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Billing for Home Infusion Therapy Services on or After January 1, 2021

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Note: We revised this article to reflect a revised CR 11880 issued on December 31. In the article, we added two codes (J1559 JB and J7799 JB) as we show in red print in Table 3.2 on page 7. Also, we revised the CR release date, transmittal numbers, and the web addresses of the transmittals. All other information remains the same.

PROVIDER TYPE AFFECTED

This MLN Matters Article is intended for qualified Home Infusion Therapy (HIT) suppliers who bill Part B Medicare Administrative Contractors (A/B MACs) for professional HIT services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article provides guidance to providers and suppliers about claims processing systems changes necessary to implement Section 5012(d) of the 21st Century Cures Act. These changes are effective on and after January 1, 2021. Make sure that your billing staff is aware of these changes.

BACKGROUND

Effective January 1, 2021, Section 5012(d) of the 21st Century Cures Act (Pub. L 114-255) amended sections 1861(s)(2) and 1861(iii) of the Social Security Act (the Act), requiring the Secretary to establish a new Medicare HIT services benefit. The Medicare HIT services benefit covers the 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 drugs furnished by a qualified HIT supplier (suppliers must have specialty code D6).

Section 1861(iii)(3)(C) of the Act defines a “home infusion drug” as a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15

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minutes or more, in the home of an individual through a pump that is an item of durable medical equipment (as defined in section 1861(n) of the Act). Such term does not include insulin pump systems or self-administered drugs or biologicals on a self-administered drug exclusion list. In the CY 2020 HH PPS final rule with comment period (84 FR 60618), the Centers for Medicare & Medicaid Services (CMS) stated that this means that "home infusion drugs" are defined as parenteral drugs and biologicals administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of DME covered under the Medicare Part B DME benefit, pursuant to the statutory definition set out at section 1861(iii)(3)(C) of the Act, and incorporated by cross reference at section 1834(u)(7)(A)(iii) of the Act.

Section 1834(u)(1)(A)(ii) of the Act states that a unit of single payment under this payment system is for each infusion drug administration calendar day in the individual's home, and requires the Secretary, as appropriate, to establish single payment amounts for different types of infusion therapy, taking into account variation in utilization of nursing services by therapy type. CMS finalized the definition of "infusion drug administration calendar day" in regulation as the day on which HIT services are furnished by skilled professional(s) 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 (42 CFR 486.505).

Section 1834(u)(1)(A)(iii) of the Act provides a limitation to the single payment amount, requiring that it shall not exceed the amount determined under the Physician Fee Schedule (PFS) (under section 1848 of the Act) for infusion therapy services furnished in a calendar day if furnished in a physician office setting. This statutory provision limits the single payment amount so that it cannot reflect more than 5 hours of infusion for a particular therapy per calendar day. CMS retained the three current payment categories, with the associated J-codes as outlined in section 1834(u)(7)(C) of the Act, to utilize an already established framework for assigning a unit of single payment (per category), accounting for different therapy types, as required by section 1834(u)(1)(A)(ii) of the Act. The payment amount for each of these three categories is different, though each category has its associated single payment amount. The single payment amount (per category) would thereby reflect variations in nursing utilization, complexity of drug administration, and patient acuity, as determined by the different categories based on therapy type. CMS set the amount equivalent to 5 hours of infusion in a physician's office. Each payment category amount would be in accordance with the six infusion CPT codes identified in section 1834(u)(7)(D) of the Act

Section 1834(u)(1)(B)(i) of the Act requires that the single payment amount be adjusted to reflect a geographic wage index and other costs that may vary by region. Subparagraphs (A) and (B) of section 1834(u)(3) of the Act specify annual adjustments to the single payment amount that are required to be made beginning January 1, 2022. In accordance with these sections the single payment amount will increase by the percent increase in the Consumer Price Index for all urban consumers (CPI-U) for the 12-month period ending with June of the preceding year, reduced by the 10 year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP).

