Advancing Transfusion and Cellular Therapies Worldwide

Centers for Medicare & Medicaid Services Proposes Medicare Hospital Outpatient Payment Rates and Policies for CY 2018

On July 20, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* a proposed rule that would update Medicare payment rates and policies under the hospital outpatient prospective payment system (OPPS) and the ambulatory surgical center (ASC) payment system for calendar year (CY) 2018. Comments are due to CMS on September 11.

CMS proposes to update payment rates under the hospital outpatient prospective payment system for CY 2018 by 1.75 percent. The proposed increase factor is based on the proposed hospital inpatient market basket percentage increase of 2.9 percent, minus the proposed multifactor productivity adjustment of 0.4 percentage points, minus a 0.75 percentage point adjustment required by the Affordable Care Act. The following document summarizes CMS' proposed payment rates and policies related to transfusion medicine and cellular therapies.

Proposed 2018 Payment Rates and Coding Changes for Blood and Blood Components

CMS proposes to continue establishing separate payment rates for blood and blood products using a blood-specific cost-to-charge ratio (CCR) methodology. In addition, CMS proposes to continue to apply the blood-specific CCR methodology when calculating the costs of blood and blood products that appear on claims with services assigned to comprehensive APCs (C-APCs). Since the costs of blood and blood products are reflected in the overall costs of the C-APCs, and the proposed payment rates of the C-APCs, CMS is proposing not to make separate payments for blood and blood products when they appear on the same claims as services assigned to the C-APCs.

Overall, CMS proposes to reduce payments for blood and blood products by an unadjusted average of 1.6 percent, when compared with the payment rates for 2017. CMS proposes payment reductions of 20 percent or more for several blood product codes, including: P9010 (whole blood for transfusion), P9011 (blood split units), P9012 (cryoprecipitate each unit), P9043 (plasma protein fract, 5%, 50 ml), P9048 (plasmaprotein fract,5%,250ml), P9055 (plt, aph/pher, l/r, cmv-neg) and P9070 (pathogen reduced plasma pool). In contrast, CMS proposes significant increases in payment for several blood product codes, including: a 65 percent increase for P9071 (Pathogen reduced plasma sing), a 61 percent increase for P9044 (Cryoprecipitatereducedplasma), a 34 percent increase for P9057 (Rbc, frz/deg/wsh, l/r, irrad), an 18 percent increase for P9019 (platelets, each unit) and a 16 percent increase for P9056 (blood, l/r, irradiated).

CMS' proposed payment rates for 2018 reflect recent coding changes for pathogen-reduced platelets and rapid bacterial testing for platelets. In the rule finalizing payment policies for hospital outpatient services for CY 2017, CMS revised HCPCS Code P9072 to read, "Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit." In response to concerns raised by AABB and other stakeholders in the blood community, the CMS HCPCS Workgroup deactivated HCPCS Code P9072 for the Medicare program, and replaced the code with two new HCPCS codes. CMS established a new separately payable testing code, HCPCS Code Q9987 (pathogen(s) test for platelets), which is to be used

to report rapid bacterial testing or other pathogen tests for platelets, and is described in more detail under the section entitled, "Proposed 2018 Payment Rates for Transfusion Laboratory Services."

Effective July 1, 2017, HCPCS Code Q9988 (platelets, pheresis, pathogen reduced, each unit) is being used to report the use of pathogen-reduction technology instead of HCPCS code P0972. It is assigned to APC 9536 (Pathogen Reduced Platelets), with a payment rate of $647.12. For 2018, CMS proposes to determine payment rate for HCPCS Q9988 by continuing to cross-walk the code to P9037 (leukoreduced irradiated apheresis platelet). The proposed CY2018 payment rate for P9037 (and thus also pathogen reduced apheresis platelets) is $627.56.

Please see Table 1 for a summary of the proposed payment rates for 2018 for blood and blood products.

