Home Infusion Therapy

Policy

Mass General Brigham Health Plan reimburses participating home infusion agencies for the provision of medically necessary home infusion therapy (drug therapy), rendered in the home to an individual who is confined to the home.

Home infusion therapy services are provided to individuals who do not need hospitalization but who need drug therapy that can be safely administered in the home environment. They also provide a wide range of services required to administer home infusion, nutritional therapies, and specialty drugs; including antibiotics, total parenteral nutrition (TPN), hydration, pain management, and cancer chemotherapy.

Frequently, home infusion agencies provide additional professional therapies; including enteral nutrition, and specialty drugs (e.g. growth hormone) that may be provided as subcutaneous or intramuscular injectable or for an injection through an IV line.

Reimbursement

Reimbursement is based on the most current Red Book AWP (average wholesale price) effective on the date of service or provider's contractual agreement.

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan's Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services

(CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to General Coding and Billing for more information.

All claims are subject to audit; medical records may be requested from the provider.

Mass General Brigham Health Plan reimbursement is based on line of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type.

Limitations

MassHealth ACO members only, please refer to MassHealth Guidelines for Medical Necessity Determination for Enteral Nutrition and Special Medical Formulas

Please refer to Mass General Brigham Health Plan Medical Policy 020, Enteral Nutrition Formulas and Supplements for state-mandated conditions, exclusions, and non-covered products.

Caremark Therapeutic Services is the designated pharmacy provider for home infusion therapy.

Member Cost-Sharing

The provider is responsible for verifying the member's coverage, out of pocket expenses (including but not limited to; copayments, coinsurance and deductible where applicable) and, benefit limitations.

Definitions

Antibiotics: A drug used to treat infections caused by bacteria and other microorganisms

Cancer Chemotherapy: A chemical that binds to and specifically kills microbes or tumor cells. Chemotherapy is usually systemic treatment where the drugs flow through the bloodstream to nearly every part of the body. Patients who need many rounds of IV chemotherapy may receive the drugs through a catheter. One end of the catheter is placed in a large vein in the chest. The other end is outside the body or attached to a small device just under the skin.

HCPCS Level II "J" Codes: Drugs administered by other than an oral method that cannot be self-administered, including chemotherapy drugs, immunosuppressive drugs, inhalation solutions, and other miscellaneous drugs and solutions.

Hydration: The addition of water to a substance or tissue.

NDC (National Drug Code): A universal product identifier for drugs by which drug products are identified and reported using a unique, three-segment number, called the National Drug Code consisting of 11 digits in a **5-4-2** format. The first 5 digits identify the manufacturer of the drug and are assigned by the Food and Drug Administration. The remaining digits are assigned by the manufacturer and identify the specific product and package size.

Some packages will display NDC numbers with less than 11 digits but, **leading zeroes** can be assumed and **must be used when billing.**

Example:

NDC Package Display	11- Digit NDC Format
XXXX-XXXX-XX	***0***XXXX-XXXX-XX
XXXXX-XXX-XX	XXXXX-***0***XXX-XX
XXXXX-XXXX-X	XXXXX-XXXX-***0***X

Pain Management: The process of providing medical care that alleviates or reduces pain through a fully implantable infusion pump (IIP) intended to provide long-term continuous or intermittent drug infusion.

Per Diem: Payment for each day that Mass General Brigham Health Plan Health Partners member is provided home infusion, prescribed by the member's physician in the home.

State Mandate: A requirement by the Commonwealth of Massachusetts that health insurers provide a defined minimum level of coverage for specific health conditions.

Total Parenteral Nutrition (TPN): Intravenous feeding that provides a patient with all of the fluid and the essential nutrients when they are unable to feed themselves by mouth.

Mass General Brigham Health Plan Reimburses

- Home infusion services on a per diem basis only when drug infusion is administered on the same date.

