REIMBURSEMENT POLICY

Home Infusion

Active

Policy Number:	General Coding – 031
Policy Title:	Home Infusion
Section:	General Coding
Effective Date:	02/16/16

Product: ☒Commercial ☒FEP ☐Medicare Advantage ☐Platinum Blue

Description

This policy addresses coding and reimbursement for home infusion.

Definitions

Home infusion is the administration of medications or nutrition intravenously in a patient's home or a home infusion suite.

Policy Statement

Home infusion services must be ordered in writing by a physician and performed by a Medicare certified/Joint Commission-accredited organizations approved home infusion agency.

Claim Submission

- Submit claims using the electronic 837P format using CPT and HCPCS codes.
- Use the Place of Service code 12 (Home) for services provided in the patient's home.
- Use the Place of Service code 49 or 11 for services provided in a home infusion suite, or the provider's office.

Professional ID numbers are issued with contracts for all participating home infusion providers. Individual provider numbers are not required. Reimbursement is subject to the member's contract benefits.

Per Diem Payment

The HCPCS "S" codes for home infusion services are based on a "per diem" reimbursement methodology. The per diem includes all supplies, care coordination and professional pharmacy services. The per diem code is billed for each day that a patient receives an infusion. Other nursing services and drug products are billed separately from the per diem.

Drugs

Code all drugs with a HCPCS or CPT code. If a specific code is not available you may use J3490, J3590, J7799 or J9999. Provide the narrative, NDC number, dosage and units supplied.

Related NDC codes for compounded products are itemized using the LIN and CTP segments on the 837P claim format. These claims may require manual review.

Use drug units as described in the HCPCS or CPT description of the code.

Nursing Services
Code home IV nursing visits lasting up to two hours using CPT code 99601. Report each additional hour beyond the initial two with 99602 with the appropriate number of units.

When provided in the infusion suite of a home infusion agency, code each nursing visit lasting up to two hours using CPT code 99199, with a narrative description. Report each additional hour beyond the initial two with 99199-52 with the appropriate number of units, in accordance with the NHIA (National Home Infusion Association) recommendations for billing.

Catheter Care
Bill catheter care per diems (S5498, S5501, S5502) when provided as a stand-alone therapy. Insertion by a nurse of a PICC line (S5522) or midline (S5523) is coded separately from the other nursing visit codes and per diems. Supplies required from non-routine catheter procedures such as de-clotting supplies (S5517), repair kits (S5518), PICC insertion supplies (S5520) and midline insertion supplies (S5521) are coded separately.

Multiple Therapies
For multiple therapies in the same category done on the same date of service as primary therapy, append the following modifiers to the “S” code per diem:

- SH- second concurrently administered infusion therapy
- SJ- third or more concurrently administered therapy

Documentation Submission

Documentation must identify and describe the services performed including total time of the service. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, Blue Cross fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	SH	SJ	GY				
ICD-10 Diagnosis:	N/A						
ICD-10 Procedure:	N/A						
CPT/HCPCS:	99601	99602	J3490	J3590	J7799	J9999	S5497
	S5498	S5501	S5502	S5517	S5518	S5520	S5521
	S5522	S5523	S9325	S9326	S9327	S9328	S9329
	S9330	S9331	S9335	S9336	S9338	S9339	S9340
	S9341	S9342	S9343	S9345	S9346	S9347	S9348
	S9349	S9351	S9353	S9355	S9357	S9359	S9361
	S9363	S9364	S9365	S9366	S9367	S9368	S9370
	S9372	S9373	S9374	S9375	S9376	93977	S9379
	99199						
Revenue Codes:	N/A						
Deleted Codes:	N/A						

Cross Reference

Cross Reference: General Coding -005 Unlisted Procedure Codes

Policy History

2/16/2016	Initial Committee Approval Date
8/30/2017	Annual Policy Review
4/20/2020	Annual Policy Review
6/29/2021	Annual Policy Review