2018 Hospital Regulatory Update

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The Hospital Outpatient Prospective Payment System (HOPPS or OPPS) is not intended to be a fee schedule, in which separate payment is made for each coded line item. Instead, the OPPS is currently a prospective payment system that packages some items and services, but not others. CMS' overarching goal is to make payments for all services covered under the OPPS more consistent with those of a prospective payment system and less like those of a per-service fee schedule. CMS estimates that total OPPS payments for CY 2018 (including beneficiary cost-sharing) to the approximately 3,900 facilities paid under the OPPS will increase by approximately $690 million over CY 2017 payments.

In calendar year CY 2018, CMS estimates that outpatient hospital payment rates will increase on average by 1.4 percent, with urban hospitals experiencing a 1.3 percent increase and rural hospitals receiving an average 2.7 percent increase. The CY 2017 conversion factor of $75.001 increases to $78.636 for CY 2018, and CMS will continue the statutory 2.0 percentage point reduction in payments for hospitals that fail to meet the hospital outpatient quality reporting requirements. CMS will also maintain the policy of providing additional payments to the 11 designated cancer hospitals so that the hospital's payment-to-cost ratio, with the adjustment, is equal to the weighted average for the other OPPS hospitals.

Outlier payments will be triggered in CY 2018 when the hospital's cost for furnishing a service exceeds a fixed-dollar threshold of $4,150, combined with the multiple threshold of 1.75 times the APC payment rate.

Critical Access Hospital Supervision

In both the CY 2009 and CY 2010 OPPS final rules with comment period, CMS clarified that direct supervision is required for hospital outpatient therapeutic services covered and paid by Medicare that are furnished in hospitals, Critical Access Hospitals (CAHs), and in provider-based departments (PBDs) of hospitals. Since CY 2011, there has been a suspension on the enforcement of the direct supervision requirement for CAHs and small rural hospitals (less than 100 beds), with the latest freeze on enforcement expiring on Dec. 31, 2016. Stakeholders commented that some small rural hospitals and CAHs have insufficient staff available to furnish direct supervision.

The primary reason stakeholders cited for this difficulty is that CAHs and small rural hospitals have in recruiting physicians and non-physician practitioners to practice in rural areas. These commenters noted that it is particularly difficult to furnish direct supervision for critical specialty services, such as radiation oncology services, that cannot be directly supervised by a hospital emergency department physician or non-physician practitioner because of the volume of emergency patients or lack of specialty expertise.

In the 2018 final rule with comment period, CMS is reinstating the non-enforcement policy for direct supervision of outpatient therapeutic services furnished in CAHs and small rural hospitals for both CY 2018 and CY 2019. The purpose of this non-enforcement policy is to give these CAHs and small rural hospitals additional time to comply with the supervision requirements for outpatient therapeutic services and to give all parties time to submit specific services to be evaluated by the Hospital Outpatient Payment (HOP) Advisory Panel for a recommended change in supervision level.

340B Drug Pricing

The 340B Program, which was established by section 340B of the Public Health Service Act by the Veterans Health Care Act of 1992, is administered by the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS). The 340B Program allows participating hospitals and other healthcare providers to purchase certain "covered outpatient drugs" at discounted prices from drug manufacturers. The statutory intent of the 340B Program is to maximize scarce federal resources as much as possible, reaching more eligible patients and providing care that is more comprehensive.

The Medicare Payment Advisory Commission (MedPAC) examined Medicare Part B spending for chemotherapy drugs and drug administration services at both 340B and non-340B hospitals for a five-year period from 2008 to 2012 and found that "Medicare spending grew faster among hospitals that participated in the 340B Program for all five years than among hospitals that did not participate in the 340B Program at any time during [the study] period." According to CMS, this is just one example of drug spending increases that are correlated with participation in the 340B

Program and calls into question whether Medicare's current policy to pay for separately payable drugs (assigned status indicator "K") at average sales price (ASP)+6 percent is appropriate in view of the discounted rates at which 340B hospitals acquire such drugs.

