet pheresis leukoreduced irradiated) and P9040 (Red blood cells leukoreduced irradiated) – are all set to increase. The most significant proposed change will be made to the reimbursement rate for P9050 (Granulocytes, pheresis unit), which will decrease by 100%. This adjustment may be due to zero claims reporting for code P9050 in CY 2015.

Transfusion, Apheresis and Stem Cell Procedures (Table 2)

The payment of services previously grouped under APC 5271 (Blood Product Exchange and Related Services) will be reassigned to APC 5241 (Level 1 Blood Product Exchange and Related Services). This proposed categorical reassignment will decrease the reimbursement rate of services such as T-cell depletion of harvest by 65%. HCPCS code 38240 (Transplant allo hct/donor) will be subject to a notable 406% rate increase for CY 2017. This procedure will be reimbursed at $15,266.83. Despite this rate being significantly less than the actual cost of an allogenic bone marrow transplant, it is a step forward in achieving adequate reimbursement for the procedure. Payments for other apheresis and stem cell procedure codes are proposed to adjust with an average decrease by 4%.

Transfusion Laboratory and Blood Processing Services (Table 3)

Proposed 2017 payments for 30 of the 34 transfusion laboratory and blood processing codes will decrease, some by as much as 55%. The remaining 4 will experience a 68% increase in reimbursement. Changes in payment rates for this grouping of services largely appears to be due to refinement of the APC assignments for this year.

Comprehensive APC Groupings (Table 4)

Comprehensive Ambulatory Payment Classifications (C-APCs) pay for high cost device dependent services using a single payment for the hospital stay; but unlike the existing device-dependent APCs, C-APCs will include room and board as well as nursing costs. There are currently 37 C-APCs. CMS is proposing 25 new C-APCs, many of which are major surgery APCs within the various existing C-APC clinical families. If all of the proposed C-APCs are finalized, there will be a total of 62 C-APCs as of January 1, 2017.

As highlighted in Table 4 below, one of the proposed C-APCs, 5244, is for "Level 4 Blood Product Exchange and Related Services." CMS proposes to assign procedures described by CPT code 38240 (Hematopoietic progenitor cell [HPC]; allogeneic transplantation per donor) to this C-APC with the associated status indicator "J1." According to CMS, the creation of a new C-APC for allogeneic HSCT and the assignment of status indicator "J1" to CPT code 38240 would allow for the costs for all covered OPD services, including donor acquisition services, included on the claim to be packaged into the C-APC payment rate. These costs will also be analyzed using a comprehensive cost accounting methodology to establish future C–APC payment rates. CMS is proposing a payment rate for prospective new C–APC 5244 of $15,267 for CY 2017.

CMS is proposing to update the Medicare hospital cost report by adding a cost center 112.50, "Allogeneic Stem Cell Acquisition," to Worksheet A, which would facilitate the development of

an accurate estimate of allogeneic HSCT donor acquisition costs for future ratesetting. In addition, CMS is proposing to use the newly created revenue code 0815 (Allogeneic Stem Cell Acquisition Services) to identify hospital charges for stem cell acquisition charges for allogeneic bone marrow/stem cell transplants separately in Field 42 on Form CMS-1450 (or UB-04), when an allogeneic transplant occurs. For FY 2017, and subsequent years, CMS proposes to no longer use revenue code 0819 for the identification of stem cell acquisition charges for allogeneic bone marrow/stem cell transplants.

In addition to increasing the number of C-APCs, CMS is proposing to recalibrate the relative payment weight of each APC. The proposed relative payment weight changes are based on claims and cost reporting data for hospital outpatient department services.

Blood Clotting Factor

For 2017, CMS is proposing to continue to pay for blood clotting factors at ASP + 6 percent. In addition, CMS will continue to pay an additional fee for furnishing clotting factors. The precise amount will be announced later this year.

Drugs

Consistent with current policy, drugs with per diem cost of $110 or more will be paid separately. The payment will continue to be based on a 106 percent of Average Sales Price (ASP), which is consistent with the rates paid for drugs provided in physician offices. Less costly drugs will continue to be packaged into the APC rate for the procedure.

