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Reimbursement Policy

Home Infusion Therapy

Policy Number: SCO 4.121
Version Number: 2
Version Effective Date: 01/01/2022

Product Applicability	☐ **All Plan⁺ Products**
Well Sense Health Plan ☐ Well Sense Health Plan	**Boston Medical Center HealthNet Plan** ☐ MassHealth MCO ☐ MassHealth ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Non-Medicare Certified Home Infusion Providers

This policy only applies to Medicare Certified Home Infusion Therapy (HIT) suppliers. For Home Infusion Therapy providers that are NOT Medicare-Certified, please refer to MassHealth's home infusion billing guidelines.

Non-Home Infused Parenteral and Enteral Drugs

For providers dispensing parenteral and enteral products not identified as home infusion drug, please refer to MassHealth's home infusion billing guidelines.

⁺ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Definitions

Home Infusion Drug: A parenteral drug or biological administered intravenously or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment. Such term does not include insulin pump systems or self-administered drugs or biologicals on a self-administered drug exclusion list.

Infusion drug administration calendar day: The day on which HIT services are furnished by skilled professional(s) in the individual's home on the day of infusion drug administration. The skilled services provided on such day must be so inherently complex that they can only be safely and effectively performed by, or under the supervision of, professional or technical personnel.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.bmchp.org.

Provider Reimbursement

Effective January 1, 2021 a separate payment for Home Infusion Therapy (HIT) professional services will be made to Medicare certified home infusion suppliers. The HIT services are professional services, including nursing services, furnished in accordance with the plan of care, patient training and education, remote monitoring, and monitoring services for the provision of home infusion drugs furnished by a qualified HIT supplier.

Professional Services

The Plan will reimburse providers a single payment amount for professional services furnished for each infusion drug administration calendar day. The payment amount for the professional service is dependent upon the payment category of the drug infused on the drug administration calendar day. The "per day" professional service will be paid at an amount under the Medicare Physician Fee Schedule (MPFS) for each infusion drug administration calendar day in the individual's home for drugs assigned to such category.

Providers and suppliers will be reimbursed a single payment amount per administration day. Suppliers should report visit length in 15-minute increments (15 minutes = 1 unit). In the event that multiple drugs, which are not all assigned to the same payment category, are administered on the same infusion drug administration calendar day, a single payment would be made that is equal to the highest payment category. Suppliers must only bill for one visit and should report the highest paying visit with the applicable drug. The Plan will only pay for one of the professional codes listed per line item date of service.

Home infusion therapy suppliers shall use the specific code to differentiate the first visit from all subsequent visits. Home infusion therapy suppliers may only bill the first visit code to indicate an initial visit for a new member or for a member who had previously received their last home infusion therapy

service visit more than 60 days prior to the new initial home infusion therapy service visit. If an initial home infusion therapy codes is reported within 60-days prior to the date of service for an initial visit, then the initial visit claim will be denied.

Home Infusion Drugs

Home infusion drugs are assigned to three payment categories, as determined by the HCPCS J-code:

- Payment category 1 includes certain intravenous antifungals and antivirals, uninterrupted long-term infusions, pain management, inotropic, chelation drugs.
- Payment category 2 includes subcutaneous immunotherapy and other certain subcutaneous infusion drugs.
- Payment category 3 includes certain chemotherapy drugs and other certain highly complex intravenous drugs.

The Plan will reimburse home infusion drugs in the 3 categories based upon the Medicare allowable amount of average sales price plus 6%.

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Claim Type

All Home Infusion professional services and drug codes must be submitted on the same 837P/CMS-1500 claim form. Providers shall not submit for these services on an 837I/UB-04 claim form. If Home Health Agencies are also certified as a Medicare HIT supplier, they must submit two separate claims – an 837I/UB-04 claim for home health services and 837P/CMS-1500 for home infusion therapy professional services and infusion drugs.