In addition, the Government Accountability Office (GAO) found that "in both 2008 and 2012, per beneficiary Medicare Part B drug spending, including oncology drug spending, was substantially higher at 340B disproportionate share hospitals than at non-340B hospitals." The GAO believes that this indicates beneficiaries at 340B hospitals were either prescribed more drugs or more expensive drugs than beneficiaries at the non-340B hospitals in GAO's analysis. Based on a study of almost 500 drugs billed in the hospital outpatient setting in 2013, the Office of Inspector General (OIG) found that, for 35 drugs, the "difference between the Part B [payment] amount and the 340B ceiling price was so large that, in at least one quarter of 2013, the beneficiary's coinsurance alone was greater than the amount a covered entity spent to acquire the drug."

It is estimated that covered entities saved $3.8 billion on outpatient drugs purchased through the 340B Program in 2013. In addition, the number of hospitals participating in the program has grown from 583 in 2005, to 1,365 in 2010, and 2,140 in 2014. In its November 2015 report, "Part B Payments for 340B-Purchased Drugs," the OIG found that Part B payments were 58 percent more than 340B ceiling prices, which allowed covered entities to retain approximately $1.3 billion in 2013. Both MedPAC and the OIG have recommended alternative drug payment methodologies for hospitals that participate in the 340B Program. Such changes would allow the Medicare program and Medicare beneficiaries to pay less for drugs when hospitals participating in the 340B Program furnish drugs to Medicare beneficiaries that are purchased under the 340B Program.

For CY 2018 CMS is exercising the Secretary's authority to adjust the applicable payment rate as necessary for separately payable drugs and biologicals (other than drugs on pass-through payment status and vaccines) acquired under the 340B Program from ASP plus 6 percent to ASP minus 22.5 percent. Rural sole community hospitals (SCHs), children's hospitals, and PPS-exempt cancer hospitals are excluded from this payment adjustment in CY 2018. CMS did not propose to adjust payment for 340-acquired drugs in non-excepted off-campus provider-based departments (paid under a non-OPPS reimbursement methodology), but may consider adopting such a policy in CY 2019.

In addition, in this final rule with comment period, CMS established two modifiers to identify whether a drug billed under the OPPS was purchased under the 340B Program—one for hospitals that are subject to the payment reduction and another for hospitals not subject to the payment reduction but that acquire drugs under the 340B Program. CMS will collect information on an ongoing basis on which drugs billed to Medicare were acquired under the 340B Program.

Therefore, pediatric hospitals, cancer hospitals, and SCH hospitals that are excluded from the 340B Program payment reduction will be required to report the following informational modifier for tracking and monitoring purposes: **TB:** Drug or biological acquired with 340B drug pricing program discount, reported for informational purposes.

Effective Jan. 1, 2018, this informational modifier will facilitate collection and tracking of 340B claims data for OPPS providers that are excepted from the payment adjustment in CY 2018; use of this modifier will not trigger a payment adjustment and these providers will continue to receive ASP+6 percent payment for separately payable drugs.

Also effective Jan. 1, 2018, providers who are subject to the 340B payment adjustment will report the following modifier to identify that a drug was acquired under the 340B Program: **JG:** Drug or biological acquired with 340B drug pricing program discount.

The application of the JG modifier will trigger the adjustment for the 340B-acquired drug to be paid at ASP minus 22.5 percent. This Medicare requirement aligns with modifiers already mandated in several states under their Medicaid programs. Therefore, this option should pose less of an administrative burden for providers.

To maintain budget neutrality within the OPPS, the estimated $1.6 billion in reduced drug payments from adoption of this final 340B payment methodology will be redistributed in an equal offsetting amount to all hospitals paid under the OPPS through increasing the payment rates by 3.2 percent for non-drug items and services furnished by all hospitals paid under the OPPS for CY 2018.

