NHIA National Coding Standard for Home Infusion Claims under HIPAA

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National Home Infusion Association

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I. Introduction and Overview

The Health Insurance Portability and Accountability Act (HIPAA) requires that health care payers use only standard medical code sets and make standard electronic transactions available for health insurance transactions. Under HIPAA regulations, payers are required to accept only "approved" medical code sets. The use of "local" or proprietary (i.e., payer-specific) medical coding is not allowed. The HCPCS[1] codes from the Centers for Medicare & Medicaid Services (CMS) include a comprehensive set of "per diem" codes that are widely used by most commercial and some government payers to process home infusion claims. This "National Coding Standard" from the National Home Infusion Association (NHIA) presents these codes as a comprehensive coding system for home infusion claims and provides procedures for and training on their use.

HCPCS contains the only HIPAA-approved, comprehensive code set available to submit home infusion and ambulatory infusion suite claims that supports the typical per diem contracts present in the marketplace. For both providers and payers, the National Coding Standard presents HCPCS as a system used for assigning codes within their provider-payer contracts for submission of claims. NHIA understands that providers and payers have found their "per diem" based contracts match this system of HCPCS codes well.

Payers that may still be funding home infusion therapy services through detailed billing code methodologies—often subject to high administrative expense and error---will find this document useful for understanding the superior per diem methodology and planning conversion to it. For example, state Medicaid health plans may use the codes presented in this National Coding Standard. The National Coding Standard does not address submission of claims to Medicare Parts A, B or D.

For providers, a purpose of this document is to serve as a tutorial for coding of claims. For payers, this document serves as a tutorial for claims processors and claim-processing system designers on what they can expect in a claim submitted by a home infusion provider.

The HCPCS codes presented in the National Coding Standard are a claims procedure coding system for medical services that include home infusion therapies, home enteral therapies, specialty drug therapies, disease state and care management services, and services provided in the Ambulatory Infusion Suite of the home infusion therapy provider (AIS). Combined with use of NDC[2] numbers and HCPCS for the coding of drug products, and CPT and HCPCS codes for home

[1] Healthcare Common Procedure Coding System.

[2] National Drug Code. Administered by U.S. Food and Drug Administration.

nurse visits, these medical services are coded under the per diem approach using the HIPAA-approved codes listed in Section VI HIPAA-Approved Coding System for Per diem Coding of Home Infusion Therapy. Use of the per diem HCPCS codes is now the universal, national standard for submission of per diem claims for home infusion therapy.

The National Coding Standard is provided free of charge as a service from the National Home Infusion Association to assist your organization in complying with the HIPAA standardized coding requirements. For those still transitioning, the goal is to make your transition to this HIPAA-compliant coding structure as easy as possible. For all who have completed transition, the goal is to provide a valuable and current home infusion therapy coding and claiming reference resource to guide you for implementing coding changes and other new developments that occur. For example, in the National Coding Standard release effective for use on January 1, 2005 we published the first national coding standard available for services provided in the *Ambulatory Infusion Suite of the home infusion therapy provider (AIS)* using standardized and specific HCPCS codes.

A Quick Reference is Worth a Thousand Words! *Thanks to the generous support from* ***Innovatix, a Premier Inc. company - the 2020 Quick Coding Reference for Home Infusion Therapy*** *is available as a member benefit. The Quick Coding Reference is an extremely useful tool once the concepts and detail in the National Coding Standard are understood. Importantly, NHIA's Quick Coding Reference visually demonstrates that using the home infusion therapy per diem coding system is actually quite simple—it is administratively efficient and easy to incorporate into managed care contracting and government payer fee schedules.* *See page 149 for details.*

As additional assistance to you, NHIA's Payor Advocacy and Relations (PAR) Committee can provide assistance on questions on home infusion therapy service coding or the transition to per diem coding not addressed in the National Coding Standard. Questions should be submitted via e-mail to **info@nhia.org**; subject line: Coding Inquiry. We will provide rapid responses (within one week) when possible. Some questions may be sent to the full PAR Committee for consideration during its regularly scheduled meetings, and we may invite you to participate. For information about the National Home Infusion Association, visit our web site at **www.nhia.org** or call 703-549-3740.

