HOME INFUSION THERAPY FACILITY
APPLICATION FOR PARTICIPATION FOR THE TRADITIONAL PROGRAM

GENERAL INFORMATION

I. BCBSM's Home Infusion Therapy Program

BCBSM's Home Infusion Therapy (HIT) Program provides benefits for eligible members for the administration of a controlled amount of medication, nutrient, or replacement fluid into a vein or other tissue. This therapy can be administered in the home setting with the objective of improving patient satisfaction, recovery time and quality of life.

Note: Enteral services are not included in the HIT benefit design but may be covered under a member's Durable Medical Equipment coverage. Some BCBSM members are required to have enteral services provided by a separate network of DME/P&O providers (e.g., SUPPORT).

Traditional

Participation with Blue Cross Blue Shield of Michigan (BCBSM) is on a formal basis only. Services provided by a non-participating Home Infusion Therapy facility are not reimbursed by BCBSM to either the facility or the member.

The attached application and required information applies to facilities that want to participate in BCBSM's network for members enrolled in our Traditional product. Please note, however, that members enrolled in BCBSM's PPO and Point of Service products (e.g., Community Blue PPO, Blue Preferred PPO, Blue Preferred Plus PPO, Blue Choice POS, etc.) use the BCBSM Traditional network *unless* a separate network for Home Infusion Therapy services has been established for those members. Members of other Blue Cross Blue Shield (BCBS) Plans also use the Traditional network. Be sure to verify benefit and eligibility for all BCBSM or BCBS members *before* providing services.

Also note: BCBSM Medicare Supplemental members, (except Option IV Exact Fill) do *not* currently use the HIT Program. Other exceptions may apply.

This application should not be completed and submitted to BCBSM until the facility has obtained proof that it meets the requirements described in Section II.

II. BCBSM's Home Infusion Therapy Program Qualification Requirements

In order to participate with BCBSM a HIT provider must, at minimum, have and maintain the following:

- A physical location on an appropriate site in Michigan where facility conducts business as a supplier of home infusion therapy services
- Full accreditation, generally three years, by:
  - the Joint Commission On Accreditation Of Healthcare Organizations (JCAHO) in each of the following services:
    - nursing infusion
    - durable medical equipment, and
    - pharmacy
  - the Community Health Accreditation Program, Inc. (CHAP) in all components of home infusion therapy, or
  - the Accreditation Commission for Health Care (ACHC) in home infusion therapy services.

  If you have questions regarding whether the accreditation status you are seeking is accepted by BCBSM, such as the level or length of accreditation, please contact the person listed at the end of the Applications Instructions section.
- A current Medicare Part B supplier number for:
  - durable medical equipment, and
  - pharmacy
- Staffing requirements: Facility must directly employ, unless otherwise indicated, all of the following:
  - a registered pharmacist, licensed in Michigan, to coordinate the patient's pharmaceutical plan
  - an employed or subcontracted Michigan licensed physician medical director who has expertise in infusion therapy services, to provide overall direction for the clinical aspect of the home infusion therapy
  - a registered nurse who will develop, coordinate, and supervise all activities of nursing services, including responsibility for assuring that only qualified individuals administer home infusion drugs
  - a licensed registered nurse or certified phlebotomist to draw blood samples for testing
  - licensed registered nurses who provide patient care must have specialized education or training in home infusion services. Facility may subcontract *additional* nursing services on an as-needed basis if such registered nurses have specialized education or training in home infusion services.
- General requirements include:
  - a toll free emergency telephone number, available on a 24 hour/seven day a week basis
  - ability to deliver covered services to the member's home within 24 hours of receipt of a physician's order
  - a system that ensures prompt delivery and appropriate storage of pharmaceuticals, medical supplies, and dependable maintenance and servicing of equipment
  - an acceptable medical waste disposal system for in-home use
  - a documented recall policy and procedure in the event of an FDA recall of an infusion product
  - care is provided under the general supervision of the patient's physician and follows a written and signed plan of care that is reviewed at least every 30 days, or as often as deemed necessary by the patient's physician

- absence of inappropriate utilization or practice patterns, as identified through valid subscriber complaints
- have an absence of fraud and illegal activity
- maintains adequate patient and financial records

Note: It is BCBSM's policy to recredential participating providers every 2-3 years to verify continued compliance with all qualification requirements.

