Transitional Payment Takes Effect in January: Five Things You Need to Know

By Bill Noyes

On January 1, 2019, the Centers for Medicare and Medicaid (CMS) will begin reimbursing for Medicare Part B home infusion professional services.

But as anyone who reads INFUSION magazine knows, this is a complicated and complex issue. Many details for reimbursement are still being worked out by the Medicare Administrative Contractors (MACs), but home infusion providers need to be prepared. Below are the five things that home infusion providers need to know in order to start billing under this benefit.

01.

The Payment Applies Only to Medicare Part B Covered Drugs

The 21st Century Cures Act and *Bipartisan Budget Act of 2018* created a professional services payment only for drugs that are covered under the External Infusion Pump local coverage determination (EIP LCD). These drugs fall into three categories:

Category #1: Select anti-fungal, anti-viral, pain management, chelation, pulmonary hypertension, and/or inotropic infusion drug(s)

Category #2: Subcutaneous immunotherapies

Category #3: Chemotherapies

In other words, it does NOT apply to Medicare Part D infused drugs, parental nutrition, enteral nutrition, or intravenous immunoglobulin. See Table 1 for a list of drugs covered under the EIP LCD.

02.

No Changes to Durable Medical Equipment (DME) Billing

When it comes to DME and drug billing, it's business as usual. Home infusion suppliers should continue to bill separately for drugs (J codes), pumps (E0781, E0779), and supply kits (A4222, A4221, K0552).

03.

Services Are Only Billable When a Professional is in the Patient's Home

Under the new policy, home infusion providers can bill for home infusion professional services only on the day a professional or nurse *is present in the home*. Yes, you read that right, but let us repeat it. Home infusion professional services can only be reimbursed on a day when the nurse (or other professional) is physically present in the patient's home.

NHIA fought this "in the home" requirement during the formal comment period, has met with CMS countless times to get them to reverse course, and is now working on legislation that would remove the requirement and allow for more frequent reimbursement of home infusion professional services. It is the association's sincere hope that we'll be able to overturn this requirement, but in the meantime, providers should prepare for, and set up, their systems to bill only for days when a nurse is present in the home.

Did you miss NHIA's December 4 all-important webinar Home Infusion Transitional Payment—Staying the Course?

NHIA's *Talk Infusion* webinar updated the home and specialty infusion industry on the CMS Final Rule, which reimburses home infusion providers only on the day a nurse is in a patient's home, but not for any of the other critically important pharmacy or professional services. CMS' rule will not only negatively impact the home infusion industry but endanger beneficiaries' ability to receive infusion therapy in the safety and comfort of their home.

Access NHIA's highly informative webinar to gain a powerful perspective on the implications of the CMS Final Rule and NHIA's work to get CMS to pay home infusion providers for each infusion calendar day, regardless of whether a nurse is present in the patient's home. Visit NHIA's website or access the webinar at: https://register.gotowebinar.com/recording/viewRecording/6996874579530052866/5841016279832651779/marilyn.tretler@nhia.