II. General Information

II.A. Home Infusion Codes Added to HIPAA-Approved HCPCS Codes

Prior to 2002, most commercial payers had required submission of home infusion claims with payer-specific codes because the HCPCS and CPT national coding systems widely used in many other health segments had not adequately supported home infusion services and products. However, beginning with the 2002 edition of the Healthcare Common Procedure Coding System (HCPCS), HIPAA-approved coding became available for home infusion claims. The HCPCS codes for home infusion provide a comprehensive framework for contracting, billing, and processing home infusion therapy claims. These codes are comparable to the local "per diem" codes that had been used by the majority of commercial payers.

The HCPCS system provides approximately 80 "S" codes for home infusion therapy services. Most codes reflect a "bundled" per diem approach, in which most or all of the supplies and services provided to a home infusion patient are billed under a single code. Certain services and products are explicitly excluded from the per diem code and are to be coded, billed and reimbursed separately—specifically, home nursing services and drug products are reimbursed separately from the per diem code—as required by HIPAA regulations[3].

This new system of "S" codes for home infusion therapy services is specifically designed for use by commercial[4] payers, as well as Medicaid and other government plans providing explicit home infusion coverage. Fee schedules that may exist for these codes are determined by provider-payer agreement or regulation.

II.A.1. Per diem: The Conceptual Framework for the Coding System

Per diem. Each home infusion per diem code specifically includes "administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment." This is an important recognition in the federal coding system that these services are a critical component of infusion therapy. The term "per diem" represents each day that a given patient is provided access to a prescribed therapy, beginning with the day the therapy is initiated and ending with the day the therapy is permanently discontinued.

Payers should benefit from providers' discussion and education on infusion services and costs, why these services and facilities are necessary to ensure safe and effective patient care, and the many regulations and standards to which

[3] HIPAA regulations require conformance to the exact HCPCS and CPT code descriptions, and trading partners may not agree to change the meaning of codes. See Section VII.

[4] Including traditional indemnity plans, PPO plans, POS plans, HMOs, BC/BS plans, employer-administered plans, etc.

providers are held accountable. Keep in mind that treatment alternatives to home infusion are generally vastly more expensive. Providers will find such discussion a most important educational process.

Providers need to know what per diem rates are necessary to cover their costs. The per diem charge covers all costs (direct and indirect) other than drug costs and nursing visit charges. NHIA's per diem definition provided in Section V provides a thorough listing of all services and costs, and has proved to be very useful to both providers and payers in understanding the per diem payment methodology.

Nursing Is Excluded From The Per diem. As designed by CMS, the HCPCS per diem "S" codes specifically exclude nursing visits from the per diem. While nursing visit utilization will vary by patient, therapy, age, and organization, most of the services and costs related to home infusion therapy are not related to nursing visits. Infusion organizations minimize nursing visits by using a range of effective strategies to manage and coordinate patient care.

All Drugs Are Excluded From The Per diem. The HCPCS "S" codes specifically exclude all drugs[5] and enteral formula from the per diem. This exclusion even includes legend[6] drugs used for catheter maintenance, reconstitution, and compounding, such as heparin, saline, D5W, and sterile water.

II.A.2 Coding for Drugs: NDC Numbers or HCPCS Codes?

In February 2003, a modification to HIPAA regulation was published which changed the standard for coding drugs in X12N electronic claims. (Home infusion claims are submitted on the X12N 837 Professional electronic format, see Section II.D.)

This modification allows drugs to be coded on X12N claims with NDC numbers although HCPCS codes are also included. For home infusion, coding and reimbursement of drugs with NDCs is the superior approach because:

1. NDCs exist for all prescription drugs because they are assigned by the FDA when a drug is approved.
2. An NDC uniquely identifies each drug, including its manufacturer, strength, dosage form, formulation and package size.
3. Specifying of billing units is simpler with NDC coding and results in fewer errors.
4. HCPCS billing units in the code descriptions frequently do not match the commonly available drug packaging sizes from the manufacturer.