Site-of-Service Price Transparency

Section 4011 of the 21st Century Cures Act enacted on Dec.13, 2016, added information to facilitate price transparency with respect to items and services for which payment may be made either to a hospital outpatient department or to an ambulatory surgical center (ASC). For CY 2018 and each subsequent year, HHS will make available to the public via a searchable website the estimated payment amount for many items and services under the OPPS and ASC payment system and the estimated beneficiary liability applicable to the item or service. CMS anticipates that this website will be available in early CY 2018.

Packaged Services

CMS states that packaging is an inherent principle of a prospective payment system. The OPPS, like other prospective payment systems, relies on the concept of averaging, where the payment may be more or less than the estimated costs of providing a service or package of services for a particular patient, but with the exception of outlier cases, is adequate to ensure access to appropriate care. Packaging and bundling

payments for multiple interrelated services into a single payment create incentives for providers to furnish services in the most efficient way by enabling hospitals to manage their resources with maximum flexibility, resulting in long-term cost containment.

In the CY 2015 OPPS final rule, CMS conditionally packaged payment for ancillary services assigned to APCs with a geometric mean cost of less than or equal to $100; these were primarily minor diagnostic tests and procedures frequently performed with a primary service. Conditional packaging means that the services will be separately paid by Medicare when they are the only procedure performed on a date of service. Excluded from this packaging in CY 2015 were certain low-cost drug administration services.

According to CMS, the exclusion of these drug administration services is an example of inconsistent application of their packaging policy. Based on the analysis of CY 2016 claims data, the geometric mean cost for **APC 5691** (Level 1 Drug Administration) is approximately $37 and the geometric mean cost for **APC 5692** (Level 2 Drug Administration) is approximately $59. In addition, Medicare data show that these drug administration services are generally provided as part of another separately payable service, which meets the intent of the ancillary services conditional packaging policy.

Last, CMS believes that conditional packaging of these drug administration services will promote equitable payment between the physician office and the hospital outpatient department. After reviewing the comments submitted, CMS finalized the policy to conditionally package low-cost drug administration services assigned to **APCs 5691** and **5692**, with the exception of add-on codes and preventive services. Tables 2 and 3, page 14, list the drug administration services relating to oncology that will be conditionally packaged (Status Indicator Q1) for CY 2018.

With respect to payment for a conditionally packaged low-cost drug administration service and an unconditionally packaged drug, the drug administration service is separately payable when not billed on the same claim as a HCPCS code with status indicator "S", "T", or "V". Payment for the threshold-packaged drug would be packaged with the payment for the highest paying separately payable procedure reported on the claim. For example, if a threshold-packaged drug, a low-cost drug administration service, and a clinic visit are reported on the same claim, payment for both the drug and drug administration service would be packaged with the clinic visit payment.

In the CY 2014 OPPS final rule, CMS finalized a policy to unconditionally package procedures described by add-on codes. However, in response to stakeholder comments on the appropriateness of packaging drug administration add-on codes, these services were not packaged at that time. CMS did not propose to package drug administration add-on codes for CY 2018, but solicited comments on this policy in the proposed rule. Many commenters raised concerns about the appropriateness of packaging drug administration add-on codes, given the variation in clinical treatment protocols. The commenters believed that packaging drug administration service add-on codes could create a barrier to access for drugs and biologicals with a long infusion time. CMS indicated that it appreciated all comments, and would take them into consideration for future rulemaking.

Oncology Comprehensive-APCs

A comprehensive APC, by definition, will provide a single payment that includes the primary service and all adjunct services performed to support the delivery of the primary service. For services that trigger a comprehensive APC payment, the comprehensive APC will treat all individually reported codes on the claim as representing components of the comprehensive service, resulting in a single prospective payment for the comprehensive service. This means that hospitals will continue to report procedure codes for all services performed on one claim submission, regardless of service date, and will receive a single payment for the total service and collect a single beneficiary copayment for the procedure and related services and supplies.

