Reimbursement Policy

Infusion/Parenteral/Tube Fed Enteral Nutritional Therapy

Policy Number: 4.121
Version Number: 5
Version Effective Date: 12/02/2013

Product Applicability

- [ ] All Plan+ Products

Well Sense Health Plan
- [ ] New Hampshire Medicaid
- [ ] NH Health Protection Program

Boston Medical Center HealthNet Plan
- [x] MassHealth
- [x] 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.

Prior-Authorization

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

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**Provider Reimbursement**

Payment to a provider for the purchase or rental of infusion, tube fed enteral or parenteral equipment, and the purchase of related supplies will be based on the terms of this policy.

**Pricing for Infusion, Tube Fed Enteral and Parenteral Equipment and Supplies with No Established Fee Schedule**

Where no rate exists for a specific item, the Plan will reimburse according to the acquisition price paid by the provider, as evidenced by an invoice.

**Tube Fed Enteral Nutrition Billing and Coding Guidelines**

The Plan has established the following policies with respect to tube fed enteral nutritional therapy.

**Tube Fed Enteral Nutrition Units of Measure**

The Plan reimburses providers for tube fed enteral nutrition solutions based on the units administered.

- Enterals will be reimbursed according to the number of calories dispensed, such that 1 unit = 100 calories.
- Food thickeners will be reimbursed based on the number of ounces dispensed, where 1 unit = 1 ounce.

Please see the CMS Enteral Nutrition Product Classification Listing that identifies name-brand enteral available by HCPCS code. Billing for enteral nutrition products using a code not listed, or using a code that is not identified as applicable to a given name brand will result in claim denial.

**Supplies Included in the Initial Setup of Tube Fed Enteral Home Therapy Systems**

Payment for the first monthly rental of enteral and parenteral pumps (B9000 – B9006) includes tubing (B4081- B4082) and any disposable supply necessary for the system to function properly. These items may be billed separately after the initial setup, as long as the provider is not also billing a per diem.

**Tube Fed Enteral Supply Kit Coding**

Enteral supply kits (B4034-B4036) include all necessary disposable supplies except tubing. The minimal items included in an enteral supply kit include a container, tape, gloves, and a flushing syringe. After initial setup, a provider may bill both the supply kits and tubing separately, as long as the provider is not billing a home therapy per diem code. The following rules also apply to the payment of enteral supply kits:

- Payment will only be made for one type of enteral supply kit per day (i.e., a pump kit cannot be billed with a gravity kit on the same day).
- The supply kit code billed to the Plan must match the method of administration authorized.
• Catheter/tube anchoring devices (A5200) are included in the supply kit and will not be billed separately.
• Syringes (example: A4206-A4209, A4213) are included in the supply kit and will not be paid separately.
• Dressings used in conjunction with a gastrostomy or enterostomy tube are included in the supply kit (B4034-B4036) and will not be paid separately.
• Supply kits cannot be billed separately when a home infusion per diem is also billed.

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**Parenteral/ Total Parenteral Nutrition (TPN) Billing and Coding Guidelines**

The Plan has established the following policies with respect to parenteral nutrition. Providers must adhere to these policies for proper payment.

**TPN Solution Components Included in the Per Diem Reimbursement**

Payment for several components of TPN formula is included in the home infusion per diem specifically identified by volume of fluid (HCPCS codes S9364 through S9368 represent per diem for TPN by liter provided). The items included in these per diem codes include, but may not be limited to:

- Non-specialty amino acids (e.g., Aminosyn, FreAmine, Travasol)
- Concentrated dextrose (e.g., D10, D20, D40, D50, D60, D70);
- Sterile water
- Electrolytes (e.g., CaCl2, KCL, KPO4, MgSo4, NaAc, NaCl, NaPO4)
- Standard multi-trace element solutions (e.g., MTE4, MTE5, MTE7)
- Standard multivitamin solutions (e.g., MVI-13)

**Separately Billable TPN Solution Components**

Not included in the TPN per diem are the following items that require separate coding to be reimbursed by the Plan:

- Specialty amino acids for renal failure (e.g., Aminess, Aminosyn-RF, NephrAmine, RenAmin)
- Specialty amino acids for hepatic failure (e.g., HepatAmine)
- Specialty amino acids for high stress conditions (e.g., Aminosyn-HBC, BranchAmin, FreAmine HBC, Trophamine)
- Specialty amino acids with concentrations of 15% and above when medically necessary for fluid restricted members (e.g., Aminosyn 15%, Novamine 15%, Clinisol 15%). If specialty amino acids are not medically necessary for the member’s condition but are standard protocol, they are not separately billable but part of the TPN per diem.
- Lipids (e.g., Intralipid, Liposyn)
- Added trace elements not from a standard multi-trace element solution (e.g., chromium, copper, iodine, manganese, selenium, zinc)
• Added vitamins not from a standard multivitamin solution (e.g., folic acid, vitamin C, vitamin K)
• Products serving non-nutritional purposes (e.g., heparin, insulin, iron dextran, Pepcid, Sandostatin, Zofran)

While extensive, the above list is not all-inclusive. In general, any component used to accomplish the same results, or that serve the same function as one listed above, will be paid in the same manner.