Services included in the per diem reimbursement include but, are not limited to;

- Initial patient assessment
- Professional pharmacy services
- Infusion therapy related supplies
- Teaching and related supplies and materials
- Delivery and removal of supplies and equipment
- Coordination of home care

Services excluded from the per diem reimbursement include but, are not limited to;

- Drugs and biologicals
- Enteral formula when administered via gravity, pump or bolus only (does not apply to nutritional formulas taken orally)
- Covered DME not related to the infusion therapy (billed separately from infusion services)
- Nursing visits related to the infusion service
- PICC and midline insertion kits
- Surgically implanted CVA (central venous access) devices.

Reimbursement is based on the fee schedule in effect at the time of service.

Mass Health ACO Members

Mass General Brigham Health Plan ACO pays per MassHealth payment methodologies. These claims shall deny, and providers are required to submit an invoice for payment.

For additional information, please see the following MassHealth Links:

- MassHealth 101 CMR 322.00: Durable medical equipment, oxygen and respiratory therapy equipment
- MassHealth Durable Medical Equipment and Oxygen Payment and Coverage Guideline Tool (v.41.8)

Procedures Codes

Note: This list of codes may not be all-inclusive.

Code	Descriptor	Comments
99601	Home infusion/specialty drug administration, per visit (up to 2 hours);	
99602	Home infusion/specialty drug administration, per visit; each additional hour. (List separately in addition to code for primary procedure: CPT 99601.)	
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 min	**Medicare Advantage**
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 min	**Medicare Advantage**
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 min	**Medicare Advantage**
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 min	**Medicare Advantage**
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 min	**Medicare Advantage**
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 min	**Medicare Advantage**
S5498	Home Infusion Therapy, catheter care / maintenance, simple (single lumen), per diem	
S5501	Home Infusion Therapy, catheter care / maintenance, complex (more than one lumen), per diem	
S5502	Home Infusion Therapy, catheter care / maintenance, implanted access device, per diem	

Code	Descriptor	Comments
S5517	Home Infusion Therapy, all supplies necessary for restoration of catheter patency or declotting	
S5518	Home Infusion Therapy, all supplies necessary for catheter repair	
S5520	Home Infusion Therapy, PICC line insertion kit	
S5521	Home Infusion Therapy, mid line catheter insertion kit	
S5522	Home Infusion Therapy, insertion of peripherally inserted central venous catheter (PICC), nursing services only.	
S5523	Home Infusion Therapy, insertion of midline venous catheter, nursing services only	
S9061	Home administration of aerosolized drug therapy(e.g. Pentamidine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment, per diem	
S9326	Home Infusion Therapy, continuous pain management infusion, per diem	
S9327	Home Infusion Therapy, intermittent pain management infusion, per diem	
S9328	Home Infusion Therapy, implanted pump pain management infusion, per diem	
S9330	Home Infusion Therapy, continuous chemotherapy infusion, per diem	
S9331	Home Infusion Therapy, intermittent chemotherapy infusion, per diem	
S9336	Home Infusion Therapy, continuous anticoagulant infusion therapy, per diem	
S9338	Home Infusion Therapy, immunotherapy, per diem	
S9341	Home Therapy; enteral nutrition via gravity, per diem	
S9342	Home Therapy; enteral nutrition via pump, per diem	
S9343	Home Therapy; enteral nutrition via bolus, per diem	
S9345	Home infusion therapy, antihemophilic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, per diem.	
S9348	Home infusion therapy, sympathomimetic/inotropic agent infusion therapy (e.g. Dobutamine); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, per diem	
S9349	Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, per diem	