III. Home Infusion Therapy Facility Reimbursement

For home infusion therapy covered services, BCBSM will pay the facility for three components; (i) pharmaceutical, (ii) durable medical equipment, medical supplies, and solutions, and (iii) nursing visits. Further details are found in the provider participation agreement.

If you obtained a copy of the application from our corporate website (bcbsm.com) you may contact us for a sample MAC list and Rate Sheet. If/when the facility is approved for participation, the most current Rate Sheet and MAC list will be sent with the participation agreement. The rates are BCBSM's standard rates and are not negotiable. Participating providers are required to bill BCBSM for covered services and to accept BCBSM's payment as payment in full for covered services, except for any member copayments and/or deductibles.

IV. The BCBSM Participation Agreement

The BCBSM HIT Participation Agreement will be sent if/when the facility is approved for participation. If, however, the facility would like to review the agreement prior to submitting the application, you may request a sample copy from the BCBSM Provider Contracting department. The participation agreement is on file with the Michigan Office of Financial and Insurance services, and its terms and provisions are not negotiable

NOTE: The information supplied in this application is general information only and is subject to change without notice. The application does not constitute a provider agreement or a provider manual and members' benefit plans will vary.

HOME INFUSION THERAPY
BCBSM TRADITIONAL PROGRAM
APPLICATION INSTRUCTIONS

Please do not submit the application until the facility believes it meets all BCBSM qualification requirements and has all documents BCBSM requires (e.g. accreditation). Print (in ink) or type the information required in the space provided. If the application was retrieved from the provider enrollment section of the BCBSM website (bcbsm.com), you may print, complete and mail the application. Be certain that the application is complete and all required attachments are enclosed at the time of submission to BCBSM. Please do not put the application in a binder or use sheet protectors, folders or dividers.

Please mail (do not fax) the completed application, along with the required attachments to:

Marilyn Smith
Provider Contracting – 513E
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Contact the person listed at the end of this section if you do not receive a letter within two weeks from the date you sent the application. It takes approximately two weeks for us to review a complete application. Incomplete applications may be returned, delaying the review process.

After we review the application and accompanying documentation, we may contact the designated representative of the facility to set up an appointment for an on-site visit. The on-site visit includes a review of a sample of medical records to evaluate the applicant's compliance with BCBSM requirements, as outlined in this application. The facility must be ready for the on-site review at the time of submitting the application. If the facility is approved for program participation, the participation agreement will be offered. If the facility is not approved, we will send notification in writing indicating the reason(s) for the denial.

The facility may not submit claims and is not eligible for reimbursement unless and until the application for participation is approved by BCBSM and both parties sign the Home Infusion Therapy facility participation agreement. If the facility is approved and offered a Traditional participation agreement, it will be asked to retain the agreement for its record and return the signed Signature Document to BCBSM. The countersigned copy of the Signature Document will be returned to the facility after the BCBSM Home Infusion Therapy facility's facility code has been activated for billing purposes, generally within three weeks of our receipt of the signed Signature Document. The effective date for participation in the BCBSM Traditional Home Infusion Therapy facility program will be the date the application is approved by BCBSM. It is not retroactive to the date the application was sent or received. If this application pertains to an ownership change and BCBSM approves an agreement effective date retroactive to the date of the ownership change, this is not in any way a guarantee that old claims will process. The facility is still subject to any applicable claims filing limitations.

A separate BCBSM PIN is assigned to each approved and contracted location. With the implementation of NPI in 2007, BCBSM will crosswalk the claims from the facility's NPI to the BCBSM PIN (i.e., BCBSM's internal identifier) for processing. Therefore, BCBSM recommends obtaining one NPI (in accordance with federal guidelines), for each location and provider type. Federal guidelines also allow for an NPI to be obtained for unique combinations of tax ID, location and taxonomy (specialty) codes. By choosing the same identification structure for your NPI numbers as your BCBSM provider codes and PINs, you will significantly reduce the degree of

change required to adopt NPI and allow us to process your claims without manual intervention (which could cause potential delays).

Upon completion of the application and contracting process, the facility will receive a welcome package with information on how to sign up for electronic billing and access to web-DENIS, BCBSM's web-based information system for providers. Through web-DENIS the facility will have access to provider manuals, newsletters (e.g., *The Record*), and patient data such as contract eligibility and benefits. It is the facility's responsibility to be familiar with and to adhere to all BCBCM billing and benefit requirements. It is also the responsibility of the facility to ensure its billing department (or billing agency) is compliant with all of BCBSM's billing requirements.