Effective Jan. 1, 2015, CMS implemented **C-APC 5627** (Level 7 Radiation Therapy) for single fraction stereotactic radiosurgery (SRS, procedure codes **77371** and **77372**). For CY 2018, CMS will continue to make separate payments for the 10 planning and preparation services adjunctive to the delivery of the SRS treatment using either the Cobalt-60-based or LINAC-based technology when furnished to a beneficiary within 30 days of the SRS treatment.

CMS also performed data collection through the use of modifier "CP" (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification [C-APC] procedure, but reported on a different claim) and identified some additional services that are adjunctive to the primary SRS treatment and reported on a different claim submission. CMS stated that the "CP" modifier was actually used by only a small number providers, in spite of the mandatory requirement for its application. The data collection period for SRS claims with modifier "CP" will conclude on Dec. 31, 2017. Accordingly, CMS is deleting this modifier for CY 2018 and discontinuing its required use. CMS will continue to analyze the CY 2016 and CY 2017 data, and will consider whether or not to repackage all adjunctive services into the cranial SRS C-APC.

In the CY 2017 OPPS final rule, CMS finalized 25 new C-APCs. Some of the HCPCS codes assigned to these C-APCs described surgical procedures for inserting brachytherapy catheters or needles, and other related brachytherapy procedures such as the insertion of tandem and/or ovoids or Heyman capsules. In this prior final rule, CMS noted that public comments were received indicating that some claims for brachyther-

apy insertion did not also include a brachytherapy treatment delivery code. The brachytherapy insertion codes with concerns included:

- **20555:** Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application.
- **31643:** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application.
- **41019:** Placement of needles, catheters or other devices into head and/or neck region for subsequent interstitial radioelement application.
- **43241:** Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube catheter.
- **55920:** Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application.
- **57155:** Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy.
- **58346:** Insertion of Heyman capsules for clinical brachytherapy.

CMS analyzed claims that included brachytherapy insertion codes assigned to this group and determined that several of these codes are frequently billed without an associated brachytherapy treatment code. Although CMS proposed to establish a code edit that requires that a brachytherapy treatment code with a brachytherapy insertion code is billed, in this final rule the agency decided not to implement this edit. However, CMS reminded hospitals to bill all HCPCS codes accurately in accordance with their code descriptors and CPT and CMS instructions, as applicable. CMS added that it will continue to examine the issues involving rate setting for brachytherapy insertion procedures assigned to C-APCs.

CMS is also finalizing its proposal to delete composite **APC 8001** (LDR Prostate Brachytherapy Composite), assign HCPCS code **55875** (Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy) to status indicator "**J1**" and to provide payment for this procedure through the C-APC methodology. This means that when code **55875** is the primary service reported on a hospital outpatient claim, payment for all adjunctive services reported on that claim will be packaged into the primary service.

In CY 2017, CMS finalized C-APC **5244** (Level 4 Blood Product Exchange and Related Services) for allogeneic hematopoietic stem cell transplantation. As provided in the Medicare Claims Processing Manual, donor acquisition charges for allogeneic HSCT include charges for the costs of several services. These services include, but are not necessarily limited to, National Marrow Donor Program fees, tissue typing of donor and recipient, donor evaluation, physician pre-procedure donor evaluation services, costs associated with the collection procedure (for example, general routine and special care services, procedure/operating room and other ancillary services, apheresis services, among others), post-operative/post-procedure evaluation of donor, and the preparation and processing of stem cells.

When the allogeneic stem cell transplant occurs in the hospital outpatient setting, providers are instructed to report stem cell donor acquisition charges for allogeneic HSCT separately in Field 42 on Form CMS-1450 (or UB-04) by using revenue code **0815** (Organ Acquisition: Other Donor). Revenue code **0815** charges should include all services required to acquire hematopoietic stem cells from a donor, as defined earlier, and should be reported on the same date of service as the transplant procedure in order to be appropriately packaged for payment purposes.