Coding Rules for TPN Solutions when Billed as a Single or Multiple Solution
As a general billing rule, providers are required to use compounded solutions for TPN services, unless other medical conditions require the use of a non-compounded solution. Compounded and non-compounded solutions should not be billed separately from a per diem unless only a portion of the supplies included in the per diem is required. When this situation arises, the individual parenteral solutions may be billed separately, subject to the following payment rules:

• When administering non-compounded solutions, carbohydrates and amino acids may not be billed separately for the same date of service, (e.g., B4164 -- parenteral solution, carbohydrates – cannot be billed with B4178 -- parenteral solution, amino acid – for the same date of service). However, lipids and some parenteral additives (specialty vitamins, trace elements, heparin, electrolytes, etc) may be billed in addition to a base solution. Lipids and additives should be billed using an appropriate J or Q HCPCS code.
• When administering the compounded solutions identified below, providers may not bill for additives (such as B4216-parenteral additives) since compounded solutions are meant to include all necessary components.

Compounded Solutions:
  o B4189, B4193, B4197, and B4199-- Parenteral solution, compounded amino acid/carbohydrates with electrolytes, trace elements and vitamins, premixed – 10 to 100+ grams of protein.
  o B5000 to B5200 –Parenteral solution, compounded amino acid/carbohydrates with electrolytes, trace elements and vitamins, renal, hepatic, or stress premixed.
  o Different compounded solutions can be billed together when more than one therapy is being administered together or consecutively. In unusual circumstances, a provider will be granted authorization to administer a compounded and non-compounded solution on the same date of service, but approval must be supported by medical necessity.

Home Infusion Billing and Coding Requirements
The Plan has established the following policies with respect to home infusion services, equipment and supplies. Providers must adhere to these policies for proper payment.

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Payment for Infusion Pumps
The Plan’s rental and purchase fees for general infusion pumps – codes E0779 through E0786 – include payment for an IV pole. As such, IV poles should not be billed separately. However, an IV pole may be billed separately with a parenteral infusion pump (code E0791) as long as the provider is not billing a home infusion therapy per diem.

Payment for Infusion Pump Supplies
In addition to the fee for general infusion pumps, providers may bill separately for catheter supply kits (A4221, A4222) after the initial setup of the equipment, as long as the provider is not billing with a home infusion per diem code.

Multiple-Same Day Therapy Billing
Under certain circumstances, multiple infusion therapies will be provided in a single day. When this occurs, providers must bill the Plan using appropriate modifiers. These modifiers are as follows and will impact payment as indicated.

- SH - Second concurrently administered therapy – reimbursement will be reduced by 50% for any per diem billed with this modifier.
- SJ – Third or more concurrently administered therapy – reimbursement will be reduced by 75% for any per diem billed with this modifier.

Per Diem and Component Billing Criteria
The Plan reimburses providers using either the per diem methodology or the component methodology, but not both unless unusual circumstances exist.

Per Diem Methodology of Payment
All ancillary equipment and supplies are included in the infusion, tube fed enteral and parenteral per diems, including:

- Weekly infusion catheter kits
- Cassettes/bags
- Infusion sets
- Syringes and needles
- Alcohol swabs
- IV poles
- Infusion pump and pump supplies
- Gauze and tape
- Enteral feeding supply kits
- Transparent film
- Enteral buttons and extension sets
- Parenteral and TPN formulas

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When billing the Plan using a per diem methodology, none of the above items may be billed separately.

Items and Services Excluded from the Infusion, Tube Fed Enteral and Parenteral Per Diems
Certain items and services are excluded from the infusion; tube fed enteral and parenteral per diems and may be billed separately, subject to Plan policies. These include:

- Nursing services associated with home enteral nutrition therapy will be paid according to the methodologies established in the Plan’s Home Health Policy.
- All tube fed enteral formulas will be paid separately according to terms stated in this policy.
- Insertion of a catheter for nutrition purposes will be paid as a separate procedure from the per diem and nursing service.
- Medications administered as a component of a tube fed enteral service are paid separately but are only reimbursed through the Plan’s pharmacy benefit. Medications billed as a part of a tube fed enteral service will be denied if billed through the medical benefit.

Additional Items and Services Excluded from the Infusion Per Diem
In addition to the items excluded from the per diem identified above, the following additional items and services may be billed separately from the per diem for home infusion therapy only.

- Injectable medications that are administered, as a part of home infusion, will be paid based on the Plan’s BMC HealthNet Plan Formulary www.bmchp.org
- PICC and midline insertion and associated supplies will be paid according to the methodologies established in the Plan’s Home Health Policy.
- Blood products will be paid separately based on the lower of the provider’s charges, or the Plan fee schedule.