Code	Descriptor	Comments
S9351	Home Infusion Therapy, continuous or intermittent anti-emetic infusion therapy, per diem	
S9355	Home Infusion Therapy, chelation therapy, per diem	
S9558	Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies, equipment, per diem	
S9559	Home injectable therapy; interferon, including administrative services, pharmacy services, care coordination, and all necessary supplies and equipment, per diem professional	
S9365	Home Infusion Therapy, TPN, 1 liter per day, per diem	
S9366	Home Infusion Therapy, TPN, >1 liter but ≤ 2 liters per day, per diem	
S9367	Home Infusion Therapy, TPN, >2 liters but ≤ 3 liters per day, per diem	
S9368	Home Infusion Therapy, TPN, >3 liters per day, per diem	
S9370	Home Therapy, intermittent anti-emetic infusion therapy, per diem	
S9372	Home therapy, intermittent anticoagulation injection therapy;(e.g. Heparin), administrative services, professional pharmacy, care coordination and all necessary supplies and equipment, per diem (Do not use this code for flushing of infusion devices with Heparin to maintain patency)	
S9374	Home Infusion Therapy, hydration therapy 1 liter per day, per diem	
S9375	Home Infusion Therapy, hydration therapy; >1 liter but ≤ 2 liters per day, per diem	
S9376	Home Infusion Therapy, hydration therapy; >2 liters but ≤ 3 liters per day, per diem	
S9377	Home Infusion Therapy, hydration therapy; >3 liters per day, per diem	
S9490	Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, per diem	
S9497	Home Infusion Therapy, antibiotic, antiviral or antifungal; once every 3 hours, per diem	
S9500	Home Infusion Therapy, antibiotic, antiviral or antifungal; once every 24 hours, per diem	
S9501	Home Infusion Therapy, antibiotic, antiviral or antifungal; once every 12 hours, per diem	

Code	Descriptor	Comments
S9502	Home Infusion Therapy, antibiotic, antiviral or antifungal; once every 8 hours, per diem	
S9503	Home Infusion Therapy, antibiotic, antiviral or antifungal; once every 6 hours, per diem	
S9504	Home Infusion Therapy, antibiotic, antiviral or antifungal; once every 4 hours, per diem	
S9537	Home Therapy, hematopoietic hormone injection therapy, per diem	
S9542	Home injectable therapy, not otherwise classified, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, per diem	

Provider Payment Guidelines and Documentation

Submit all bills for home infusion on a CMS 1500 form, or its electronic equivalent.
Enter the authorization number in Form Locator 23 on CMS 1500, or its electronic equivalent.
When more than one date of service is submitted per claim form, itemize each date of service on a separate claim line in Form Locator 45.

For each drug submit the appropriate HCPCS code in addition to the:

- 11-digit format NDC Number
- Dosage administered to the member that day
- Units administered
- Frequency of administration
- Duration of infusion (if applicable).

For **drugs**, enter the drug units implicit in the NDC number (e.g. number of vials).

Please Note: HCPCS "**J**" codes for drugs submitted without an NDC number will *deny* for missing NDC.

Please Note: Do *not* enter number of cases or the Red Book value listed in milligrams (ml) in the units' field.

NDC Units: These units are based on the numeric quantity administered to the patient and the unit of measurement. The unit of measurement (UOM) codes follow:

UOM Code	Descriptor
F2	International Unit
GR	Gram
ML	Milliliter
UN	Unit (each)

The actual metric decimal quantity administered, and the units of measurement are required for billing. If reporting a fraction (part of a unit), use a decimal point. (I.e. If three 0.5 ml vials are dispensed, report 1.5 ml.).

Examples of how units of measure qualifiers relate to NDC dose/volume:

NDC Dose	Volume Unit Qualifier
1,000ML	ML
50,000IU	F2
1Unit	UN
50mg	GR
100mg/4ml	ML

How to bill administration of drugs, using NDC units in millimeters or units

- If a drug is supplied in a *vial* in *liquid form*, bill in millimeters. (**ML**)
- International Units will mainly be used when billing for Factor VIII-Antihemophilic Factors. (**F2**)

Reporting multiple NDCs on a Professional claim: If the drug administered is comprised of more than one ingredient, each NDC must be represented in the service lines. The HCPCS code should be repeated as necessary to cover each unique NDC code.