HCPCS code **38205** describes blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic; a donor acquisition cost for an HSCT. In order to be consistent with other donor acquisition costs and ensure that the costs for allogeneic HSCT are captured accurately, CMS will change the status of procedure code **38205** from "**B**" (OPPS non-allowed service) to "**S**" (Significant procedure not subject to multiple procedure discounting) and assign this code to APC **5242** (Level 2 Blood Product Exchange and Related Services).

Pass-Through Drug & Biological Payments

Section 1833 of the Social Security Act permits CMS to make pass-through payments for a period of at least two, but not more than three years after the product's first payment as a hospital outpatient service under Medicare Part B. The longstanding practice has been to provide pass-through payment for a period of two to three years, with expiration of pass-through status proposed and finalized through the annual rulemaking process. Beginning in CY 2017, pass-through status expired on a quarterly basis so that the biological will receive pass-through status for as close to three full years as possible. Table 4, page 15, lists the drugs and biologicals whose pass-through status will expire on Dec. 31, 2017.

Payment for drugs and biologicals with pass-through status under the OPPS in CY 2018 will be made at the rate of ASP+6 percent. However, hospitals will actually receive no extra payment for most of these pass-through drugs because they would receive the difference between the regular OPPS drug payment and the pass-through payment. At this time, both of these payment amounts are ASP+6 percent, so the difference is $0. Hospitals will receive payment for pass-through drugs that are classified as "policy-packaged," such as diagnostic radiopharmaceuticals, contrast agents, and anesthesia drugs, since the regular OPPS drug payment for these biologicals is $0. Table 5, page 15, lists drugs and biologicals with pass-through status in CY 2018.

Drugs and therapeutic radiopharmaceuticals without pass-through status are paid separately only if the average per diem cost is greater than that year's packaging threshold. For CY 2018, the threshold is $120,

up from $110 in CY 2017. CMS adds that packaging costs into a single aggregate payment for a service, procedure or episode-of-care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. CMS is also continuing its policy of making a single packaging decision for all dosages of a drug that is available in multiple dosages that have separate HCPCS codes.

Last, CMS finalized a policy in the CY 2018 Medicare Physician Fee Schedule (PFS) final rule to implement separate HCPCS codes for biosimilar biological products. After considering public comments, CMS stated that all biosimilar biological products will be eligible for pass-through payment and not just the first biosimilar for a reference product.

Blood and Blood Products

In the CY 2018 OPPS final rule, CMS finalized the proposal to establish payment rates for blood and blood products using the current blood-specific cost-to-charge ratio (CCR) methodology. CMS also finalized its proposal for reporting pathogen-reduced platelets and rapid bacterial testing for platelets. Essentially, the changes involve replacing the temporary HCPCS Q codes with permanent HCPCS Level II codes. Specifically, **Q9987:** Pathogen(s) test for platelets will be replaced with **P9100:** Pathogen(s) test for platelets and **Q9988:** Platelets, pheresis, pathogen-reduced, each unit will be replaced with **P9073:** Platelets, pheresis, pathogen-reduced, each unit.

In addition, HCPCS code **P9072** (Platelets, pheresis, pathogen-reduced or rapid bacterial tested, each unit) is deleted effective Dec. 31, 2017.

Brachytherapy Sources

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires CMS to continue to separate payment for brachytherapy sources. These sources are reimbursed on a prospective basis, with 2018 payment rates set using the 2016 geometric mean unit costs for each source. For CY 2018, CMS assigned status indicator "**U**" (Brachytherapy sources, paid under OPPS; separate APC payment) to HCPCS codes **C2636** (Brachytherapy, linear, non-stranded, palladium-103, per 1 mm), and **C2645** (Brachytherapy planar, palladium-103, per square millimeter).