Table 1: Drug G-Code Crosswalk

HCPCS Code	Description	HCPCS Unit	Category	G Code	Payment Amount*
J0133	Acyclovir	5 MG	1	G0068	$141.12
J0285	Amphotericin B	50 MG	1	G0068	$141.12
J0287	Amphotericin B lipid complex	10 MG	1	G0068	$141.12
J0288	Amphotericin B cholesteryl sul	10 MG	1	G0068	$141.12
J0289	Amphotericin B liposome	10 MG	1	G0068	$141.12
J0895	Deferoxamine mesylate	500 MG	1	G0068	$141.12
J1170	Hydromorphone	4 MG	1	G0068	$141.12
J1250	Dobutamine hcl	250 MG	1	G0068	$141.12
J1265	Dopamine	40 MG	1	G0068	$141.12
J1325	Epoprostenol	0.5 MG	1	G0068	$141.12
J1455	Foscarnet sodium	1000 MG	1	G0068	$141.12
J1457	Gallium nitrate	1 MG	1	G0068	$141.12
J1570	Ganciclovir sodium	500 MG	1	G0068	$141.12
J2175	Meperidine hydrochl	100 MG	1	G0068	$141.12
J2260	Morphine sulfate	10 MG	1	G0068	$141.12
J2274	Morphine sulfate, preservative-free		1	G0068	$141.12
J2278	Ziconotide	1 MG	1	G0068	$141.12
J3010	Fentanyl citrate	0.1 MG	1	G0068	$141.12
J3285	Treprostinil	1 MG	1	G0068	$141.12
J1555 JB	Cuvitru	100 MG	2	G0069	$224.28
J1559 JB	Hizentra	100 MG	2	G0069	$224.28
J1561 JB	Gamunex/ Gammaked	500 MG	2	G0069	$224.28
J1562 JB	Vivaglobin	100 MG	2	G0069	$224.28
J1569 JB	Gammagard liquid	500 MG	2	G0069	$224.28
J1575 JB	Hyqvia	100 MG	2	G0069	$224.28
J9000	Doxorubicin hcl	10 MG	3	G0070	$239.76
J9039	Blinatumomab	1 MG	3	G0070	$239.76
J9040	Bleomycin	15 units	3	G0070	$239.76
J9065	Cladribine	1 MG	3	G0070	$239.76
J9100	Cytarabine hcl 100 MG inj	100 MG	3	G0070	$239.76
J9190	Fluorouracil inj	500 MG	3	G0070	$239.76
J9200	Floxuridine Inj	500 MG	3	G0070	$239.76
J9360	Vinblastine sulfate inj	1 MG	3	G0070	$239.76
J9370	Vincristine sulfate inj	1 MG	3	G0070	$239.76

*Payment amount based on 2018 reference data

04.

Providers Must Report Specific G-codes, Service Length, and Other Information

CMS created three new "G-codes" for providers to use when they bill for professional services. They are:

G0068: Anti-infective, pain management, pulmonary hypertension and inotropic infusion drugs

G0069: Subcutaneous immunotherapy

G0070: Chemotherapy

Providers will have to report service length in fifteen minute increments (15 minutes = 1 unit), and the midpoint rule applies. Under the midpoint rule, "a unit of time is attained when the midpoint is passed." In other words, you can only bill for the second unit of time after you've surpassed eight minutes. See Table 2 for examples of units and timeframes.

Units are for data collection proposes only; the rate paid for the service codes will be the same regardless of the number of units billed. So for example, the allowable for G0068 is $141.12 (based on 2018 references), the DME MACs would pay 80 percent, or $112.90, for each calendar day that the code is billed, regardless of the number of units billed – same amount for 15 units as 1 unit.

Noteworthy, only one G-Code will be reimbursed per calendar day. If a patient is on multiple therapies, you will only be reimbursed for the G-code with the highest payment rate.

Other details are still scant, but it is certain that CMS and the DME MACs will require specific information as part of each claim, including:

- Documentation to support a G-code
- Service provision with time documented (In/Out)
- If you are using a home health agency, make sure you have infusion related nursing time documentation
- Documentation for the plan of care

05.

No Matter How Many Units You Bill, the Payment Will Be the Same

Congress created a "single unit of payment" for home infusion professional services, and that does not vary depending on the amount of time a pharmacist or nurse spends on a single patient. Whether it's fifteen minutes or five hours, the payment will be the same.

Table 2: Reporting unit for time in home (does not affect payment rate)

Units	Timeframe
1	< 23 minutes
2	= 23 minutes < 38 minutes
3	= 38 minutes < 53 minutes
4	= 53 minutes < 68 minutes
5	= 68 minutes < 83 minutes
6	= 83 minutes < 98 minutes
7	= 98 minutes < 113 minutes
8	= 113 minutes < 128 minutes
9	= 128 minutes < 143 minutes
10	= 143 minutes < 158 minutes
11	= 158 minutes < 173 minutes
12	= 173 minutes < 188 minutes
13	= 188 minutes < 203 minutes
14	= 203 minutes < 218 minutes
15	= 218 minutes < 233 minutes
16	= 233 minutes < 248 minutes

About the Author

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TAKE NOTE!

This is a rapidly evolving issue and all of this information may be out-of-date by the time this issue goes to print. So double-check the association's website for the latest information or contact NHIA's Bill Noyes at Bill.Noyes@nhia.org or Sharon Pearce at Sharon.pearce@nhia.org if you have any questions.