

Medicare Plus Blue Home infusion therapy Applies to:



**Blue Cross
Blue Shield**
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

Medicare Plus BlueSM PPO Medicare Plus BlueSM Group PPO Both

Home infusion therapy

Home infusion therapy is the continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy. It involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin) equipment (for example, a pump), and supplies (for example, tubing and catheters).

Original Medicare

Original Medicare covers home infusion therapy services under several separate Part A, Part B and Part D benefit provisions. These provisions include drugs, parenteral nutrition solutions, durable medical equipment, supplies and home health services.

Coverage criteria for infusion services, including drugs, durable medical equipment and supplies are based on national coverage determinations mandated by the Centers for Medicare & Medicaid Services and local coverage determinations established by Durable Medical Equipment Medicare Administrative Contractors. Home health services, including those related to home infusion therapy, are available when the Medicare beneficiary:

- Is confined to the home
- Is under the care of a physician
- Is receiving services under a plan of care established and periodically reviewed by a physician
- Is in need of skilled nursing care on an intermittent basis or physical therapy or speech–language pathology
- Has a continuing need for occupational therapy

Home health services are paid according to a prospective payment system. All services under the home health plan of care, except for durable medical equipment (includes prosthetics, orthotics, and oxygen) and osteoporosis drugs, are included in the home health prospective payment system payment amount.

Home health agencies may also become approved as DME suppliers, in which case they can submit bills for durable medical equipment, prosthetics, orthotics and supplies services providing to the DME MAC in the relevant jurisdiction (as established by CMS).

Home infusion therapy coverage under Original Medicare is limited and subject to specific coverage criteria. If durable medical equipment, drugs, supplies and home health services aren't covered under Medicare Part A and Part B, coverage for the home infusion drugs may fall under Part D. Ancillary services, such as durable medical equipment, supplies and nursing services aren't covered under Part D.

If Medicare doesn't cover the ancillary services under Part A and or Part B, then the beneficiary may have to pay for these services out of his or her own pocket or opt to receive the infusion services in a covered Part A or Part B setting (e.g., physician's office, outpatient hospital, infusion center).

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Effective beginning on January 1, 2021, the Medicare home infusion therapy benefit covers:

- Professional services, including nursing services, furnished in accordance with the plan of care
- Patient training and education (not otherwise covered under the durable medical equipment benefit)
- Remote monitoring, and monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.

Home infusion therapy means the items and services furnished by a qualified home infusion therapy supplier, which are furnished in the individual's home. Payment is for an "infusion drug administration calendar day," which means the day on which home infusion therapy services are furnished by skilled professionals 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.

Medicare Plus BlueSM PPO enhanced benefit

Medicare Plus Blue is a Medicare Advantage plan that provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Since Original Medicare has very limited coverage for home infusion therapy, enhanced coverage is provided to individual Medicare Plus Blue PPO and Medicare Plus Blue Group PPO plans that select this benefit.

Coverage for enhanced home infusion therapy service components are provided as the member's condition dictates, consistent with Original Medicare benefits, the enhanced Medicare Plus Blue home infusion therapy benefit, or the member's Part D prescription drug plan.

The enhanced Medicare Plus Blue home infusion therapy benefit provides coverage for the in-home administration of infusion therapy services when the Original Medicare coverage criteria aren't met. Coverage is available when the infusion therapy is:

- Prescribed by a physician within his or her scope of practice to:
 - Manage an incurable or chronic condition
 - Treat a condition that requires acute care if it can be managed safely at home
- Certified by the physician as medically necessary for the treatment of the condition
- Appropriate for use in the patient's home
- Medical IV therapy, injectable therapy or total parenteral nutrition therapy

The following components of care are available as an enhanced Medicare Plus Blue benefit regardless of whether the patient is confined to the home:

- Nursing visits needed to:
 - Administer home infusion therapy or parenteral nutrition
 - Instruct the patient or caregivers on infusion administration techniques
 - Provide IV access care (catheter care)
- Durable medical equipment, medical supplies and solutions needed for home infusion therapy or parenteral nutrition

Note: Coverage for home infusion drugs that don't meet Original Medicare coverage criteria isn't provided under the Medicare Plus Blue enhanced home infusion therapy benefit. However, such drugs may be covered under the member's Part D prescription drug plan.