Proposed 2018 Payment Rates and Coding Changes for Transfusion, Apheresis, and Stem Cell Procedures

Overall, CMS' proposed payment rates for CY 2018 for transfusion, apheresis, and stem cell procedures are 7 percent lower than the payment rates that were in the final rule for CY 2017. However, this reflects CMS' proposal to stop paying for HCPCS code 36515 (apheresis adsorp/reinfuse) under the OPPS. Additionally, the net reduction in payment rates reflects CMS' proposal to reduce the payment rate for HCPCS code 38240 (transplt allo hct/donor) from $27,752.75 to $26,049.70. Omitting these two codes from the comparison of payment rates finalized in 2017 to the 2018 proposed payment rates results in an overall unadjusted net increase of 3.3 percent for the payment rates for transfusion, apheresis and stem cell procedures. Please see Table 2 for a summary of the proposed payment rates for transfusion, apheresis and stem cell procedures for 2018.

CMS explains that in 2017, the Agency finalized a comprehensive APC (C-APC) for allogeneic hematopoietic stem cell transplant (HSCT), and that payment for donor acquisition services for HSCT is included in the C-APC payment for the allogeneic stem cell transplant when the transplant occurs in the hospital outpatient setting. Therefore, CMS instructs that all donor costs for HCPCS code 38205 be reported on the same date of service as the transplant procedure (HCPCS code 38240 (hematopoietic progenitor (HPC); allogeneic transplantation per donor)). However, CMS recognizes that other donor acquisition costs, including costs for the procedure described by HCPCS code 38230 (Bone marrow harvesting for transplantation; allogeneic), are assigned to the status indicator "S." CMS proposes to change the status indicator assignment for HCPCS code 38205 from "B" to "S," which indicates that the procedure is paid under the OPPS and receives separate payment, to ensure consistency and adequately capture donor acquisition costs.

CMS proposes to assign HCPCS code 38205, which describes blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic, to APC 5242 (Level 2 Blood Product Exchange and Related Services). CMS' claims data from claims submitted in calendar year 2016 and processed on or before December 31, 2016 indicate a geometric mean cost of approximately $580 for HCPCS code 38205, which is based on 2 claims out of a total of 8 claims. Thus, CMS reasons that the procedure described by HCPCS code 38205 requires similar resources and is clinically similar to APC 5242.

Proposed 2018 Payment Rates and Coding Changes for Transfusion Laboratory Services

CMS proposes a net increase of 9.7 percent for transfusion laboratory services for CY 2018, when compared with the payment rates that were finalized for 2017. CMS proposes payment increases, which generally range between 5 and 12 percent, for all of the transfusion laboratory services codes. CMS proposes substantial increases for two codes, including a 135 percent increase for HCPCS code 86978 (Rbc pretreatment serum) and a 73 percent increase for HCPCS code 86900 (blood typing serologic abo).

As mentioned above, the payment rates for 2018 for transfusion laboratory services reflect the addition of HCPCS code Q9987 (pathogen(s) test for platelets). CMS instructs that the code, "shall be used to report rapid bacterial testing or other pathogen tests for platelets, instead of HCPCS code P0972. We note that HPCPS code Q9987 should be reported to describe the test used for the detection of bacterial contamination in platelets as well as any other test that may be used to detect pathogen contamination. HCPCS code Q9987 should not be used for reporting donation testing for infectious agents such as viruses…. [E]ffective July 1, 2017, HCPCS code Q9987 is assigned to New Technology APC 1493 [(New Technology – Level 1C ($21 - $30)], with a payment rate of $25.50."

CMS notes that "currently, there is one test approved by the FDA that is described by the HCPCS code Q9987. The test is a rapid bacterial test and the manufacturer estimates the cost of the test to be between $26 and $35." For 2018, CMS proposes "to continue to assign Q9987 to New Technology APC 1493, with a proposed payment rate of $25.50, until such time as claims data are available to support assignment to a clinical APC." CMS is soliciting information on the "actual costs of pathogen tests for platelets before assigning HCPCS Code Q9987 to a clinical APC."