Other Provisions

In addition to the major provisions listed above, the 2018 OPPS final rule addresses the Ambulatory Surgical Center (ASC) payment update, the hospital value-based purchasing program, the hospital outpatient quality reporting (OQR) program, reimbursement for diagnostic imaging for specific services, and New Technology APC groups. Refer to the PFS summary, pages 17–23, for information on Appropriate Use Criteria (AUC) for advanced diagnostic imaging services.

Table 2. APC 5691—Level 1 Drug Administration Services Packaged in CY 2018

CODE	DESCRIPTOR	SI
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection	Q1
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	Q1
96549	Unlisted chemotherapy procedure	Q1

Table 3. APC 5692—Level 2 Drug Administration Services Packaged in CY 2018

CODE	SHORT DESCRIPTOR	SI
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	Q1
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	Q1
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal antineoplastic	Q1
96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal antineoplastic	Q1
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	Q1

Table 4. Drugs and Biologicals for Which Pass-Through Status Will Expire Dec. 31, 2017

CY 2018 HCPCS CODE	CY 2018 LONG DESCRIPTOR	FINAL CY 2018 SI	FINAL CY 2018 APC
A9586	Florbetapir fl8, diagnostic, per study dose, up to 10 mci	N	N/A
C9447	Injection, phenylephrine and ketorolac, 4 ml vial	N	N/A
J0596	Injection, c-1 esterase inhibitor (human), Ruconest, 10 units	K	9445
J0695	Injection, ceftolozane 50 mg and tazobactam 25 mg.	K	9452
J0875	Injection, dalbavancin, 5 mg.	K	1823
J1833	Injection, isavuconazonium sulfate, 1 mg.	K	9456
J2407	Injection, oritavancin, 10 mg.	K	1660
J2502	Injection, pasireotide long acting, 1 mg.	K	9454
J2547	Injection, peramivir, 1 mg.	K	9451
J2860	Injection, siltuximab, 10 mg.	K	9455
J3090	Injection, tedizolid phosphate, 1 mg.	K	1662
J7313	Injection, fluocinolone acetonide intravitreal implant, 0.01 mg.	K	9450
J8655	Netupitant (300 mg) and palonosetron (0.5.mg.)	K	9448
J9032	Injection, belinostat, 10 mg.	K	1658
J9039	Injection, blinatumomab, 1 mcg.	K	9449
J9271	Injection, pembrolizumab, 1 mg.	K	1490
J9299	Injection, nivolumab, 1 mg.	K	9453
Q4172	PluraPly, & PluraPly Antimicrobial, any type, per sq cm.	N	N/A
Q9950	Injection, sulfur hexafluoride lipid microsphere, per ml.	N	N/A

Table 5. Drugs and Biologicals With Pass-Through Status in CY 2018

CY 2017 HCPCS CODE	CY 2018 HCPCS CODE	CY 2018 LONG DESCRIPTOR	CY 2018 SI	CY 2018 APC
A9515	**A9515**	Choline C 11, diagnostic, per study dose	G	9461
A9587	**A9587**	Gallium ga-68, dotatate, diagnostic, 0.1 mci	G	9056
A9588	**A9588**	Fluciclovine f-18, diagnostic, 1 mci	G	9052
C9140	**J7210**	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), I IU	G	9043
C9460	**C9460**	Injection, cangrelor, 1 mg.	G	9460
C9482	**C9482**	Injection, sotalol hydrochloride, 1 mg.	G	9482
C9483	**J9022**	Injection, atezolizumab, 10 mg.	G	9483
C9484	**J1428**	Injection, eteplirsen, 10 mg.	G	9484
C9485	**J9285**	Injection, olaratumab, 10 mg.	G	9485
C9486	**J1627**	Injection, granisetron extended release, 0.1 mg.	G	9486
C9488	**C9488**	Injection, conivaptan hydrochloride, 1 mg.	G	9488
C9489	**J2326**	Injection, nusinersen, 0.1 mg.	G	9489