Professional Services Coding

Code	Description	Comments
G0068	Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes	Report with Category 1 drug; subsequent visit
G0069	Professional services for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes	Report with Category 2 drug; subsequent visit

Code	Description	Comments
G0070	Professional services for the administration of intravenous chemotherapy or other intravenous highly complex drug or biological infusion for each infusion drug administration calendar day in the individual's home, each 15 minutes.	Report with Category 3 drug; subsequent visit
G0088	Professional services, initial visit, for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes	Report with Category 1 drug; initial visit
G0089	Professional services, initial visit, for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes.	Report with Category 2 drug; initial visit
G0090	Professional services, initial visit, for the administration of intravenous chemotherapy or other highly complex infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes.	Report with Category 3 drug; initial visit

Home Infusion Drugs Coding

Category 1	
J-Code	**Description**
J0133	Injection, acyclovir, 5 mg
J0285	Injection, amphotericin b, 50 mg
J0287	Injection, amphotericin b lipid complex, 10 mg
J0288	Injection, amphotericin b cholesteryl sulfate complex, 10 mg
J0289	Injection, amphotericin b liposome, 10 mg
J0895	Injection, deferoxamine mesylate, 500 mg
J1170	Injection, hydromorphone, up to 4 mg
J1250	Injection, dobutamine hydrochloride, per 250 mg
J1265	Injection, dopamine hcl, 40 mg
J1325	Injection, epoprostenol, 0.5 mg
J1455	Injection, foscarnet sodium, per 1000 mg
J1457	Injection, gallium nitrate, 1 mg
J1570	Injection, ganciclovir sodium, 500 mg
J2175	Injection, meperidine hydrochloride, per 100 mg
J2260	Injection, milrinone lactate, 5 mg
J2270	Injection, morphine sulfate, up to 10 mg
J3010	Injection, fentanyl citrate, 0.1 mg

J3285	Injection, treprostinil, 1 mg
Category 2	
J-Code	**Description**
J1555 JB	Injection, immune globulin (cuvitru), 100 mg
J1558 JB	Injection, immune globulin (xembify), 100mg
J1559 JB	Injection, immune globulin (hizentra), 100mg
J1561 JB	Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g. liquid), 500 mg
J1562 JB	Injection, immune globulin (vivaglobin), 100 mg
J1569 JB	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg
J1575 JB	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin
J7799 JB	This NOC code may be used to identify the subcutaneous immune globulin (cutaquig)
Category 3	
J-Code	**Description**
J9000	Injection, doxorubicin hydrochloride, 10 mg
J9039	Injection, blinatumomab, 1 microgram
J9040	Injection, bleomycin sulfate, 15 units
J9065	Injection, cladribine, per 1 mg
J9100	Injection, cytarabine, 100 mg
J9190	Injection, fluorouracil, 500 mg
J9360	Injection, vinblastine sulfate, 1 mg
J9370	Injection, vincristine sulfate, 1 mg
J7799	Not otherwise classified drugs, other than inhalation drugs, administered through DME

Professional Time Units Coding

Unit	Time
1	<23 minutes
2	= 23 minutes to <38 minutes
3	= 38 minutes to <53 minutes
4	= 53 minutes to <68 minutes
5	= 68 minutes to <83 minutes
6	= 83 minutes to <98 minutes
7	= 98 minutes to <113 minutes
8	= 113 minutes to <128 minutes
9	= 128 minutes to <143 minutes
10	= 143 minutes to <158 minutes

Taxonomy

The Plan requires providers to submit the Medicare approved taxonomy in field locator 81 for paper claims, or the electronic equivalent. Claims submitted without the taxonomy code will be denied.

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/15/2020	01/01/2021	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/14/2021	Annual Review	01/01/2022	Payment policy Committee

Other Applicable Policies

- General Billing and Coding Guidelines, SCO 4.31
- Home Health Agency Services: Medicare Certified, SCO 4.71
- Home Health Agency Services: Non-Medicare Certified, SCO 4.6

References

- Medicare Claims Processing Manual Chapter 32 – Billing Requirements for Special Services
- Medicare Benefit Manual Chapter 15, Section 320 -
- Medicare Claims Processing Manual 100-04, Chapter 10 Home Health Agency Billing
- CMS-1730-F: CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Requirements
- Local Coverage Determination (LCD): External Infusion Pumps (L33794)
- Medicare Learning Network Matters: MM11880

Disclaimer Information

This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.

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