Please see Table 3 for a summary of the proposed payment rates for transfusion laboratory services.

Laboratory Date of Service Policy

CMS is soliciting comments from stakeholders on billing for molecular pathology tests and advance diagnostic laboratory tests (ADLTs) ordered less than 14 days of a hospital outpatient discharge. Specifically, stakeholders raised concerns that although molecular pathology tests and laboratory tests expected to be designated at ADLTs are not packaged under the OPPS, under the current date of service (DOS) policy, if the tests are ordered within 14 calendar days of a patient's discharge from the hospital, Medicare treats the tests as though they were ordered and furnished by the hospital itself. As a result, laboratories cannot directly seek Medicare payment for the molecular pathology test or ADLT. Rather, the hospital must bill Medicare for the test, and the laboratory must seek payment from the hospital.

CMS is considering creating a new exception to the DOS policy for molecular pathology tests and ADLTs, which would allow laboratories to bill Medicare directly for certain laboratory tests excluded from OPPS packaging. CMS specifies that "these tests are relatively new and may have a different pattern of clinical use than more conventional laboratory tests, which may make them generally less tied to a primary service in the hospital outpatient setting than more common and routine laboratory tests that are packaged." CMS is soliciting input regarding whether the nature of the tests makes them appropriately separable from the preceding hospital stay.

CMS is considering several possible modifications to the DOS policy. One proposed modification would apply to molecular pathology tests or an ADLT, and would require the DOS to be the date of performance only if:

- The physician orders the test following the date of a hospital outpatient's discharge from the hospital outpatient department;
- The specimen was collected from a hospital outpatient during an encounter;
- It would be medically inappropriate to have collected the sample from the hospital outpatient other than during the hospital outpatient encounter;
- The results of the test do not guide treatment provided during the hospital outpatient encounter; and
- The test was reasonable and medically necessary for the treatment of an illness.

CMS is also considering an exception to the current DOS policy that would apply to ADLTs only. Additionally, CMS is soliciting comments on the DOS policy, such as potentially modifying the "under arrangements" provisions to except molecular pathology tests and ADLTs that are excluded from the OPPS packaging policy.

Blood Clotting Factors

CMS proposes to continue paying for blood clotting factors at ASP + 6 percent. Additionally, CMS proposes to continue paying an additional fee for furnishing clotting factor. The updated payment amount will be announced in the future.

Request for Information on CMS Flexibilities and Efficiencies

CMS is soliciting ideas for regulatory, subregulatory, policy, practice and procedural changes which could improve the health care delivery system and reduce unnecessary burdens for clinicians, providers and patients. CMS suggests that "Ideas could include payment system redesign, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements and processes with those of Medicaid and other payers, operational flexibility, feedback mechanisms and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery, and facilitation of individual preferences."

Additionally, CMS is requesting comments on potential payment policy options to address payment differences between hospital services furnished in the inpatient and outpatient settings. CMS acknowledges that similar hospital inpatient and hospital outpatient services are paid differently, and is committed to eliminating inappropriate Medicare payment differences.