Section 1834(u)(1)(C) of the Act allows the Secretary discretion to adjust the single payment amount to reflect outlier situations and other factors as the Secretary determines appropriate, in a budget neutral manner. Section 1834(u)(4) of the Act also allows the Secretary discretion, as appropriate, to consider prior authorization requirements for HIT services.

In accordance with section 1834(u)(1)(B)(i) of the Act, we are using the Geographic Adjustment Factor (GAF) to wage adjust the home infusion therapy services payment. In order to make the application of the GAF budget neutral we are going to apply a budget-neutrality factor. Additionally, in CY 2022, we will adjust the single payment amount by the percent increase in the Consumer Price Index for all urban consumers (CPI-U) for the 12-month period ending with June of the preceding year, reduced by the 10 year moving average of changes in annual economy-wide private nonfarm business multifactor productivity (MFP).

Finally, Medicare is increasing the payment amounts for each of the three payment categories for the initial infusion therapy service visit by the relative payment for a new patient rate over an existing patient rate using the physician evaluation and management (E/M) payment amounts for a given year. Overall, this adjustment would be budget-neutral, resulting in a small decrease to the payment amounts for any subsequent infusion therapy service visits.

In the event that multiple drugs, which are not all assigned to the same payment category, are administered on the same infusion drug administration calendar day, a single payment would be made that is equal to the highest payment category.

The G-codes are:

- 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 minutes Short Descriptor: Adm IV infusion drug in home
- 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 minutes Short Descriptor: Adm SQ infusion drug in home
- 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 minutes. Short Descriptor: Adm of IV chemo drug in home
- 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 minutes. Short Descriptor: Adm IV drug 1st home visit
- 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 minutes. Short Descriptor: Adm SubQ drug 1st home visit

- 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 minutes. Short Descriptor: Adm IV chemo 1st home visit

NOTE: The G-code payment rates are being added to the PFS fee schedule incorporating the required annual and geographic wage adjustments. The G codes will appear on the PFS as status "X."

A qualified HIT supplier is only required to enroll in Medicare as a Part B supplier and is not required to enroll as a DME supplier, therefore, the G-codes will be billed through the A/B MACs and the Multi-Carrier System (MCS) for Medicare Part B claims. DME suppliers, also enrolled as qualified HIT suppliers, would continue to submit DME claims through the DME MACs; however, they would also be required to submit HIT service claims (G-codes) to the A/B MACs for processing. The qualified HIT supplier will submit all HIT service claims on the 837P/CMS-1500 professional and supplier claims form to the A/B MACs. DME suppliers, concurrently enrolled as qualified HIT suppliers, will need to submit one claim for the DME, supplies, and drug on the 837P/CMS-1500 professional and supplier claims form to the DME MAC and a separate 837P/CMS-1500 professional and supplier claims form for the professional HIT services to the A/B MAC. Similarly, home health agencies, concurrently enrolled as qualified HIT suppliers, will need to continue submitting a standard 837/CMS-1450 institutional claims form for the professional home health services to the A/B MAC (HHH) and a separate 837P/CMS-1500 professional and supplier claims form for the professional HIT services to the A/B MAC.

Because the HIT services are contingent upon a home infusion drug J-code being billed, the appropriate drug associated with the visit must be billed with the visit or no more than 30 days prior to the visit. To identify and process claims for the items and services furnished under the home infusion therapy benefit, a Common Working File (CWF) edit will be implemented for the submitted G-code claims. The claims processing system will recycle the G-code claim for the professional services associated with the administration of the home infusion drug until a claim containing the J-code for the infusion drug is received in the CWF. The professional visit G-code claim will recycle three times (with a 30-day look back period) for a total of 15 business days. After 15 business days, if no J-code claim is found in claims history, the G-code claim will be denied.

Suppliers must ensure that the appropriate drug associated with the visit is billed with no more than 30 days prior to the visit. In the event that multiple visits occur on the same date of service, suppliers must only bill for one visit and should report the highest paying visit with the applicable drug. Claims reporting multiple visits on the same line item date of service will be returned as unprocessable.