Nursing visits

The purpose of the nursing visit is to assess the patient's infusion technique and the patient's response to therapy.

- Nursing visits must correspond with the frequency of therapy (i.e., therapy administered twice a month requires a nursing visit twice a month).
- The visits must be documented in the home infusion clinical record, including the start and end time of each visit.

The nursing visit requirement doesn't apply in the following situations:

- When a patient or caregiver has experience in infusion administration and therefore declines nursing visits. Medicare Plus Blue will waive the nursing visit requirement, as long as the clinical record contains a physician order and documentation stating that:
 - The nursing visit requirement was explained to the patient, family or caregiver
 - The family or caregiver is capable and willing to provide infusion-related care, and nursing visits can be provided on an as-needed basis
- When infusion services have temporarily stopped and the patient needs only catheter care.

Durable medical equipment, medical supplies and solutions

Home infusion therapy related services such as durable medical equipment, medical supplies, solutions and diluents, flushes, administrative services, professional pharmacy services, care coordination and patient education are covered under a bundled per diem. This per diem rate includes all services not included in the pharmaceutical or nursing service component.

Catheter care

Catheter care isn't payable when billed on the same day as medical IV therapy, total parenteral nutrition, injectable therapy or line insertion. If the patient has temporarily suspended home infusion therapy, one catheter care service is payable per day.

Injectable therapy

Injectable therapy is payable only when billed on the same day as an approved medical IV therapy.

Drugs

Medicare Plus Blue will provide coverage for all drugs or nutrients that meet Original Medicare coverage criteria. Drugs or nutrients that don't meet Original Medicare coverage criteria may be covered under the member's Part D prescription drug coverage.

Provider qualifications

- The provider must have a valid National Provider Identifier and must not be excluded by Medicare.
- The provider must be licensed or certified by the state and be acting within the scope of that license or certification.

Provider documentation requirements

Before providing home infusion therapy services, a provider must have on file:

- A physician's order, certificate of medical necessity or statement of medical necessity
- The physician's prescription

Physician order, certificate of medical necessity and statement of medical necessity

A written physician order dated and signed, CMN or SMN is required for each service provided.

The CMN or SMN must include the following information:

- Patient's full name, address, gender and birth date
- Diagnosis related to the infusion therapy
- Dosage, infusion time, fluids, frequency and duration of medication

- The type or route of infusion administration, required equipment and supplies
- Nursing orders that include frequency of visits, flushes, central line changes, IV restarts and other treatment orders, type of lab specimens the home infusion therapy nurse needs to obtain from the patient, and lab tests for which the physician is requesting the specimens. Nursing visits that aren't authorized by the physician aren't payable.

New orders

A new physician's order, CMN or SMN is required in the following situations:

- The current service is discontinued and a new one is initiated.
- The patient is hospitalized or admitted to a nursing home.
- The CMN or SMN duration (120 day maximum) has expired. The recertification must contain the same information as required on the initial physician order, CMN or SMN.

Physician prescription

The prescription must include the following information:

- Patient's full name
- Patient's date of birth
- Prescriber's signature and prescription date
- Prescriber's printed name and address
- Drug name and strength
- Quantity prescribed
- Directions for use
- Number of refills authorized
- Any other information needed to comply with federal and state pharmacy laws.

A new prescription is needed with a change in drug or therapy, and after 12 months even without a change in drug or therapy. The CMN or SMN and a prescription can be combined in one document.