If the facility is approved and contracted, the HIT PIN is to be used for billing BCBSM for *all* HIT services (i.e., nursing care, supplies, solutions and pharmacy). **Note: Electronic billing is a requirement of the HIT Program.** Once the facility is notified that the HIT PIN is activated (i.e., when the facility receives its countersigned Signature Document back from BCBSM), you will need to call our Electronic Data Input (EDI) Helpline at (800)-542-0945 for instruction. You will also need to contact the web-DENIS Help Desk at (248) 486-2489 to request a web-DENIS identification number. If the facility already has a web-DENIS identification number, you still need to contact the web-DENIS Help Desk to request adding the facility's HIT PIN to its web-DENIS identification in order to enable the facility to "status" HIT claims. Also, if the facility has an outside biller, please be sure to forward all relevant billing information to the billing service. HIT facilities must submit claims on the electronic equivalent of a CMS-1500 claim form.

Facilities that participate in the Traditional program must notify BCBSM *immediately* of any change in the facility's ownership, tax identification number, CMS supplier numbers, NPI, address, telephone number, etc.

Multiple Locations

If the facility is applying for participation (or an ownership change) for more than one location, each location must meet all requirements in order to be approved. A separate BCBSM provider code is issued for each approved location and each approved location receives its own participation agreement. A separate application must be submitted for each location. Before completing the application, please make/print additional copies. The application for the first location must be completed in its entirety (with all attachments submitted. For each additional application submitted, complete the following sections: General Information (1.0), Accreditation (3.0), Medicare B supplier information (4.0), Pharmacy Licensure (5.0), and Staffing (7.0). For all other sections, indicate "same" where there is no difference. Where the information for a location is different than the first location, answer the questions and submit corresponding attachments. Before submitting the applications, please review all sections carefully to be sure appropriate information was completed for each location. If however, you prefer to submit a "complete" application for each site, you may choose to do so.

Please direct any questions regarding completion of the application to:

Marilyn Smith
Qualifications Consultant
msmith1@bcbsm.com

Telephone: 313-448-7895

Attention: Provider Contracting Dept.
MC 513E

BLUE CROSS BLUE SHIELD OF MICHIGAN
HOME INFUSION THERAPY APPLICATION
TRADITIONAL PROGRAM

1.0 General Information

Indicate the type of application being submitted: (Check all that apply)

☐ The facility would like to formally participate in BCBSM's Traditional Program

☐ Ownership change involving a change in the facility's federal Tax Identification Number. **Please contact the person listed on the previous page regarding the ownership change before completing this application.**

1.1 Business Name (This is the name the facility uses when doing business, or the DBA. It will be used for directories)
____

1.2 Facility Site Address (for directory)

Street:____

Suite Number __________ County ____________

City ______________________________ State MI Zip code _____________

1.3 Facility Telephone Number (for directory) (___) ________________

Toll Free 24 hour Telephone Number (___) ________________

1.4 Business hours
____

1.5 Date facility began servicing home infusion patients under the federal tax ID indicated in 1.11 (MM/DD/YEAR) _____________

1.6 Is the facility accepting new patients at this time?
☐ Yes
☐ No

1.7 Indicate the days and hours the facility is available to service clients.
____

1.8 Remittance Address (This is the location where all BCBSM vouchers, checks and remittance advices should be sent.)
____

Suite Number _________ County ___________

City ________________________ State ______ Zip code ___________

1.9 Enter the facility's 10 digit National Provider Identifier (NPI) that will be used for billing HIT services to BCBSM.
____

1.10 Tax Name (This is the name on file with the IRS and may be different from the facility's business name.)
____

1.11 Enter the facility's federal tax identification number (TIN)
____

1.12 **Attach a copy of Federal Tax Deposit Coupon (form-8109), or a copy of IRS notification letter (form SS4-147c), EFTPS (form–9787), or another document issued by the IRS with the facility's federal tax identification number (TIN) on it.**

1.13 Check applicable field:
☐ For Profit
☐ Nonprofit/Tax Exempt

1.14 **If the facility is tax-exempt, attach the IRS document authorizing tax exempt status.**

1.15 Facility's website (URL), if applicable:_______________________________

Note: *The percentage of ownership for items 1.16 and 1.17 combined must equal 100%.*

1.16 List the following information for the facility ***if*** it is owned by an individual(s). Attach additional pages if necessary.