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[5] There is one exception. Per diem coding for provision of PN requires that drugs that are part of a standard PN formula included in the per diem. See Section III.G.

[6] "Legend drug" is a term often used in state law and means the drug is labeled as requiring a prescription for dispense.

5. In HCPCS, providers may have multiple HCPCS codes to select from for the same drug and there is lack of clarity as to which one to use.

Much more information on drug coding is presented in the introduction to our Section IV, Claim Coding Examples.

II.B. "S" Codes for Home Infusion Are Permanent

HCPCS "S" codes are placed into the HCPCS system to provide coding solutions for submission of claims to commercial and some government payers for cases in which Medicare claims require different codes, or in the event adequate codes are not included in the CPT system. Despite their label as "temporary" codes, the "S" codes for home infusion are permanent code assignments. According to CMS, the "S" codes in the national HCPCS alphanumeric code list are added to the list based on the national needs of third party payers. The codes will remain in the HCPCS alphanumeric code list unless they are replaced by a permanent code in HCPCS or CPT, or become obsolete. Replacement is not currently foreseen, as explained next.

For Medicare, replacement of "S" codes by other "permanent" codes would require Medicare recognition and payment for the services provided with home infusion on a per diem basis similar to commercial insurance coverage. Should that happen, we would anticipate new code values with the same description would be defined in future editions of HCPCS.

For CPT, it is highly unlikely for most of the "S" codes that they would become included in CPT, due to the per visit/per procedure structure of the CPT system, which differs considerably from the per diem approach used in funding home infusion therapy services. If you have more questions about this, contact NHIA.

II.C. The Home Infusion Provider and Home Infusion Therapy

Home infusion providers are licensed pharmacies that provide a wide range of services required to safely and effectively administer home infusion and nutritional therapies, specialty drugs, and disease state and care management services. Home infusion pharmacies are often accredited by organizations such as…

The Joint Commission (**www.jointcommission.org**)
Accreditation Commission for Health Care (**www.achc.org**)
Community Health Accreditation Program (**www.chapinc.org**)
Healthcare Quality Association on Accreditation (**http://www.hqaa.org/**)
National Association of Boards of Pharmacy (**http://www.nabp.net/**)
The Compliance Team (**www.thecomplianceteam.org/**)

Some accrediting bodies review all service components offered by home infusion providers, whereas others limit their accreditation to specific services. Accreditation is often a payer requirement in contracting for the provision of home infusion therapy services, and some payers limit the accrediting organizations they recognize.

Drug therapies typically provided by a home infusion pharmacy include compounded solutions for parenteral antibiotics, chemotherapy, pain medications, parenteral nutrition (PN), and other drug therapies (such as hydration). However, home infusion pharmacies frequently provide additional professional therapies, including enteral nutrition, inhalation therapies using nebulizers, and specialty therapies (such as erythropoietin, growth hormone, infliximab, IVIG and low molecular heparin) that may be provided as a subcutaneous injection or for injection through an IV line. Some home infusion pharmacies also provide disease state and care management services; as with home infusion, provision of these additional therapies must be accompanied by extensive pharmacy professional services to optimize efficacy and compliance. Other organizations provide specialty drugs or disease state management without provision of home infusion therapy per se. Many home infusion therapy providers also operate one or more health facilities called Ambulatory Infusion Suites of the home infusion therapy provider (AIS) where clinical care is provided pursuant to physician orders to ambulatory patients; care is managed and performed by RN's and registered pharmacists that are highly skilled in provision of infusion/specialty drug administration. Because of the overlap of these services, the HCPCS set of "S" codes for home infusion therapies also provides codes for enteral, specialty drug, and disease state and care management services and a code modifier used for AIS service coding. The nation's health care community labels all of these professional therapies as "home infusion therapy".

In 2006, the National Uniform Claims Committee (NUCC) (**www.nucc.org**) added a taxonomy code for *home infusion therapy pharmacy* and *Specialty Pharmacy* to the national taxonomy code set. This action was taken along with adding taxonomy codes for other well-established types of pharmacies, all released by the NUCC in January of 2006.