Catheter Care per Diem Payment
The catheter care per diem identified below will only be paid when provided as a stand-alone therapy, or when no other per diem is billed. Catheter care coding specifies maintenance as single or multiple lumen, or for an implanted access device. All supplies necessary for catheter care are included in the payment of the below per diem, and no additional supplies will be paid separately. However, nursing and medications may be reimbursed according to the applicable Plan policy.

- S5498— Home infusion catheter care, simple (single lumen)
- S5501— Home infusion catheter care, complex (more than one lumen)
- S5502— Home infusion catheter care, implanted access device
Catheter Supply per Diem
Catheter supply per diem codes are used to identify all supplies necessary for the insertion or restoration of a catheter. These codes are not payable when billed on the same date of service as a catheter care per diem code. However, it is appropriate for a catheter supply code to be used in combination with catheter insertion procedure coding.

- S5517– Home infusion therapy, all supplies necessary for restoration of catheter patency or declotting supply kit
- S5518– Home infusion therapy, catheter repair
- S5520– Home infusion therapy, PICC line
- S5521– Home infusion therapy; Midline

Catheter Insertion Services
Catheter insertion services may be billed in addition to the home infusion per diem codes. However, a catheter care per diem may not be billed for any day on which a catheter insertion procedure is performed. Valid codes for catheter insertion services are:

- S5523– Midline Insertion

Equipment Rental and Purchase Options
Not all infusion, tube fed enteral or parenteral equipment may be purchased. The Plan utilizes the CMS standards for classifying equipment and payment categories. These categories must be followed for correct payment. When an option to rent or purchase is available, the decision regarding a purchase or rental authorization will be made by the Plan based on member need and duration.

Partial Month Rental Payments
Some items may require rental periods of less than a full month due to the type of equipment needed, or when the member requires the item for a short period of time. The Plan will determine if an item is required for less than 30 days on a case-by-case basis. When it is determined that less than a month is required, the provider must bill the Plan on a daily basis using 1 unit/day and the appropriate modifier (KR). Authorizations for such rentals will be administered according to the number of days an item is needed.

Replacement of Rental Equipment
If damaged or defective equipment is no longer covered by warranty, and repairs are more costly than a replacement, the Plan will allow for replacement but will not reimburse providers more than the cost to rent the original piece of equipment. Rental payments will be made for the remaining period of time authorized.

General Supply Guidelines
Providers must bill the plan for supplies in quantities consistent with the authorization. When supplies are required in quantities at regular intervals over multiple dates of service, the claims should be
submitted such that the “from” and “to” dates are the same, using the authorized number of units and approved code(s) and modifiers. Failure to bill the Plan using the information provided in the authorization will result in claim denial.

**Infusion, Tube Fed Enteral and Parenteral Equipment and Supply Modifiers**
The Plan requires the use of appropriate HCPCS modifiers. Certain items require a modifier for proper payment, such as tube fed enteral formula, inhalation solutions, and equipment that can be rented. Failure to use appropriate modifiers, or use of a modifier not listed, may result in adverse determinations.

**Service Limitations**
The following items and services are not covered benefits.
- Shipping, handling, sales tax, and any insurance costs
- Maintenance and repair for any item that is being rented
- Aids for the blind (Massachusetts Commission for the Blind provides assessment and appliances for people who have been certified as blind by an ophthalmologist)
- Services and items for members in an institutional setting for temporary acute treatment purposes - Items provided to members within a facility setting are not payable unless such items are for home use and are supported by documentation in the member’s discharge records, or the institution serves as the member’s residence

**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.

**Policy History**

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**Policy Revisions History**

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### Policy Revisions History

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<tr>
<td>12/06/2006</td>
<td>Modified to support policy changes for 12/1/2006 and the Commonwealth Care product implementation. Updated CPT/HCPCS coding.</td>
<td>12/06/2006 Payment Policy Committee</td>
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<tr>
<td>10/05/2011</td>
<td>Deleted definitions, applicable plan products, updated coding, removed references to oral enteral nutrition</td>
<td>10/05/2011 Payment Policy Committee</td>
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<tr>
<td>12/02/2013</td>
<td>Updated template, product applicability section, and references for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare</td>
<td>12/02/2013 Payment Policy Committee</td>
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<td>06/01/2017</td>
<td>Policy put in updated template</td>
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### References

- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Evidence of Coverage, Commonwealth Care, Form No. BMCHP-CC-8
- Evidence of Coverage, CommChoice, Form No. BMCHP CCchoice-1
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan
- 114.3 CMR 22.00 - Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment
- 130 CMR 409 – Durable Medical Equipment
- 130 CMR 409 – Durable Medical Equipment Subchapter 6
- Centers for Medicare and Medicaid, Medicare Claims Processing Manual, Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage

### 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

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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.