Name:____Ownership___%
Home Address: ____
Occupation: ____

Name: ____Ownership___%
Home Address: ____
Occupation: ____

Name: ____Ownership___%
Home Address: ____
Occupation: ____

1.17 Provide the following information for the facility ***if*** an organization owns it or has managing control (e.g., hospital, corporation, governmental and/or tribal organizations, partnerships and limited partnerships, charitable and/or religious organizations, etc.)

Organization's name Percent ownership (if applicable)

____Ownership___%

____Ownership___%

1.18 If the facility is 100% hospital owned and operated, indicate the name, address and BCBSM facility code of the hospital.

____

____

2.0 Administration

2.1 Attach a copy of the HIT facility's organizational chart.

2.2 List the name and credentials of the facility's administrator.

Name ____

Credentials (Degrees/Certificates, etc.) _____________________________

2.3 Administrator's scheduled number of hours per week at facility ___________

2.4 Attach a copy of the administrator's job description and qualifications.

2.5 Has the facility or an officer, director, owner (e.g., individuals or parent organizations) or principal (those with significant authority and responsibility) of the facility ever had any convictions, guilty pleas, nolo contendere pleas, remands to diversion programs, civil judgments or settlement of civil actions that are related to the provision or payment of health care services?

☐ Yes
☐ No

If "Yes," please explain:

____

2.6 Has the facility or its owner(s) (e.g. individuals or parent organizations) ever been subject to a Corporate Integrity Agreement or been found to have been non-compliant with self-dealing and/or anti-kickback laws and regulations?

☐ Yes
☐ No

If "Yes," please provide a complete explanation below and/or attach additional pages if necessary

____

____

3.0 Accreditation

3.1 Check all that apply

☐ JCAHO - Joint Commission on Accreditation of Healthcare Organizations
☐ CHAP - Community Health Accreditation Program, Inc. in home infusion therapy
☐ ACHC – Accreditation Commission for Health Care
☐ None

3.2 Attach a copy of the facility's current accreditation certificate and a complete copy of the most current accreditation survey report for all home infusion services the facility provides. Note: For facilities covered under a hospital's general accreditation, the accreditation certificate must specifically reference that the HIT facility site was surveyed and included in the hospital's accreditation.

3.3 If this application is being submitted due to a change of ownership, attach a copy of the letter indicating the transfer or extension of accreditation to the new owner.

4.0 Medicare – Centers for Medicare and Medicaid Services (CMS) for DME Equipment

4.1 Provide the facility's Medicare supplier number(s) for durable medical equipment (DME).

____

4.2 Attach copies of the facility's Medicare approval letter(s) for the response in 4.1 above.

4.3 Has the facility's Medicare supplier number(s) ever been revoked, suspended or terminated for DME equipment, or has the facility or any of its owners ever been excluded from federal programs?

☐ Yes
☐ No

If "Yes," provide a complete explanation below:

____

____

4.4 If this application is being submitted due to a change of ownership, attach a copy of the CMS letter indicating authorization of the change of ownership.

5.0 Pharmacy Licensure

5.1 Attach a copy of the HIT facility's current Michigan pharmacy license.

6.0 Staffing

BCBSM requires the facility to directly employ, at a minimum, a registered pharmacist and a registered nurse. It must also have an employed or contracted physician medical director.

6.1 Attach a copy of a current staff roster with credentials (e.g., MD, DO, RN, etc.) and job titles for all professional/clinical staff (including physicians), indicating employed vs. contracted status for each staff member.

6.2 Attach a copy of the current Michigan licenses for all professional/clinical staff listed in 6.1.

6.3 Name of facility's medical director

____

☐ MD
☐ DO

6.4 Medical director's specialty

____

6.5 Indicate whether the medical director is board certified or board eligible in above specialty.
☐ Board Certified
☐ Board Eligible

6.6 Medical director's scheduled number of hours per week

____

6.7 Indicate whether the medical director is directly employed or contracted by facility
☐ Employed
☐ Contracted

6.9 **Attach a copy of the medical director's board certification(s) or proof of board eligibility, including documentation of training and experience in home infusion therapy.**

6.10 **Attach a sample copy of the facility's contract(s) for any contracted staff who provide home infusion services, including the medical director, if applicable.**

7.0 Staffing Training and Development

7.1 Attach a copy of all certifications and/or proof of specialized training in home infusion for each employed or contracted RN.