Suppliers should report visit length in 15-minute increments (15 minutes = 1 unit). See Table 1 for guidance on billing time increments.

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Table 1 shows the time increments providers should report visit length in 15-minute increments (15 minutes = 1 unit). See the table below for the rounding of units:

Table 1: Time Increments

Unit	Time
1	<23 minutes
2	= 23 minutes to <38 minutes
3	= 38 minutes to <53 minutes
4	= 53 minutes to <68 minutes
5	= 68 minutes to <83 minutes
6	= 83 minutes to <98 minutes
7	= 98 minutes to <113 minutes
8	= 113 minutes to <128 minutes
9	= 128 minutes to <143 minutes
10	= 143 minutes to <158 minutes

Home infusion therapy suppliers will use a new G-code to differentiate the first visit from all subsequent visits. Home infusion therapy suppliers may only bill the new G-code to indicate an initial visit for a new patient who had previously received their last home infusion therapy service visit more than 60 days prior to the new initial home infusion therapy service visit. If any of the home infusion therapy G-codes is found in the claims history within 60-days prior to the date of service for an initial visit, then the initial visit claim will be rejected. Table 2 below shows the use of the G-codes established for the home infusion therapy services benefit, and reflects the therapy type and complexity of the drug administration per category.

Table 2: Payment Categories for Home Infusion Therapy Professional Services (G-Codes)

	Category 1	Category 2	Category 3
Description **G-Code**	Intravenous anti-infective, pain management, chelation, pulmonary hypertension, inotropic, and other certain intravenous infusion drugs	Subcutaneous immunotherapy and other certain Subcutaneous infusion drugs	Chemotherapy and other certain highly complex intravenous drugs
Initial Visit	G0088	G0089	G0090
Subsequent Visit	G0068	G0069	G0070

Home infusion drugs are assigned to three payment categories, as determined by the HCPCS J-code:

- Payment category 1 includes certain intravenous antifungals and antivirals, uninterrupted long-term infusions, pain management, inotropic, chelation drugs.

- Payment category 2 includes subcutaneous immunotherapy and other certain subcutaneous infusion drugs.

- Payment category 3 includes certain chemotherapy drugs and other certain highly complex intravenous drugs.

CMS has established a single payment amount for each of the three categories for professional services furnished for each infusion drug administration calendar day. Each payment category will be paid at amounts in accordance with infusion codes and units for such codes under the physician fee schedule for each infusion drug administration calendar day in the individual's home for drugs assigned to such category. The payment amounts are equal to 5 hours of infusion therapy in a physician's office. Tables 3.1, 3.2, and 3.3 below provide a list of J-codes associated with the home infusion drugs that fall within each category.

Tables 3.1, 3.2, and 3.3: Payment Categories for Home Infusion Drugs (J-Codes)

Table 3.1 – Category 1

J-Code	Description
J0133	Injection, acyclovir, 5 mg
J0285	Injection, amphotericin b, 50 mg
J0287	Injection, amphotericin b lipid complex, 10 mg
J0288	Injection, amphotericin b cholesteryl sulfate complex, 10 mg
J0289	Injection, amphotericin b liposome, 10 mg
J0895	Injection, deferoxamine mesylate, 500 mg
J1170	Injection, hydromorphone, up to 4 mg
J1250	Injection, dobutamine hydrochloride, per 250 mg
J1265	Injection, dopamine hcl, 40 mg
J1325	Injection, epoprostenol, 0.5 mg
J1455	Injection, foscarnet sodium, per 1000 mg
J1457	Injection, gallium nitrate, 1 mg
J1570	Injection, ganciclovir sodium, 500 mg
J2175	Injection, meperidine hydrochloride, per 100 mg
J2260	Injection, milrinone lactate, 5 mg
J2270	Injection, morphine sulfate, up to 10 mg
J3010	Injection, fentanyl citrate, 0.1 mg
J3285	Injection, Treprostinil, 1 mg