Submitting a paper claim:

- Enter modifier **KP** (first drug of a multiple drug unit dose formulation) for the first drug of a multiple drug formulation.
- Enter modifier **KQ** (second or subsequent drug of a multiple drug unit dose formulation) to

represent the second or subsequent drug formulations.

How to bill administration of drugs, using NDC units in millimeters or units

- If a drug is supplied in a *vial* in *liquid form*, bill in millimeters. (**ML**)
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Reporting multiple NDCs on a Professional claim: If the drug administered is comprised of more than one ingredient, each NDC must be represented in the service lines. The HCPCS code should be repeated as necessary to cover each unique NDC code.

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- Enter modifier **KP** (first drug of a multiple drug unit dose formulation) for the first drug of a multiple drug formulation.
- Enter modifier **KQ** (second or subsequent drug of a multiple drug unit dose formulation) to represent the second or subsequent drug formulations.

When home nursing services are required for home infusion and specialty drug administration, bill using CPT 99601 for each nursing visit lasting up to two hours, in addition to CPT 99602 for nursing visits lasting more than two hours, with the applicable number of unit(s) for each additional hour.

When a member receives two or more concurrently administered therapies, append one of the modifiers listed below:

Modifier	Descriptor
SH	Second concurrently administered infusion therapy
SJ	Third or more concurrently administered infusion therapy

Drug Wastage

The drug wastage amount is the amount of a single use vial or other single use package that remains after administering a dose/quantity of the drug.

Providers must bill for drug wastage on a separate claim line appended with modifier JW to identify the unused or discarded drug/biological (from single use vial/packages only).

Do not bill for discarded drugs if none of the drug was administered to the patient.

Do not bill for drug wastage associated with multi use vial drugs.

Modifier	Descriptor
JW	Drug amount discarded/not administered to any patient

Medical and Payment Policy Home Page
Medical Policies
Provider Payment Guidelines

Related Mass General Brigham Health Plan Payment Guidelines

Durable Medical Equipment
Home Health Care Agency
Hospice Care
Physician Administered Medications
Enteral Formulae Parenteral Nutritional Solutions

Related Mass General Brigham Health Plan Medical policies

Medical specialty and pharmacy drug policies
Prior authorization and infusion drug information
Enteral Nutrition Formulas and Supplements
Specialty Medication Administration – Site of Care
Provider Pharmacy Guidelines
Site of Care Drug List

References

CMS, Home Infusion Therapy/Home IVIG Services
CMS, JW Modifier and Billing Requirements
CMS, MLN Matters, Updated Billing Requiremnts for Home Infusion Therapy (HIT) Services on or After January 1, 3031 (MM12108)
MassHealth 101 CMR 322.00: Durable medical equipment, oxygen and respiratory therapy equipment

- 101 CMR 322
- 101 CMR 322 related and supporting documents

MassHealth Home Health Agency Manual Transmittal Number HHA 40, 11/10/2007
MassHealth Pharmacy Manual Transmittal Number PHM 58, 9/15/2008
MassHealth Physician Bulletin 87, August 2008: Clarification of Coverage of Formulas (Enteral-Nutrition Products)
Mass. Division of Medical Assistance Provider Manual Series, Durable Medical Equipment Manual. Subchapter 4, Program Regulations (130 CMR 409.000) Pages 4-26
M.G.L. Chapter 176G. Health Maintenance Organizations.Ch 176G: § 4D

Publication History

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July 21, 2009	*Original Publication*
January 1, 2019	*Document restructure; codes, code descriptor and references updated*
May 1, 2021	*Added JW Modifier billing requirements and CMS link*
August 26, 2021	*Updated related medical, payment policies and administrative edits*
January 1, 2023	*Document rebrand; updated references*
April 1, 2023	*Updated MassHealth links*
January 1, 2024	*Annual review, no policy change*
January 1, 2025	*Annual review, no policy change*
June 26, 2026	*Added links for Medical and Payment Policies*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail.

Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.