Table 1. Blood and Blood Products[1]									
HCPCS Code	**Short Descriptor**	**Proposed APC Codes for 2018[2]**	**Final 2016 Payment**	**Final 2017 Payment**	**Proposed 2018 Payment**	**$ Change 2016-2017**	**% Change 2016-2017**	**$ Change 2017-2018**	**% Change 2017-2018**
P9010	Whole blood for transfusion	9510	$221.62	$155.44	$119.39	-66.18	-30%	-36.05	-23%
P9011	Blood split unit	9520	$102.50	$131.93	$97.99	29.43	29%	-33.94	-26%
P9012	Cryoprecipitate each unit	9511	$59.64	$53.00	$38.29	-6.64	-11%	-14.71	-28%
P9016	Rbc leukocytes reduced	9512	$184.34	$185.75	$184.23	1.41	1%	-1.52	-1%
P9017	Plasma 1 donor frz w/in 8 hr	9508	$72.56	$73.70	$71.96	1.14	2%	-1.74	-2%
P9019	Platelets, each unit	9515	$118.03	$96.45	$113.58	-21.58	-18%	17.13	18%
P9020	Platelet rich plasma unit	9516	$120.16	$131.63	$120.52	11.47	10%	-11.11	-8%
P9021	Red blood cells unit	9517	$145.79	$142.30	$143.27	-3.49	-2%	0.97	1%
P9022	Washed red blood cells unit	9518	$307.46	$344.22	$367.98	36.76	12%	23.76	7%
P9023	Frozen plasma, pooled, sd	9509	$75.90	$66.80	$60.81	-9.10	-12%	-5.99	-9%
P9031	Platelets leukocytes reduced	9526	$116.32	$125.68	$119.16	9.36	8%	-6.52	-5%
P9032	Platelets, irradiated	9500	$159.09	$167.34	$168.46	8.25	5%	1.12	1%
P9033	Platelets leukoreduced irrad	9521	$162.08	$162.02	$166.17	-0.06	0%	4.15	3%
P9034	Platelets, pheresis	9507	$425.15	$411.92	$435.88	-13.23	-3%	23.96	6%
P9035	Platelet pheres Leukoreduced	9501	$488.29	$499.74	$481.24	11.45	2%	-18.50	-4%
P9036	Platelet pheresis Irradiated	9502	$528.11	$556.35	$541.23	28.24	5%	-15.12	-3%
P9037	Plate pheres leukoredu irrad	9530	$641.85	$647.12	$627.56	5.27	1%	-19.56	-3%
P9038	Rbc irradiated	9505	$205.82	$218.85	$215.12	13.03	6%	-3.73	-2%
P9039	Rbc deglycerolized	9504	$380.32	$383.42	$412.61	3.10	1%	29.19	8%
P9040	Rbc leukoreduced irradiated	9522	$267.63	$266.17	$259.89	-1.46	-1%	-6.28	-2%
P9043	Plasma protein fract, 5%,50ml	9514	$28.28	$19.76	$15.10	-8.52	-30%	-4.66	-24%

[1] Payment rates are updated by CMS on a quarterly basis. These payment rates reflect the 2016 and 2017 final rule and 2018 proposed rule.
[2] APC codes are the same for all P-codes in CY2016-2018.