Site Neutral Payment Provision

Section 603 of the Bipartisan Budget Act of 2015 equalized Medicare payment rates for hospital outpatient departments and certain off-campus provider-based departments (PBDs). The site-neutral payment policy is intended to address practice of hospitals acquiring physician offices and then billing patients under the OPPS, which has higher reimbursement rates than the physician fee schedule. The proposed rule implements section 603 of the Bipartisan Budget Act of 2015 by requiring items and services furnished at certain PBDs to be paid under the "applicable payment system." For CY 2017, this will be the Medicare physician fee schedule for most items and services. Certain items and services are excluded from the site-neutral payment policy and may continue to be billed under the OPPS, including items and services: (1) furnished in a dedicated emergency department; (2) furnished and billed by an off-campus PBD prior to November 2, 2015; or (3) furnished in a hospital department within 250 yards of a remote location of the hospital.

Changes in Packaging of Services

CMS is continuing the trend of packaging all integral, ancillary, supportive, dependent, or adjunctive services into primary services under its prospective payment system, with the strategic goal of using larger payment bundles to maximize hospitals' incentives to provide care in the most efficient manner. As detailed below, for CY 2017, CMS proposes to modify its

packaging policies by: (1) packaging based on claim instead of based on date of service; (2) expanding the molecular pathology laboratory test exception to include certain advanced diagnostic laboratory tests (ADLTs); and (3) discontinuing the unrelated laboratory test exception (and the "L1" modifier).

- **Packaging based on date of service:** The conditional packaging of items and services is designated through status indicators (SIs) assigned to CPT and HCPCS codes. CMS does not believe that the same claim should report certain conditional packaging SIs packaged based on the date of service and other conditional packaging SIs packaged based on services. For CY 2017, CMS is proposing to align and modify the packaging logic for all of the conditional packaging status indicators. These packaging modifications would occur at the claim level and are intended to promote consistency and ensure appropriate packaging for multiple day hospital stays according to OPPS packaging policies.

- **Expanding Molecular Pathology Text Exception:** In 2014, CMS began excluding certain molecular pathology testing described by CPT codes in the ranges of 81200 through 81383, 81400 through 81408, and 81479 from the packaging policy. This policy was expanded in 2016 to include all new molecular pathology test codes. For CY 2017, CMS is proposing to further expand the laboratory packaging exception to include all advanced diagnostic laboratory tests (ADLTs). ADLTs include genetic testing and HLA typing and will be assigned the status indicator "A."

- **Unrelated Laboratory Text Exception:** Laboratory tests are considered "unrelated" when they appear on the same claim as other hospital outpatient services, but are ordered for a different diagnosis than the other outpatient services, and are ordered by a separate practitioner than the practitioner who ordered the hospital outpatient services. Unrelated laboratory tests are paid separately under OPPS and are conditionally packaged with the status indicator "L1." As multiple hospitals and CMS agree that the unrelated packaging exemption is not useful, CMS is proposing to discontinue the unrelated laboratory test exception (and the "L1" modifier). Rather, all laboratory tests will be packaged if they appear on a claim with other hospital outpatient services.

For CY 2017, CMS is proposing to apply a budget neutrality adjustment factor of 1.0003 to increase the conversion factor to account for the proposed packaging of unrelated laboratory tests into the OPPS payment.