(Table 5 continued on page 16)

(continued from page 15)

Table 5. Drugs and Biologicals With Pass-Through Status in CY 2018

CY 2017 HCPCS CODE	CY 2018 HCPCS CODE	CY 2018 LONG DESCRIPTOR	CY 2018 SI	CY 2018 APC
C9490	**J0565**	Injection, bezlotoxumab, 10 mg.	G	9490
C9491	**J9023**	Injection, avelumab, 10 mg.	G	9491
C9492	**C9492**	Injection, durvalumab, 10 mg.	G	9492
C9493	**C9493**	Injection, edaravone, 1 mg.	G	9493
C9494	**J2350**	Injection, ocrelizumab, 1 mg.	G	9494
J0570	**J0570**	Buprenorphine implant, 74.2 mg.	G	9058
J1942	**J1942**	Injection, aripiprazole lauroxil, 1 mg.	G	9470
J2182	**J2182**	Injection, mepolizumab, 1 mg.	G	9473
J2786	**J2786**	Injection, reslizumab, 1 mg.	G	9481
J2840	**J2840**	Injection, sebelipase alfa, 1 mg.	G	9478
J7179	**J7179**	Injection, von Willebrand factor (recombinant), (Vonvendi), 1 IU vwf:rco	G	9059
J7202	**J7202**	Injection, Factor IX, albumin fusion protein (recombinant), Idelvion, 1 IU	G	9171
J7207	**J7207**	Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 IU	G	1844
J7209	**J7209**	Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), per IU	G	1846
J7322	**J7322**	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg.	G	9471
J7328	**J7328**	Hyaluronan or derivative, Gelsyn-3, for intra-articular injection, 0.1 mg.	G	1862
J7342	**J7342**	Instillation, ciprofloxacin otic suspension, 6 mg.	G	9479
J7503	**J7503**	Tacrolimus, extended release, (Envarsus xr), oral, 0.25 mg.	G	1845
J9034	**J9034**	Injection, bendamustine HCl (Bendeka), 1 mg.	G	1861
J9145	**J9145**	Injection, daratumumab, 10 mg.	G	9476
J9176	**J9176**	Injection, elotuzumab, 1 mg.	G	9477
J9205	**J9205**	Injection, irinotecan liposome, 1 mg.	G	9474
J9295	**J9295**	Injection, necitumumab, 1 mg.	G	9475
J9325	**J9325**	Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)	G	9472
J9352	**J9352**	Injection, trabectedin, 0.1 mg.	G	9480
N/A	**J9203**	Injection, gemtuzumab ozogamicin, 0.1 mg.	G	9495
Q5101	**Q5101**	Injection, filgrastim (G-CSF), biosimilar, 1 microgram	G	1822
Q5102	**Q5102**	Injection, infliximab, biosimilar, 10 mg.	G	1847
Q9982	**Q9982**	Flutemetamol F18, diagnostic, per study dose, up to 5 mci	G	9459
Q9983	**Q9983**	Florbetaben F18, diagnostic, per study dose, up to 8.1 mci	G	9458
Q9989	**J3358**	Ustekinumab, for intravenous injection, 1 mg.	G	9487
N/A	**C9014**	Injection, cerliponase alfa, 1 mg.	G	9014
N/A	**C9015**	Injection, c-1 esterase inhibitor (human), Haegarda, 10 units	G	9015
N/A	**C9016**	Injection, triptorelin extended release, 3.75 mg.	G	9016
N/A	**C9024**	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	G	9302
N/A	**C9028**	Injection, inotuzumab ozogamicin, 0.1 mg.	G	9028
N/A	**C9029**	Injection, guselkumab, 1 mg.	G	9029
N/A	**J7345**	Aminolevulinic acid HCl for topical administration, 10% gel, 10 mg.	G	9301