

Coding Options for CAR-T Therapy Services - Updated as of March 18, 2026

	Inpatient Claim - Facility Reporting and Payment Implications <sup>1</sup>			Outpatient Claim - Facility Reporting and Payment Implications				Physician Claim / Facility Place of Service (POS) - Professional Services Reporting and Payment Implications		
	Revenue Codes for Charges <sup>2</sup>	ICD-10-PCS Codes	Description	Revenue Codes for Charges <sup>2</sup>	CPT/HCPCS Codes	Description	Payment Implications	CPT/HCPCS Codes	Description	Payment Implications
Coding Options for Reporting Administration of Autologous CAR-T	874	XW033C7 or XW043C7	Introduction of Autologous Engineered Chimeric Antigen Receptor T-cell Immunotherapy into Peripheral Vein (or Central), Percutaneous Approach, New Technology Group 7  (Used for an autologous CAR-T product, such as those currently under trial, where there is no product-specific ICD-10-PCS code to describe the product)	874	38228 (Effective 1/1/2025) <sup>3</sup>	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	Medicare OPPS Status Indicator (SI) = "S" ("significant procedure") which signifies separate APC payment; the code is assigned to APC 5694 - Level 4 Drug Administration.  For Commercial and Medicaid plans, reference individual payer policies and contracts to determine payment.	38228 (Effective 1/1/2025) <sup>3</sup>	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	Assigned status code "A" in the Medicare PFS, meaning the service receives separate payment and is assigned Relative Value Units (RVUs). <sup>5</sup>  For Commercial and Medicaid plans, reference individual payer policies and contracts to determine payment.
		XW033J7 or XW043J7	Introduction of Tisagenlecleucel Immunotherapy into Peripheral Vein (or Central), Percutaneous Approach, New Technology Group 7							
		XW033H7 or XW043H7	Introduction of Axicabtagene Ciloleucel Immunotherapy into Peripheral Vein (or Central), Percutaneous Approach, New Technology Group 7							
		XW033M7 or XW043M7	Introduction of Brexucabtagene Autoleucel Immunotherapy into Peripheral Vein (or Central), Percutaneous Approach, New Technology Group 7							
		XW033N7 or XW043N7	Introduction of Lisocabtagene Maraleucel Immunotherapy into Peripheral Vein (or Central), Percutaneous Approach, New Technology Group 7							
		XW033K7 or XW043K7	Introduction of Idecabtagene Vicleucel Immunotherapy into Peripheral Vein (or Central), Percutaneous Approach, New Technology Group 7							
		XW033A7 or XW043A7	Introduction of Ciltacabtagene Autoleucel into Peripheral Vein (or Central), Percutaneous Approach, New Technology Group 7							
		XW0338A or XW0438A	Introduction of Obecabtagene Autoleucel into Peripheral Vein (or Central), Percutaneous Approach, New Technology Group 10							
Coding Options for Reporting Administration of Allogeneic CAR-T		XW033G7 or XW043G7	Introduction of Allogeneic Engineered Chimeric Antigen Receptor T-cell Immunotherapy into Peripheral Vein (or Central), Percutaneous Approach, New Technology Group 7		Recommended:  38999 <sup>4</sup>	Unlisted procedure, hemic or lymphatic system	Medicare typically assigns unlisted codes to the lowest-paying APC within the applicable APC range.  All payers and providers must comply with HIPAA-mandated code sets and guidelines, including AMA CPT® codes and instructions. Because CPT code 38999 is a non-specific (unlisted) code, other payers may require additional documentation or supporting information. Providers should refer to their payer contracts for specific requirements.	Recommended:  38999 <sup>4</sup>	Unlisted procedure, hemic or lymphatic system	CPT code 38999 does not have a nationally assigned RVU under the MPFS. Payment is determined by the MAC on a case-by-case basis and typically requires supporting documentation describing the service rendered. As an unlisted code, additional documentation may also be required by other payers; providers should refer to payer-specific requirements.

<sup>1</sup> MS-DRG 018 is assigned for inpatient CAR T-cell therapy administration when an applicable ICD-10-PCS procedure code is reported. CMS may apply a payment adjustment in certain circumstances, including cases involving clinical trials (e.g., ICD-10-CM diagnosis code Z00.6) or expanded access use. For situations involving expanded access, providers should report condition code 90. For cases where a CAR T-cell product is purchased in the usual manner but the admission involves a clinical trial of a different product, additional claim notation may be required. See the Coding Options for Reporting CAR-T Products Grid and CMS guidance for complete reporting requirements and payment adjustment details.

<sup>2</sup> Hospital should report a procedure charge for the cell administration whether inpatient or outpatient.

**Note:** 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: <https://www.nubc.org/system/files/media/file/2020/02/CeGene%20Therapy%20Code%20Changes.pdf>; all providers and payers have to use these codes per the HIPAA transaction code set regulation

<sup>3</sup> On December 9, 2025, CMS issued a formal transmittal titled, "Removal of Chimeric Antigen Receptor (CAR) T-cell Therapy and Risk Evaluation Mitigation Strategy (REMS) – NCD 110.24 and the "KX" Modifier for CAR-T Cell Therapy Claims" (<https://www.cms.gov/files/document/113432cp.pdf>). This transmittal had an effective date of June 26, 2025, and an implementation date of February 6, 2026. The transmittal instructs MACs to discontinue the REMS and KX modifier requirements. Part B MACs shall no longer require modifier-KX to be appended to claims for CAR T-cell therapies. Part A MACs shall no longer require CAR T-cell therapy services to be submitted by or performed in an FDA REMS approved facility. Claims with dates of service on or after June 27, 2025, and prior to the February 6, 2026 implementation date may be appealed.

<sup>4</sup> Since there is no specific CPT code for allogeneic CAR-T administration, per AMA/CPT guidance, do not select a CPT code that merely approximates the service provided. If there are no codes that accurately identify the service being provided, report the service using the approximate unlisted procedure or service code. See Introduction section, "Instructions for the Use of the CPT Codebook", in American Medical Association (AMA). CPT® 2026 Professional Edition. Chicago, IL: American Medical Association.

<sup>5</sup> See the MPFS (Medicare Physician Fee Schedule) status code descriptions for additional details on status code "A" (<https://www.cms.gov/status-indicators>)

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