Table 1 Blood Products								
HCPCS Code	Short Descriptor	2016 SI*	2017 SI*	2016 APC	2017 APC	2016 Payment	Proposed 2017 Payment	% Change
P9010	Whole blood for transfusion	R	R	9510	9510	$221.62	$79.97	-64%
P9011	Blood split unit	R	R	9520	9520	$102.50	$133.47	30%
P9012	Cryoprecipitate each unit	R	R	9511	9511	$59.64	$55.60	-7%
P9016	Rbc leukocytes reduced	R	R	9512	9512	$184.34	$190.52	3%
P9017	Plasma 1 donor frz w/in 8 hr	R	R	9508	9508	$72.56	$75.52	4%
P9019	Platelets, each unit	R	R	9515	9515	$118.03	$99.60	-16%
P9020	Platelet rich plasma unit	R	R	9516	9516	$120.16	$145.56	21%
P9021	Red blood cells unit	R	R	9517	9517	$145.79	$146.68	1%
P9022	Washed red blood cells unit	R	R	9518	9518	$307.46	$347.63	13%
P9023	Frozen plasma, pooled, sd	R	R	9509	9509	$75.90	$76.75	1%
P9031	Platelets leukocytes reduced	R	R	9526	9526	$116.32	$128.28	10%
P9032	Platelets, irradiated	R	R	9500	9500	$159.09	$167.41	5%
P9033	Platelets leukoreduced irrad	R	R	9521	9521	$162.08	$161.50	0%
P9034	Platelets, pheresis	R	R	9507	9507	$425.15	$426.65	0%
P9035	Platelet pheres leukoreduced	R	R	9501	9501	$488.29	$514.76	5%
P9036	Platelet pheresis irradiated	R	R	9502	9502	$528.11	$579.97	10%
P9037	Plate pheres leukoredu irrad	R	R	9530	9530	$641.85	$660.53	3%
P9038	Rbc irradiated	R	R	9505	9505	$205.82	$224.45	9%
P9039	Rbc deglycerolized	R	R	9504	9504	$380.32	$387.05	2%
P9040	Rbc leukoreduced irradiated	R	R	9522	9522	$267.63	$272.07	2%
P9043	Plasma protein fract,5%,50ml	R	R	9514	9514	$28.28	$25.99	-8%
P9044	Cryoprecipitatereducedplasma	R	R	9523	9523	$51.12	$66.17	29%
P9048	Plasmaprotein fract,5%,250ml	R	R	9519	9519	$40.33	$93.64	132%
P9050	Granulocytes, pheresis unit	R	E2	9506		$1,518.48		-100%
P9051	Blood, l/r, cmv-neg	R	R	9524	9524	$200.46	$221.15	10%
P9052	Platelets, hla-m, l/r, unit	R	R	9525	9525	$704.98	$752.21	7%
P9053	Plt, pher, l/r cmv-neg, irr	R	R	9531	9531	$443.65	$621.49	40%
P9054	Blood, l/r, froz/degly/wash	R	R	9527	9527	$321.28	$320.36	0%
P9055	Plt, aph/pher, l/r, cmv-neg	R	R	9528	9528	$462.48	$426.73	-8%
P9056	Blood, l/r, irradiated	R	R	9529	9529	$127.41	$127.96	0%
P9057	Rbc, frz/deg/wsh, l/r, irrad	R	R	9532	9532	$203.35	$194.73	-4%
P9058	Rbc, l/r, cmv-neg, irrad	R	R	9533	9533	$249.23	$253.20	2%
P9059	Plasma, frz between 8-24hour	R	R	9513	9513	$73.08	$75.03	3%
P9060	Fr frz plasma donor retested	R	R	9503	9503	$51.42	$63.38	23%
P9070	Pathogen reduced plasma pool		R		9534	$73.08	$75.03	3%
P9071	Pathogen reduced plasma sing		R		9535	$72.56	$75.52	4%
P9072	Pathogen reduced platelets		R		9536	$641.85	$660.53	3%