Home Infusion Therapy Pharmacy 3336H0001X[7]

Pharmacy-based, decentralized patient care organization with expertise in USP 797-compliant sterile drug compounding that provides care to patients with acute or chronic conditions generally pertaining to parenteral administration of drugs, biologics and nutritional formulae administered through catheters and/or needles in home

[7] To see complete taxonomy code set, link to **www.wpc-edi.com/taxonomy**.

and alternate sites. Extensive professional pharmacy services, care coordination, infusion nursing services, supplies and equipment are provided to optimize efficacy and compliance.

Specialty Pharmacy 3336S0011X

A pharmacy that dispenses generally low volume and high cost medicinal preparations to patient who are undergoing intensive therapies for illnesses that are generally chronic, complex and potentially life threatening. Often these therapies require specialized delivery and administration.

A provider is required by CMS to describe itself with one or more taxonomy codes when it applies for a HIPAA National Provider Identifier (NPI)[8]. A home infusion therapy provider may select this taxonomy when applying for an NPI for services it provides in the home or other alternate sites such as the Ambulatory Infusion Suite of the home infusion therapy provider. More information on taxonomy codes is provided by the NUCC at **www.nucc.org**.

II.D. The Electronic Claim Format

Conforming to HIPAA regulations[9] for submission of professional pharmacy claims, home infusion therapy providers submit claims for all services, products and drugs using the ASC ANSI X12N 837 professional electronic transaction standard, which software developers and others may purchase from Washington Publishing Company at **www.wpc-edi.com/hipaa.**

In the X12N 837 professional electronic claim, most services and products are encoded using the HCPCS "S" codes for services, while drugs may be coded with NDC numbers although HCPCS codes are also provided. While the HIPAA requirement to use HIPAA-approved codes applies to electronic transactions, the reality is that payers will not maintain two sets of code systems, one for electronic claims and one for paper claims. Hence, the HCPCS "S" codes are the universal, national standard for submission of per diem claims for home infusion therapy.

[8] An organization-level provider is required by CMS to describe itself with one or more taxonomy codes when it applies for an NPI. A home infusion therapy provider may select taxonomy code 3336H0001X when applying for an NPI for services it provides in the home or other alternate sites such as the Ambulatory Infusion Suite of the home infusion therapy provider. For NHIA members, we make available a HIPAA NPI Resource Center found at **www.nhia.org/resource/hipaa/** which includes complete educational material on defining organizational NPI subparts.

[9] See Section VII.

The X12N transactions are also used for other insurance-related transactions between provider and payer, and the same codes are used to specify products and services where relevant to these transactions. An example would be the electronic remittance advice.

II.E. New Code Requests

Home infusion therapy is a dynamic sector, marked by the frequent introduction of new therapies, technologies and services. As a result, new home infusion coding needs will continue to arise. The National Home Infusion Association serves as a national clearinghouse for recommendations for additions and modifications for home infusion therapy per diem. NHIA evaluates recommendations for coding modifications in an open process, and we allow requesters to actively participate in the evaluation of their coding change requests. Approved recommendations for coding change requests will be provided as a formal recommendation from NHIA to the administrators of the HCPCS or CPT coding systems. We encourage you to submit coding requests to NHIA following procedures found in the Reimbursement Resource Center section of the association's web site, **www.nhia.org**. Previous requests submitted by NHIA to the HCPCS and CPT administrators have resulted in resolution of coding gaps and improved code descriptions.

II.F. Meaning of "Standard"

The procedures presented in this document are provided for educational purposes and are voluntary, although we have included HIPAA regulatory requirements. NHIA develops these procedures, which express its assessment of best coding practices that will encourage electronic claiming and administrative simplification under the framework provided by HIPAA. We have taken great care to ensure that if an organization follows the procedures in this document, they will be fully compliant with HIPAA regulations, as well as guidelines provided by the administrators of the HCPCS and CPT coding systems. Every organization must assume responsibility for all compliance aspects of their coding and other claiming practices, HIPAA and otherwise. While we are comfortable with the quality of this document, NHIA assumes no liability that use of these procedures conforms to regulations or other norms of good business practices. The process for future revisions is available to any person or organization that identifies potential regulatory or other issues, and is open to participation by all as explained next.