7.2. Attach a copy of the facility's policies and requirements for continuing education for employed or contracted staff who provide infusion therapy services to patients.

8.0 <u>Medical Record Documentation</u>

The medical record must contain documentation of the need for and the provision of all services rendered. All documentation must be clearly legible, signed, and dated.

BCBSM general requirements for medical record documentation include, but are not limited to:

- Patient identification information
- History
- Clinical Findings
- Physician orders (certification of treatment)
- Results of diagnostic testing (if applicable)
- Diagnostic assessment
- Progress notes
- Treatment plan
- Periodic review of treatment plan
- Discharge summary

Additionally the HIT program requires:

- an ability to deliver covered services to the member's home within 24 hours of receipt of a physician's order
- a system that ensures prompt delivery and appropriate storage of pharmaceuticals, medical supplies, and dependable maintenance and servicing of equipment
- an acceptable medical waste disposal system for in-home use
- a documented recall policy and procedure in the event of an FDA recall of an infusion product

8.1 Attach a copy of the facility's policies and procedures for medical record documentation and other requirements outlined in 8.0.

9.0 <u>Utilization Management</u>

A utilization management system can result in improved member care and improved planning for more appropriate, effective, and efficient use of the facility's resources.

- The program must provide a written utilization evaluation system designed to review the appropriateness of admissions to the program, lengths of stay, discharge practices, use of services, quality, timeliness and completeness of member records, and any other factors that may contribute to the effective utilization of program resources.

- Utilization management must be administered by a multidisciplinary committee of staff who provide direct member services. The committee shall meet at least on a quarterly basis.

- Written utilization management findings and recommendations should be made available to administrative and treatment staff for study and appropriate action.

9.1 Attach a copy of the facility's current utilization management policies and procedures.

9.2 Attach a copy of the names and credentials (i.e., MD, DO, RN, PT, etc.) of the Utilization Management Committee's members.

9.3 Attach minutes from the last two quarterly Utilization Management Committee meetings.

10.0 Service Area

Please refer to the Michigan County listing below and indicate the counties the facility provides services to.

____ ALCONA	____ DICKINSON	____ LAKE	____ OCEANA
____ ALGER	____ EATON	____ LAPEER	____ OGEMAW
____ ALLEGAN	____ EMMET	____ LEELANAU	____ ONTONAGON
____ ALPENA	____ GENESEE	____ LENAWEE	____ OSCEOLA
____ ANTRIM	____ GLADWIN	____ LIVINGSTON	____ OSCODA
____ ARENAC	____ GOGEBIC	____ LUCE	____ OTSEGO
____ BARAGA	____ GRAND TRAVERSE	____ MACKINAC	____ OTTAWA
____ BARRY	____ GRATIOT	____ MACOMB	____ PRESQUE ISLE
____ BAY	____ HILLSDALE	____ MANISTEE	____ ROSCOMMON
____ BENZIE	____ HOUGHTON	____ MARQUETTE	____ SAGINAW
____ BERRIEN	____ HURON	____ MASON	____ SAINT CLAIR
____ BRANCH	____ INGHAM	____ MECOSTA	____ SAINT JOSEPH
____ CALHOUN	____ IONIA	____ MENOMINEE	____ SANILAC
____ CASS	____ IOSCO	____ MIDLAND	____ SCHOOLCRAFT
____ CHARLEVOIX	____ IRON	____ MISSAUKEE	____ SHIAWASEE
____ CHEBOYGAN	____ ISABELLA	____ MONROE	____ TUSCOLA
____ CHIPPEWA	____ JACKSON	____ MONTCALM	____ VAN BUREN
____ CLARE	____ KALAMAZOO	____ MONTMORENCY	____ WASHTENAW
____ CLINTON	____ KALKASKA	____ MUSKEGON	____ WAYNE
____ CRAWFORD	____ KENT	____ NEWAYGO	____ WEXFORD
____ DELTA	____ KEWEENAW	____ OAKLAND	

11.0 Financial and Billing Information

11.1 Does the facility maintain records of transactions that conform to generally accepted accounting principles?

☐ Yes
☐ No

11.2 Are billing charges uniformly applied? That is, for identical services is the charge the same for all patients?

☐ Yes
☐ No

If "No," provide an explanation below:

____
____

11.3 Does the facility use a billing agency that is located outside Michigan?

☐ Yes
☐ No

If "Yes," please indicate the contact person, company name, address, telephone number (and e-mail address if available) for the company or billing agency that is responsible for submitting claims for services provided at the facility.