Table 2 Transfusion, Apheresis, and Stem Cell Procedures								
HCPCS Code	Short Descriptor	2016 SI*	2017 SI*	2016 APC	2017 APC	2016 Payment	Proposed 2017 Payment	% Change
36430	Blood transfusion service	S	S	5241	5241	$349.14	$364.93	5%
36440	Bl push transfuse 2 yr/<	S	S	5241	5241	$349.14	$364.93	5%
36450	Bl exchange/transfuse nb	S	S	5241	5241	$349.14	$364.93	5%
36455	Bl exchange/transfuse non-nb	S	S	5241	5241	$349.14	$364.93	5%
36460	Transfusion service fetal	S	S	5241	5241	$349.14	$364.93	5%
36511	Apheresis wbc	S	S	5271	5242	$1,047.76	$1,077.78	3%
36512	Apheresis rbc	S	S	5271	5242	$1,047.76	$1,077.78	3%
36513	Apheresis platelets	S	S	5271	5241	$1,047.76	$364.93	-65%
36514	Apheresis plasma	S	S	5271	5242	$1,047.76	$1,077.78	3%
36515	Apheresis adsorp/reinfuse	S	S	5281	5243	$3,015.06	$2,984.70	-1%
36516	Apheresis selective	S	S	5281	5243	$3,015.06	$2,984.70	-1%
36522	Photopheresis	S	S	5281	5243	$3,015.06	$2,984.70	-1%
38206	Harvest auto stem cells	S	S	5271	5242	$1,047.76	$1,077.78	3%
38207	Cryopreserve stem cells	S	S	5241	5241	$349.14	$364.93	5%
38208	Thaw preserved stem cells	S	S	5241	5241	$349.14	$364.93	5%
38209	Wash harvest stem cells	S	S	5241	5241	$349.14	$364.93	5%
38210	T-cell depletion of harvest	S	S	5271	5241	$1,047.76	$364.93	-65%
38211	Tumor cell deplete of harvst	S	S	5271	5241	$1,047.76	$364.93	-65%
38212	Rbc depletion of harvest	S	S	5271	5241	$1,047.76	$364.93	-65%
38213	Platelet deplete of harvest	S	S	5271	5241	$1,047.76	$364.93	-65%
38214	Volume deplete of harvest	S	S	5271	5241	$1,047.76	$364.93	-65%
38215	Harvest stem cell concentrte	S	S	5271	5241	$1,047.76	$364.93	-65%
38220	Bone marrow aspiration	T	J1	5073	5072	$941.98	$1,236.27	31%
38221	Bone marrow biopsy	T	J1	5073	5072	$1,414.28	$1,236.27	-13%
38230	Bone marrow harvest allogen	S	S	5281	5242	$3,015.06	$1,077.78	-64%
38232	Bone marrow harvest autolog	S	S	5281	5243	$3,015.06	$2,984.70	-1%
38240	Transplt allo hct/donor	S	J1	5281	5244	$3,015.06	$15,266.83	406%
38241	Transplt autol hct/donor	S	S	5281	5242	$3,015.06	$1,077.78	-64%
38242	Transplt allo lymphocytes	S	S	5271	5242	$1,047.76	$1,077.78	3%
38243	Transplj hematopoietic boost	S	S	5271	5242	$1,047.76	$1,077.78	3%
88184	Flowcytometry/ tc 1 marker	Q2	Q2	5673	5673	$209.42	$173.20	-17%
88185	Flowcytometry/tc add-on	N	N					
88187	Flowcytometry/read 2-8	B	B					
88188	Flowcytometry/read 9-15	B	B					
88189	Flowcytometry/read 16 & >	B	B					
G0364	Bone marrow aspirate &biopsy	N	N					