Home infusion therapy providers must update the physician regarding the patient's condition at least every 30 days, or more often if necessary. Documentation of the update must be in the clinical record.

Medical records

The patient's medical records must reflect the need for the care provided. This documentation must be available to Medicare Plus Blue upon request.

Conditions for payment

The table below specifies payment conditions for home infusion therapy. Note: Use ICD-9 diagnosis codes for DOS through September 30, 2015. For DOS beginning with October 1, 2015, and later, ICD-10 codes must be used.

Conditions for payment	
Eligible provider	Home infusion therapy providers, home health agencies
Payable location	Home, Home infusion suite
Frequency	Restrictions apply

Conditions for payment			
CPT/HCPCS codes	Services that meet Original Medicare coverage criteria		
	External infusion pump	Parenteral nutrition	Home health services
	DME: E0779, E0780, E0781, E0791, K0455 Medical supplies: A4221, A4222, A4602, K0552, K0604, K0605 Drugs: J0133, J0285, J0287, J0288, J0289, J0895, J1170, J1250, J1265, J1325, J1455, J1457, J1555, J1561, J1562, J1569, J1570, J1575, J1817, J2175, J2260, J2270, J3010, J3285, J7799, J9000, J9039, J9040, J9065, J9100, J9190, J9360, J9370 Home Infusion Therapy: G0068, G0069, G0070, G0088, G0089, G0090	DME: B9004, B9006, E0776 Medical supplies: B9999 Nutrients: B4164, B4168, B4172, B4176, B4178, B4180, B4185, B4187, B4189, B4193, B4197, B4199, B4216, B4220, B4222, B4224, B5000, B5100, B5200	Consistent with Original Medicare

Conditions for payment		
CPT/HCPCS codes	Enhanced benefits	
		DME, medical supplies and solutions: S5497, S5498, S5501, S5502, S5517, S5518, S5520, S5521, S5522, S5523, S9061, S9325, S9326, S9327, S9328, S9329, S9330, S9331, S9336, S9338, S9346, S9347, S9348, S9351, S9355, S9357, S9359, S9361, S9363, S9364, S9365, S9366, S9367, S9368, S9370, S9372, S9373, S9374, S9375, S9376, S9377, S9379, S9490, S9494, S9497, S9500, S9501, S9502, S9503, S9504, S9537, S9542, S9810 Nursing services: 99601, 99602 Drugs: Report the drug to the member's Part D prescription drug plan.
Diagnosis restrictions	Services that meet Original Medicare coverage criteria	Consistent with Original Medicare.
	DME, medical supplies and solutions	Covered for: <ul style="list-style-type: none"> Managing an incurable or chronic condition A condition that requires acute care if it can be managed safely at home
	Nursing services	
	Drugs	Consistent with Original Medicare. If not covered, submit claim to member's Part D prescription drug plan
Age restrictions	No restrictions	

Reimbursement

Medicare Plus Blue plan's maximum payment amounts for home infusion therapy benefits are available on our provider website, www.bcbsm.com/providers/help/faqs/medicare-advantage/provider-toolkit/enhanced-benefits.html in the MA enhanced benefits fee schedule.

The provider will be paid the lesser of this allowed amount or the provider's charge, minus the member's cost share. This represents payment in full and providers aren't allowed to bill the member for the difference between the allowed amount and the charge.

Allowed amounts

When home infusion therapy is administered through an external infusion pump or parenteral nutrition therapy consistent with Original Medicare coverage criteria, the Medicare Plus Blue allowed amount is consistent with Original Medicare. When the home infusion therapy coverage criteria under Original Medicare cannot be met, the Medicare Plus Blue allowed per diem amounts will apply.