Table 3.2 – Category 2

J-Code	Description
J1555 JB	Injection, immune globulin (cuvitru), 100 mg
J1558 JB	Injection, immune globulin (xembify), 100mg
J1559 JB	Injection, immune globulin (hizentra), 100mg
J1561 JB	Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g. liquid), 500 mg
J1562 JB	Injection, immune globulin (vivaglobin), 100 mg
J1569 JB	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg
J1575 JB	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin
J7799 JB	This NOC code may be used to identify the subcutaneous immune globulin (cutaquig)

Table 3.3 – Category 3

J-Code	Description
J9000	Injection, doxorubicin hydrochloride, 10 mg
J9039	Injection, blinatumomab, 1 microgram
J9040	Injection, bleomycin sulfate, 15 units
J9065	Injection, cladribine, per 1 mg
J9100	Injection, cytarabine, 100 mg
J9190	Injection, fluorouracil, 500 mg
J9360	Injection, vinblastine sulfate, 1 mg
J9370	Injection, vincristine sulfate, 1 mg

The payment category may be determined by the DME MAC for any new home infusion drug additions to the Local Coverage Determination (LCD) for External Infusion Pumps as identified by the following not-otherwise-classified (NOC) codes:

J7799 - Not otherwise classified drugs, other than inhalation drugs, administered through DME
J7999 - Compounded drug, not otherwise classified.

Note that qualified home infusion suppliers must have a specialty code of D6, effective for claim lines for HIT services on or after January 1, 2021. Claims lines from specialties other than D6 will be denied with the following messages:

- Claim Adjustment Reason Code (CARC) 16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) N256 - Missing/incomplete/invalid billing provider/supplier name.
- Group Code: CO

Also, note that Medicare will only pay for one of the G-codes listed per line item date of service. If more than one G-code line item is billed for the same day, it will be denied using the following messages:

- CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
- Group Code CO

If G-codes are billed for a date of service on or after January 1, 2021, and there is not a timely billed DME claim with one of the allowable drug J-codes as noted above (and after the G-code is recycled up to three times for a minimum of up to 15 days, MACs will deny the G-code with the following messages:

- CARC 16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N657 - This should be billed with the appropriate code for these services.
- Group Code - CO (Contractual Obligation)

If more than one claim line is billed with one of the G-codes within a 60-day period, subsequent lines will be denied with the following messages:

- CARC 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N640 - Exceeds number/frequency approved/allowed within time period.
- Group Code - CO (Contractual Obligation)

ADDITIONAL INFORMATION

The official instructions, CR11880, issued to your MAC regarding this change are available at https://www.cms.gov/files/document/r10547bp.pdf and https://www.cms.gov/files/document/r10547cp.pdf.

Additional instruction, CR 11750, issued to your MAC regarding the new supplier specialty code for home infusion therapy services is in two transmittals. The first updates the Medicare Claims

Processing Manual and it is available at https://www.cms.gov/files/document/r10124cp.pdf. The second updates the Medicare Financial Management Manual and it is at https://www.cms.gov/files/document/r10124fm.pdf.

MACs will post the HIT fees on their websites as soon as possible.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
December 31, 2020	We revised this article to reflect a revised CR 11880 issued on December 31. In the article, we added two codes (J1559 JB and J7799 JB) as we show in red print in Table 3.2 on page 7. Also, we revised the CR release date, transmittal numbers, and the web addresses of the transmittals. All other information remains the same.
November 13, 2020	We revised this article to reflect a revised CR 11880 issued on November 13. In the article, we added statements related to the status indicator for the G codes on the Physician Fee Schedule and noting that MACs will post the HIT fees on their websites as soon as possible. Also, we revised the CR release date, transmittal numbers, and the web addresses of the transmittals. All other information remains the same.
August 7, 2020	Initial article released.