Table 3 Transfusion Laboratory Services								
HCPCS Code	Short Descriptor	2016 SI*	2017 SI*	2016 APC	2017 APC	2016 Payment	Proposed 2017 Payment	% Change
86850	Rbc antibody screen	Q1	Q1	5671	5671	$47.75	$39.39	-18%
86860	Rbc antibody elution	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86870	Rbc antibody identification	Q2	Q2	5673	5673	$209.42	$173.20	-17%
86880	Coombs test direct	Q1	Q1	5733	5732	$55.94	$25.20	-55%
86885	Coombs test indirect qual	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86886	Coombs test indirect titer	Q1	Q1	5672	5672	$102.20	$101.40	-1%
86890	Autologous blood process	Q1	Q1	5681	5673	$209.42	$173.20	-17%
86891	Autologous blood op salvage	Q1	Q1	5681	5674	$440.53	$426.57	-3%
86900	Blood typing serologic abo	Q1	Q1	5733	5733	$55.94	$57.03	2%
86901	Blood typing serologic rh(d)	Q1	Q1	5732	5732	$30.51	$25.20	-17%
86902	Blood type antigen donor ea	Q1	Q1	5681	5673	$103.02	$173.20	68%
86904	Blood typing patient serum	Q1	Q1	5733	5732	$30.51	$25.20	-17%
86905	Blood typing rbc antigens	Q1	Q1	5681	5673	$103.02	$173.20	68%
86906	Bld typing serologic rh phnt	Q1	Q1	5732	5732	$30.51	$25.20	-17%
86920	Compatibility test spin	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86921	Compatibility test incubate	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86922	Compatibility test antiglob	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86923	Compatibility test electric	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86927	Plasma fresh frozen	S	S	5693	5673	$209.42	$173.20	-17%
86930	Frozen blood prep	Q1	Q1	5681	5673	$103.02	$173.20	68%
86931	Frozen blood thaw	Q1	Q1	5733	5673	$209.42	$173.20	-17%
86932	Frozen blood freeze/thaw	Q1	Q1	5732	5732	$30.51	$25.20	-17%
86945	Blood product/irradiation	Q1	Q1	5732	5732	$30.51	$25.20	-17%
86950	Leukacyte transfusion	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86960	Vol reduction of blood/prod	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86965	Pooling blood platelets	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86970	Rbc pretx incubatj w/chemicl	Q1	Q1	5733	5732	$30.51	$25.20	-17%
86971	Rbc pretx incubatj w/enzymes	Q1	Q1	5681	5673	$103.02	$173.20	68%
86972	Rbc pretx incubatj w/density	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86975	Rbc serum pretx incubj drugs	Q1	Q1	5732	5732	$30.51	$25.20	-17%
86976	Rbc serum pretx id dilution	Q1	Q1	5732	5732	$30.51	$25.20	-17%
86977	Rbc serum pretx incubj/inhib	Q1	Q1	5681	5672	$103.02	$101.40	-2%
86978	Rbc pretreatment serum	Q1	Q1	5732	5731	$12.70	$12.31	-3%
86985	Split blood or products	Q1	Q1	5734	5672	$102.20	$101.40	-1%
86999	Transfusion procedure	Q1	Q1	5731	5731	$12.70	$12.31	-3%

Table 4 CY 2017 C-APCs							
C-APC	APC Title	Clinical Family	Proposed New C-APC	C-APC	APC Title	Clinical Family	Proposed New C-APC
5072	Level 2 Excision/ Biopsy/ Incision and Drainage	EBIDX	*	5302	Level 2 Upper GI Procedures	GIXXX	*
5073	Level 3 Excision/ Biopsy/ Incision and Drainage	EBIDX	*	5303	Level 3 Upper GI Procedures	GIXXX	*
5091	Level 1 Breast/Lymphatic Surgery and Related Procedures	BREAS	*	5313	Level 3 Lower GI Procedures	GIXXX	*
5092	Level 2 Breast/Lymphatic Surgery and Related Procedures	BREAS	*	5331	Complex GI Procedures	GIXXX	
5093	Level 3 Breast/Lymphatic Surgery & Related Procedures	BREAS		5341	Abdominal/Peritoneal/Biliary and Related Procedures	GIXXX	*
5094	Level 4 Breast/Lymphatic Surgery & Related Procedures	BREAS		5361	Level 1 Laparoscopy & Related Services	LAPXX	
5112	Level 2 Musculoskeletal Procedures	ORTHO	*	5362	Level 2 Laparoscopy & Related Services	LAPXX	
5113	Level 3 Musculoskeletal Procedures	ORTHO	*	5373	Level 3 Urology & Related Services	UROXX	*
5114	Level 4 Musculoskeletal Procedures	ORTHO		5374	Level 4 Urology & Related Services	UROXX	*
5115	Level 5 Musculoskeletal Procedures	ORTHO		5375	Level 5 Urology & Related Services	UROXX	
5116	Level 6 Musculoskeletal Procedures	ORTHO		5376	Level 6 Urology & Related Services	UROXX	
5153	Level 3 Airway Endoscopy	AENDO	*	5377	Level 7 Urology & Related Services	UROXX	
5154	Level 4 Airway Endoscopy	AENDO	*	5414	Level 4 Gynecologic Procedures	GYNXX	*
5155	Level 5 Airway Endoscopy	AENDO	*	5415	Level 5 Gynecologic Procedures	GYNXX	
5164	Level 4 ENT Procedures	ENTXX	*	5416	Level 6 Gynecologic Procedures	GYNXX	
5165	Level 5 ENT Procedures	ENTXX		5431	Level 1 Nerve Procedures	NERVE	*
5166	Cochlear Implant Procedure	COCHL		5432	Level 2 Nerve Procedures	NERVE	*
5191	Level 1 Endovascular Procedures	VASCX	*	5462	Level 2 Neurostimulator & Related Procedures	NSTIM	
5192	Level 2 Endovascular Procedures	VASCX		5463	Level 3 Neurostimulator & Related Procedures	NSTIM	

