Coding Options for Administration of Autologous CAR-T Updated as of January 1, 2021

	Inpatient Claim - Facility Reporting and Payment Implications*			Outpatient Claim - Facility Reporting and Payment Implications					Physician Claim - Professional Services Reporting and Payment Implications			
	ICD-10-PCS Codes	Revenue Codes for Charges**	Description	CPT/HCPCS Codes	Revenue Codes for Charges**	Description	Medicare Payment Implications	Commercial Payment Implications	CPT/HCPCS Codes	Description	Medicare Considerations and Payment Implications	Commercial Payment Implications
Coding Options for Reporting Administration of Autologous CAR-T	XW033C3 or XW043C3 XW23346 or XW24346 XW23376 or XW24376	0874	Introduction, Peripheral Vein(or Central Vein), Percutaneous Engineered Autologous Chimeric Antigen Receptor T Cell Immunotherapy for Tisagenlecleucel (Kymriah), Axicabtagene Ciloleucel (Yescarta), or for any other non-FDA approved autologous CAR-T administration Transfusion, Peripheral Vein(or Central Vein), Percutaneous Brexucabtagene Autoleucel (Tecartus) Immunotherapy administration Transfusion, Peripheral Vein(or Central Vein), Percutaneous Lisocabtagene Maraleucel Immunotherapy administration	0540T	0874	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	OPPS Indicator = "S" ("significant procedure") Placed in APC 5694 While assigned a payment rate by Medicare, providers should still reach out to their MACs to confirm the code will be allowed/recognized, as the MAC may have a local policy that limits usage or applies edits to Category III codes.	Providers should contact their commercial payers and share this information to ensure the code is accepted as part of their contract	0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	Recognized as a carrier priced service as designated by status code "C" in the MPFS. Category III codes are manually priced by the MAC based on a written explanation of the service and usually a code provided by the clinician as a reasonable proxy to cross-walk to for payment purposes; CPT code 38241 is a possible cross-walk code choice if the clinician feels CAR-T administration requires similar resource utilization as autologous hematopoietic progenitor cell (HPC) transplantation; if not, then a different code/service will need to be provided to the MAC Despite being deemed carrier priced, providers will need to reach out to their MACs to confirm the code will be allowed/recognized, as the MAC may have a local policy that that limits usage or applies edits to Category III codes.	Providers should contact their commercial payers and share this information to ensure the code is accepted as part of their contract

** For Medicare, MS-DRG 018 is assigned for inpatient CAR-T administration based on reporting a CAR-T administration ICD-10-PCS procedure code. A payment adjustment will be applied to claims that group to MS-DRG 018 and include ICD-10-CM diagnosis code Z00.6 or when there is expanded access use of immunotherapy. However, when the provider incurs a cost for the CAR T-cell therapy product and the case involves a clinical trial of a different product, the payment adjustment will not be applied, and the provider will receive the full MS-DRG 018 payment. Providers will have to notify their MACs of these situations. To notify the MAC of a case where there was expanded access of CAR T-cell therapy products, the provider may enter a Billing Note NTE02 "Expand Acc Use" on the electronic claim 837I or a remark "Expand Acc Use" on a paper claim. To notify the MAC of a case where the CAR T-cell therapy product is purchased in the usual manner, but the case involves a clinical trial of a different product (and ICD-10-CM diagnosis code Z00.6 on the claim), the provider may enter a Billing Note NTE02 "Diff Prod Clin Trial" on the electronic claim 837I or a remark "Diff Prod Clin Trial" on a paper claim. Providers should carefully review the guidance released by CMS in Transmittal R10360CP, effective Oct 5, 2020. This can be found at: https://www.cms.gov/files/document/r10360cp.pdf . For commercial payer or State Medicaid inpatient payment, providers need to check their contracts or agreements.*

***Hospital should report a procedure charge for the cell administration whether inpatient at the bedside or outpatient*

Note 1: Do not report unlisted code 38999 for cell collection or cell processing services now that more specific codes are available - see the National Correct Coding Initiative (NCCI) edit manual
Note 2: New revenue codes have been in place since April 1, 2019 for reporting cell collection and cell processing services; see the National Uniform Billing Committee (NUBC) manual: http://www.nubc.org/subscribersonly/PDFs/Cell%20Therapy%20Changes%20August%202018.pdf ; All providers and payers have to use the new codes per the HIPAA transaction code set regulation .

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