Member cost sharing

- Medicare Plus Blue providers should collect the applicable cost sharing from the member at the time of the service when possible. Cost sharing refers to a flat dollar copayment, a percentage coinsurance or a deductible. Providers can only collect the appropriate Medicare Plus Blue cost-sharing amounts from the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with that service.
- Providers may not have members sign an Advance Beneficiary Notice of Noncoverage to accept financial responsibility for noncovered items or services. If there is any question about whether an item or service is covered, seek a coverage determination from Blue Cross before providing the item or service to the member. If a provider provides a noncovered item/service to a member without first obtaining a coverage determination, the member must be held harmless for all charges except for any applicable cost-share.

To verify benefits and cost share, providers may utilize web-DENIS or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form, UB-04 or the 837 equivalent claim consistent with the home infusion therapy coverage scenarios and claim formats in the charts below.
2. Use the Medicare Advantage PPO unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to Blue Cross or your local Blue plan as indicated in the scenario charts below.
6. Use electronic billing consistent with the direction provided in the scenario chart:

- a. Michigan providers

Copies of the ANSI ASCX 12N 837 and 835 Institutional Health Care Claim and Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents are available on the Blue Cross website under the reference library section at: <http://www.bcbsm.com/providers/help/faqs/electronic-connectivity-edi.html>.

- b. Providers outside of Michigan should contact their local Blue Cross plan.

Billing scenarios and instructions

Claims for home infusion therapy services provided to individual Medicare Plus Blue PPO and select Medicare Plus Blue Group PPO members should be completed and submitted consistent with the home infusion therapy coverage scenarios identified in the following charts.

The scenarios and related billing instructions vary by the type of coverage available for the home infusion therapy service:

- Original Medicare
- Enhanced Medicare Plus Blue benefits
- Prescription drug coverage

Scenario 1 – All HIT services meet Original Medicare coverage criteria			
HIT Service	Claim Type	Coding	Send Claims to
Home health services	UB-04 or electronic equivalent	Follow Original Medicare	Your local Blue plan
DME, supplies and drugs	CMS-1500 (02/12)	Follow Original Medicare	Blue Cross Medicare Plus Blue if the DME, supplies or drugs are subject to the jurisdiction of the CMS contracted regional DME carrier.

Scenario 2 – Home health services meet Original Medicare coverage criteria, but DME, supplies or drugs don't			
HIT service	Claim type	Coding	Send claims to
Home health services	UB-04 or electronic equivalent	Follow Original Medicare	Your local Blue Cross plan
DME, supplies and solutions	CMS-1500 (02/12) or electronic equivalent	Follow Medicare Plus Blue enhanced HIT benefit billing guidelines and report the appropriate per diem S HCPCS level II procedure code	Your local Blue Cross plan
Drugs	Follow the billing guidelines of the member's Part D prescription drug plan		Member's Part D prescription drug plan

Scenario 3 – Home health services, DME, supplies and drugs don't meet Original Medicare coverage criteria			
HIT service	Claim type	Coding	Send claims to
Home health services	CMS-1500 (02/12) or electronic equivalent	Follow Medicare Plus Blue enhanced HIT benefit billing guidelines and report nursing visits using CPT procedure codes 99601 and 99602 and the appropriate per diem S HCPCS level II procedure code for DME, supplies and solutions. Report these services on the same claim.	Your local Blue Cross plan
DME, supplies and solutions			
Drugs	Follow the billing guidelines of the member's Part D prescription drug plan		Member's Part D prescription drug plan

Billing guidelines for enhanced benefit services

Medicare Plus Blue billing guidelines for home infusion therapy services that don't meet Original Medicare coverage criteria are provided below.

Nursing services, durable medical equipment, supplies and solutions must all be reported on the same CMS-1500 (02/12) or electronic equivalent claim.