Table 1. Blood and Blood Products[3]									
HCPCS Code	**Short Descriptor**	**Proposed APC Codes for 2018[4]**	**Final 2016 Payment**	**Final 2017 Payment**	**Proposed 2018 Payment**	**$ Change 2016-2017**	**% Change 2016-2017**	**$ Change 2017-2018**	**% Change 2017-2018**
P9044	Cryoprecipitate-Reducedplasma	9523	$51.12	$63.26	$101.65	12.14	24%	38.39	61%
P9048	Plasmaprotein fract,5%,250ml	9519	$40.33	$92.63	$47.37	52.30	130%	-45.26	-49%
P9050	Granulocytes, pheresis unit		$1,518.48	$0.00	$0.00	-1518.48	-100%	0	0%
P9051	Blood, l/r, cmv-neg	9524	$200.46	$206.39	$189.65	5.93	3%	-16.74	-8%
P9052	Platelets, hla-m, l/r, unit	9525	$704.98	$737.83	$751.05	32.85	5%	13.22	2%
P9053	Plt, pher, l/r cmv-neg, irr	9531	$443.65	$618.63	$589.67	174.98	39%	-28.96	-5%
P9054	Blood, l/r, froz/degly/wash	9527	$321.28	$275.46	$246.02	-45.82	-14%	-29.44	-11%
P9055	Plt, aph/pher, l/r, cmv-neg	9528	$462.48	$421.82	$328.98	-40.66	-9%	-92.84	-22%
P9056	Blood, l/r, irradiated	9529	$127.41	$124.32	$144.66	-3.09	-2%	20.34	16%
P9057	Rbc, frz/deg/wsh, l/r, irrad	9532	$203.35	$207.37	$277.60	4.02	2%	70.23	34%
P9058	Rbc, l/r, cmv-neg, irrad	9533	$249.23	$249.99	$251.17	0.76	0%	1.18	0%
P9059	Plasma, frz between 8-24 hour	9513	$73.08	$73.97	$75.50	0.89	1%	1.53	2%
P9060	Fr frz plasma donor retested	9503	$51.42	$67.16	$56.51	15.74	31%	-10.65	-16%
P9070	Pathogen reduced plasma pool	9534	$73.08	$73.97	$59.32	0.89	1%	-14.65	-20%
P9071	Pathogen reduced plasma sing	9535	$72.56	$73.70	$121.44	1.14	2%	47.74	65%
P9072	Plate path red/rapid bac tes	9536	$641.85	$647.12	N/A	5.27	1%	n/a	n/a
Q9988[5]	Platelets pheresis path reduc	9536	n/a	n/a	$627.56	n/a	n/a	n/a	n/a

[3] Payment rates are updated by CMS on a quarterly basis. These payment rates reflect the 2016 and 2017 final rule and 2018 proposed rule.
[4] APC codes are the same for all P-codes in CY2016-2018.
[5] In 2017, CMS modified the HCPCS code established in CY 2016 for pathogen-reduced platelets (HCPCS code 9072) to include the use of pathogen-reduction technology or rapid bacterial testing. As noted in the text, CMS deactivated the use of code P9072 for the Medicare program, and established two new codes, Q9987 and Q9988. Q9988 (platelets, pheresis, pathogen reduced, each unit) is a product code, and is reflected in Table 1. Q9987, pathogen test(s) for platelets, is a new, separately payable testing code, and is reflected in Table 3.

Table 2. Transfusion, Apheresis, and Stem Cell Procedures[6]								
HCPCS Code	**Short Descriptor**	**Proposed 2018 SI**	**2017 APC**	**Proposed APC Codes for 2018**	**Final 2017 Payment**	**Proposed 2018 Payment**	**$ Change 2017-2018**	**% Change 2017-2018**
36430	Blood transfusion service	S	5241	5241	$354.39	$366.84	12.45	4%
36440	Bl push transfuse 2 yr/<	S	5241	5241	$354.39	$366.84	12.45	4%
36450	Bl exchange/transfuse nb	S	5241	5241	$354.39	$366.84	12.45	4%
36455	Bl exchange/transfuse non-nb	S	5241	5241	$354.39	$366.84	12.45	4%
36456	Prtl exchange transfuse nb	S	5241	5241	$354.39	$366.84	12.45	4%
36460	Transfusion service fetal	S	5241	5241	$354.39	$366.84	12.45	4%
36511	Apheresis wbc	S	5242	5242	$1,098.22	$1,193.40	95.18	9%
36512	Apheresis rbc	S	5242	5242	$1,098.22	$1,193.40	95.18	9%
36513	Apheresis platelets	S	5241	5241	$354.39	$366.84	12.45	4%
36514	Apheresis plasma	S	5242	5242	$1,098.22	$1,193.40	95.18	9%
36515	Apheresis adsorp/reinfuse	D	5243		$3,186.48	$0	-3,186.48	-100%
36516	Apheresis selective	S	5243	5243	$3,186.48	$3,135.99	-50.49	-2%
36522	Photopheresis	S	5243	5243	$3,186.48	$3,135.99	-50.49	-2%
38205	Harvest allogeneic stem cell	S		5242		$1,193.40		
38206	Harvest auto stem cells	S	5242	5242	$1,098.22	$1,193.40	95.18	9%
38207	Cryopreserve stem cells	S	5241	5241	$354.39	$366.84	12.45	4%
38208	Thaw preserved stem cells	S	5241	5241	$354.39	$366.84	12.45	4%
38209	Wash harvest stem cells	S	5241	5241	$354.39	$366.84	12.45	4%
38210	T-cell depletion of harvest	S	5241	5241	$354.39	$366.84	12.45	4%
38211	Tumor cell deplete of harvst	S	5241	5241	$354.39	$366.84	12.45	4%