Contact Person ____

Company Name ____

Mailing Address ____

City ______________________________ State _______ Zip Code ________

Telephone Number ( ) ____

E-mail Address ____

11.4 In the past five years, has the facility or any of its owners filed a petition for relief under the U.S. Bankruptcy Code, or has any action been taken to dissolve, liquidate, terminate, consolidate, merge, or sell all or substantially all of facility's assets?

☐ Yes
☐ No

If "Yes," provide an explanation below.

____
____

12.0 Management Contracts

12.1 Does the facility have management contract(s) with an outside organization for the provision of core services (e.g., administrative services, staffing services, personnel management, etc.)?

☐ Yes
☐ No

If "Yes," provide the name of the organization and describe the services provided by this outside organization in the space provided below. BCBSM may request a copy of the management contract at a later date.

____
____
____

13.0 Contact Person

13.1 Please give the following information for a contact person for any questions BCBSM may have regarding this application:

Name: ____

Title: ____

Mailing Address: ____

Telephone number: ____

E-mail address: ____

14.0 Signature and Attestation

I certify by my signature below that:

- I have reviewed the information in this application and to the best of my knowledge it is a complete and accurate representation of this facility's operations.
- I understand that BCBSM may choose to do an on-site survey after review of this application to verify program compliance and to verify the accuracy of any information provided.
- All licenses for professional providers who provide direct patient care for this facility are current and valid in Michigan.
- Facility's accreditation and Medicare supplier numbers are current and valid.
- Michigan pharmacy license is current and valid
- The enclosed policies and procedures have been implemented and are enforced by this facility.
- The facility maintains financial records that conform to generally accepted accounting principles and practices.
- I understand the effective date of participation is the date the application is actually approved by BCBSM and is **not** the date the application was sent or received**.**
- I understand the facility is not eligible to submit claims for payment under this program until it is approved by BCBSM, both parties sign the participating agreement, BCBSM's claims processing systems are activated, and the facility has received a copy of the countersigned Signature Document from BCBSM.
- I understand BCBSM's payment rates and the terms of its standard participation agreement are not negotiable.

Note: This application must be signed by the person at the facility who is responsible for the overall administration of the HIT program.

Authorized facility representative

By X ____
(signature - required)

Name ____
(print or type)

Title ____
(print or type)

Date ____

Return completed application with all the attachments to:

Marilyn Smith
Blue Cross Blue Shield of Michigan
Provider Contracting – 513E
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Checklist for HIT Application Attachments

- ❑ Federal Tax Deposit Coupon (form-8109), copy of the facility's IRS notification letter (form SS4-147c) or EFTPS (form-9787)
- ❑ IRS document authorizing tax exempt status (if applicable)
- ❑ facility's organizational chart
- ❑ administrator's job description and qualifications
- ❑ current JCAHO, CHAP or ACHC accreditation certificate
- ❑ copy of accreditation extension letter to new owner for an ownership change (if applicable)
- ❑ proof of Medicare Part B suppliers number(s)
- ❑ copy of the Medicare letter authorizing change of ownership (if applicable)
- ❑ copy of the facility's current Michigan pharmacy license
- ❑ facility's current staff roster, credentials, and job titles
- ❑ current Michigan licenses for all professional/clinical staff, including the facility's medical director
- ❑ proof of medical director's board certification or eligibility, and documentation of training and experience in home infusion therapy
- ❑ certifications and/or proof of specialized training or experience in home infusion therapy for each RN
- ❑ policies and requirements for continuing education
- ❑ policies and procedures pertaining to medical record documentation of home infusion therapy services
- ❑ facility's utilization review and quality assurance program(s) policies and procedures
- ❑ signed attestation by an authorized facility representative