To report	Item reported	Instructions
DME supplies and solutions	Date of service	Report the date of service as an individual date or a range of dates, depending on the number of days reported. The dates of service for per diem S HCPCS level II procedure codes must correspond with the beginning and end dates of the patient's received home infusion services.
	Code	Report the appropriate per diem S HCPCS level II procedure code.
	Modifiers	Multiple therapies should be reported using modifier SH or SJ. Report the primary therapy administration procedure code and include modifier SH or SJ to distinguish delivery of additional therapies: <ul style="list-style-type: none">• SH – Second concurrently administered infusion therapy• SJ – Third or more concurrently administered infusion therapy Note: Multiple therapies are only payable with medical IV therapy or TPN therapy. The same payment amount will be made per day regardless of the number of additional concurrent therapies.
	Quantity	Enter the total number of days the patient was infused for the therapy. The quantity (days) must be greater than zero. Note: S codes can't be processed without a quantity.

To report	Item reported	Instructions
Nursing services	Date of service	Enter the actual date of the visits.
	Code	Report nursing visits using CPT procedure codes 99601 and 99602. When billing procedure code 99602, it must be reported on the same day as 99601.
	Quantity	<p>99601 – Report the quantity as one (001). 99602 – Report the number of additional hours.</p> <p>Note: A maximum of two hours are payable per day for this code.</p> <p>Report no more than four hours of nursing services per day and no more than 12 hours per week.</p> <p>Exception: We'll consider payment of additional nursing visits for HIT services in these situations:</p> <ul style="list-style-type: none"> • Restoring catheter patency – Report procedure code S5517 and the one additional nursing visit. • Catheter repair – Report procedure code S5518 and the one additional nursing visit. • PIC line insertion – Report procedure code S5520 and the one additional nursing visit. • Midline insertion – Report procedure code S5521 and the one additional nursing visit. • Peripheral start – Report 99601. • Manufacturer's recommended time for drug infusion and monitoring. <p>Note: If you report additional nursing visits beyond the three allowed per week, along with the claim, please include documentation for all the nursing visits for that week. For the last item listed above, you need to include only the drug manufacturer's requirements or recommendations.</p>
Procedure code S9379 – HIT, NOC, per diem	Documentation	<p>Include detailed documentation that describes:</p> <ul style="list-style-type: none"> • The service provided • The route of administration • The drugs used
Same day reporting		<p>Only the following services may be reported on the same day:</p> <ul style="list-style-type: none"> • Line insertion services with line insertion supplies • Injectable therapy with medical IV therapy
State Health Plan MA Procedure code S9355 – Chelation Therapy		<p>Diagnostic restrictions apply.</p> <p>Payable Service Location:</p> <ul style="list-style-type: none"> • Home (12) • Nursing Home (32) <p>Member Cost share 10% after deductible</p>

Revision

Policy Number: MAPPO 1010

Reviewed: 08/20/2020, 10/01/2019, 07/23/2018

Revised: 08/20/2020, 04/29/2020, 10/01/2019, 08/18/2015, 2012

08/20/2020: Updated Original Medicare section to include new coverage for Home Infusion Therapy effective January 1, 2021. The new HIT benefit covers the service component, meaning the professional services, training and education (not otherwise covered under the DME benefit), and monitoring furnished by a qualified HIT supplier needed to administer the home infusion drug in the patient's home. Removed codes J2274, J2278, J1559, and J9200 as they are not covered under the HIT benefit beginning CY 2021. Added codes J1555, J1575, J9039, B4187, G0086, G0069, G0070 to align with Original Medicare covered codes, per NCD 180.2 and LCD L33794.

04/29/2020: Added State Health Plan MA Chelation Therapy benefit, diagnosis restrictions and drug administration instructions.

10/1/2019: Removed codes S9345, S9349 and S9353, as these codes are not payable under this enhanced benefit.

08/18/2015: Updated formatting, updated equipment and drug codes per LCD L33794 (deleted end dated codes: J2271, J2275, J9110, J9375, J9380; added codes: A4305, A4306, A4602, A9274, J1559, J1561, J1569, J2274), updated billing information and web links, removed CAREN reference, added revision history section.

Home Infusion Therapy Decision Chart