[6] Payment rates are updated by CMS on a quarterly basis. These payment rates reflect the 2017 final rule and 2018 proposed rule.

Table 2. Transfusion, Apheresis, and Stem Cell Procedures[6]								
HCPCS Code	**Short Descriptor**	**Proposed 2018 SI**	**2017 APC**	**Proposed APC Codes for 2018**	**Final 2017 Payment**	**Proposed 2018 Payment**	**$ Change 2017-2018**	**% Change 2017-2018**
38212	Rbc depletion of harvest	S	5241	5241	$354.39	$366.84	12.45	4%
38213	Platelet deplete of harvest	S	5241	5241	$354.39	$366.84	12.45	4%
38214	Volume deplete of harvest	S	5241	5241	$354.39	$366.84	12.45	4%
38215	Harvest stem cell concentrte	S	5241	5241	$354.39	$366.84	12.45	4%
38220	Bone marrow aspiration	J1	5072	5072	$1,236.10	$1,268.53	32.43	3%
38221	Bone marrow biopsy	J1	5072	5072	$1,236.10	$1,268.53	32.43	3%
38230	Bone marrow harvest allogen	S	5242	5242	$1,098.22	$1,193.40	95.18	9%
38232	Bone marrow harvest autolog	S	5243	5243	$3,186.48	$3,135.99	-50.49	-2%
38240	Transplt allo hct/donor	J1	5244	5244	$27,752.75	$26,049.70	-1703.05	-6%
38241	Transplt autol hct/donor	S	5242	5242	$1,098.22	$1,193.40	95.18	9%
38242	Transplt allo lymphocytes	S	5242	5242	$1,098.22	$1,193.40	95.18	9%
38243	Transplj hematopoietic boost	S	5242	5242	$1,098.22	$1,193.40	95.18	9%
88184	Flowcytometry/ tc 1 marker	Q2	5673	5673	$183.93	$194.36	10.43	6%
88185	Flowcytometry/tc add-on	N						
88187	Flowcytometry/read 2-8	B						
88188	Flowcytometry/read 9-15	B						
88189	Flowcytometry/read 16 & >	B						
G0364	Bone marrow aspirate &biopsy	D						