5193	Level 3 Endovascular Procedures	VASCX		5464	Level 4 Neurostimulator & Related Procedures	NSTIM	
5194	Level 4 Endovascular Procedures	VASCX		5471	Implantation of Drug Infusion Device	PUMPS	
5200	Implantation Wireless PA Pressure Monitor	WPMXX	*	5491	Level 1 Intraocular Procedures	INEYE	*
5211	Level 1 Electrophysiologic Procedures	EPHYS		5492	Level 2 Intraocular Procedures	INEYE	
5212	Level 2 Electrophysiologic Procedures	EPHYS		5493	Level 3 Intraocular Procedures	INEYE	
5213	Level 3 Electrophysiologic Procedures	EPHYS		5494	Level 4 Intraocular Procedures	INEYE	
5222	Level 2 Pacemaker and Similar Procedures	AICDP		5495	Level 5 Intraocular Procedures	INEYE	
5223	Level 3 Pacemaker and Similar Procedures	AICDP		5503	Level 3 Extraocular, Repair, and Plastic Eye Procedures	EXEYE	*
5224	Level 4 Pacemaker and Similar Procedures	AICDP		5504	Level 4 Extraocular, Repair, and Plastic Eye Procedures	EXEYE	*
5231	Level 1 ICD and Similar Procedures	AICDP		5627	Level 7 Radiation Therapy	RADTX	
5232	Level 2 ICD and Similar Procedures	AICDP		5881	Ancillary Outpatient Services When Patient Dies	N/A	
5244	Level 4 Blood Product Exchange and Related Services	SCTXX	*	8011	Comprehensive Observation Services	N/A	

** Explanation of Status Indicators*		
Status Indicator	**Item/Code/Service**	**OPPS Payment Status**
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. ● May be paid by MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. ● An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
E2	Items and Services: For which pricing information and claims data are not available	Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
J1	Hospital Part B services paid through a comprehensive APC	Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
K	Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals	Paid under OPPS; separate APC payment.
N	Items and Services Packaged into APC Rates	Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.
Q1	STV-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "S," "T," or "V." (2) Composite APC payment if billed with specific combinations of services based on OPPS composite-specific payment criteria. Payment is packaged into a single payment for specific combinations of services. (3) In other circumstances, payment is made through a separate APC payment.
Q2	T-Packaged Codes	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator "T." (2) In other circumstances, payment is made through a separate APC payment.
R	Blood and Blood Products	Paid under OPPS; separate APC payment.
S	Procedure or Service, Not Discounted When Multiple	Paid under OPPS; separate APC payment.
T	Procedure or Service, Multiple Procedure Reduction Applies	Paid under OPPS; separate APC payment.