Table 3. Transfusion Laboratory Services[7]								
HCPCS Code	**Short Descriptor**	**Proposed 2018 SI**	**2017 APC**	**Proposed APC Codes for 2018**	**Final 2017 Payment**	**Proposed 2018 Payment**	**$ Change 2017-2018**	**% Change 2017-2018**
86850	Rbc antibody screen	Q1	5671	5671	$39.68	$42.40	2.72	7%
86860	Rbc antibody elution	Q1	5672	5672	$103.83	$115.21	11.38	11%
86870	Rbc antibody identification	Q2	5673	5673	$183.93	$194.36	10.43	6%
86880	Coombs test direct	Q1	5732	5732	$28.37	$29.65	1.28	5%
86885	Coombs test indirect qual	Q1	5672	5672	$103.83	$115.21	11.38	11%
86886	Coombs test indirect titer	Q1	5672	5672	$103.83	$115.21	11.38	11%
86890	Autologous blood process	Q1	5673	5673	$183.93	$194.36	10.43	6%
86891	Autologous blood op salvage	Q1	5674	5674	$453.97	$477.66	23.69	5%
86900	Blood typing serologic abo	Q1	5733	5734	$54.53	$94.27	39.74	73%
86901	Blood typing serologic rh(d)	Q1	5732	5732	$28.37	$29.65	1.28	5%
86902	Blood type antigen donor ea	Q1	5673	5673	$183.93	$194.36	10.43	6%
86904	Blood typing patient serum	Q1	5732	5732	$28.37	$29.65	1.28	5%
86905	Blood typing rbc antigens	Q1	5673	5673	$183.93	$194.36	10.43	6%
86906	Bld typing serologic rh phnt	Q1	5732	5732	$28.37	$29.65	1.28	5%
86920	Compatibility test spin	Q1	5672	5672	$103.83	$115.21	11.38	11%
86921	Compatibility test incubate	Q1	5672	5672	$103.83	$115.21	11.38	11%
86922	Compatibility test antiglob	Q1	5672	5672	$103.83	$115.21	11.38	11%
86923	Compatibility test electric	Q1	5672	5672	$103.83	$115.21	11.38	11%
86927	Plasma fresh frozen	S	5673	5673	$183.93	$194.36	10.43	6%
86930	Frozen blood prep	Q1	5673	5673	$183.93	$194.36	10.43	6%
86931	Frozen blood thaw	Q1	5673	5673	$183.93	$194.36	10.43	6%

[7] Payment rates are updated by CMS on a quarterly basis. These payment rates reflect the 2017 final rule and 2018 proposed rule.

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HCPCS Code	**Short Descriptor**	**Proposed 2018 SI**	**2017 APC**	**Proposed APC Codes for 2018**	**Final 2017 Payment**	**Proposed 2018 Payment**	**$ Change 2017-2018**	**% Change 2017-2018**
86932	Frozen blood freeze/thaw	Q1	5732	5732	$28.37	$29.65	1.28	5%
86945	Blood product/irradiation	Q1	5732	5732	$28.37	$29.65	1.28	5%
86950	Leukacyte transfusion	Q1	5672	5672	$103.83	$115.21	11.38	11%
86960	Vol reduction of blood/prod	Q1	5672	5672	$103.83	$115.21	11.38	11%
86965	Pooling blood platelets	Q1	5672	5672	$103.83	$115.21	11.38	11%
86970	Rbc pretx incubatj w/chemicl	Q1	5732	5732	$28.37	$29.65	1.28	5%
86971	Rbc pretx incubatj w/enzymes	Q1	5673	5673	$183.93	$194.36	10.43	6%
86972	Rbc pretx incubatj w/density	Q1	5672	5672	$103.83	$115.21	11.38	11%
86975	Rbc serum pretx incubj drugs	Q1	5732	5732	$28.37	$29.65	1.28	5%
86976	Rbc serum pretx id dilution	Q1	5732	5732	$28.37	$29.65	1.28	5%
86977	Rbc serum pretx incubj/inhib	Q1	5672	5672	$103.83	$115.21	11.38	11%
86978	Rbc pretreatment serum	Q1	5731	5732	$12.61	$29.65	17.04	135%
86985	Split blood or products	Q1	5672	5672	$103.83	$115.21	11.38	11%
86999	Transfusion procedure	Q1	5731	5731	$12.61	$14.16	1.55	12%
Q9987[8]	Pathogen test for platelets	S	n/a	1493	n/a	$25.50	n/a	n/a

[8] In 2017, CMS modified the HCPCS code established in CY 2016 for pathogen-reduced platelets (HCPCS code 9072) to include the use of pathogen-reduction technology or rapid bacterial testing. As noted in the text, CMS deactivated the use of code P9072 for the Medicare program, and established two new codes, Q9987 and Q9988. Q9988 (platelets, pheresis, pathogen reduced, each unit) is a product code, and is reflected in Table 1. Q9987, pathogen test(s) for platelets, is a new, separately payable testing code, and is reflected in Table 3.