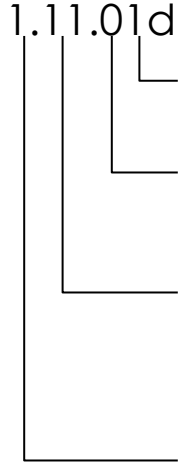
II.G. Revisions to the National Coding Standard

Periodically, the National Home Infusion Association will release new versions of the National Coding Standard. New versions will be necessary to support new therapies, technologies and services; new clinical and business models; changes in HIPAA-compliant code sets; and government mandates; as well as to add clarifications and make other improvements. We encourage you to submit recommendations for changes to the National Coding Standard. Submit them via e-mail to **info@nhia.org**; subject line: Coding Recommendation. NHIA will carefully consider your recommendations, and we may ask you to present and/or provide more information.

We will include approved recommendations in a future version of the National Coding Standard. We will submit changes needed in HCPCS or CPT to the administrators of these coding systems (see Section II.E).

Meaning of Version Number. The National Coding Standard's version identifier is structured with digits separated by periods followed by a character. The latest version is found on NHIA's web site, **www.nhia.org**. We think you will find it useful to know how we assign these values. We display this identifier on the next page, and explain what it means if these numbers have changed on a later version that you may be reading.

Meaning of Version Number:



Example version identifier with meaning of changes to the sub-components of version identifier.

Corrections and updates are made that do not change the substance of the National Coding Standard, i.e. your organization will not have compliance issues resulting from these changes.

Modifications are made to improve presentation, add more examples, and make corrections; but do not actually change the National Coding Standard, i.e. it is unlikely your organization would require changes to remain compliant with it.

Substantive modifications are made to the National Coding Standard that may require changes by your organization to remain compliant with it. This would include improvements and clarifications, as well updates necessitated by additions, changes or deletions pertaining to HCPCS or CPT codes, HIPAA rules on use of codes, or other related HIPAA requirements.

A major expansion in scope or other major change to the National Coding Standard. Occurrences are rare.

II.H. NHIA Copyright[10]

NHIA provides this National Coding Standard free of charge, with intent for its use by home infusion participants to incorporate into their administrative operations. NHIA provides you with permission to use all or portions of this document if you use it within your organization for this purpose, or for not-for-profit presentations and other educational purposes. You must use the NHIA copyright (see footer) in your materials. If using excerpts, you must also include the National Coding

[10] Since the code values and their HIPAA-compliant descriptions are obtained from the widely available HCPCS and CPT code sets, there is no intent to include them under NHIA's copyright protection, although the systematized ordering we use in their presentation is covered under the copyright.

Standard's version number. If you plan to incorporate all or portions of this document into a product or service that you sell (e.g. coding books, coding software, coding web sites, for-fee seminars, etc.), contact NHIA for permission.

II.I. What's New?

The previous release of the National Coding Standard was version 1.11.01g.

Other Enhancements. Changes are made to keep the National Coding Standard current. Most are minor; those that we thought should be pointed out to you are denoted with blue font.

Denotation of Updates to the National Coding Standard. Most lines containing significant changes from the previous version of this National Coding Standard are provided with blue font that is visible through display on your PC screen and on color printed output. Where deletions are made, the lines surrounding the deleted text are also provided in blue font.

III. Procedures for Use of the HIPAA-Approved Billing Codes

III.A. Most Therapies.

The per diem "S" codes are used to code the provision of home therapy administration. The per diem includes all of pharmacy professional and cognitive services, including drug admixture, patient assessment, clinical monitoring, and care coordination; infusion-related equipment and supplies; and comprehensive 24 hour per day, seven days per week delivery and pick-up services. Except for components included in standard PN formulae, all drugs and enteral formula are coded, billed and reimbursed separately through NDC numbers and HCPCS drug codes.

Using "Not Otherwise Classified" Codes in X12N 837 Professional Claim. The X12N electronic claim standard[11] requires entry of a note with a claim line when "not otherwise classified" codes are used. Computer systems should allow a biller to enter a definitive description of the service or product being submitted on the claim.

Claim notes are always required when the following "S" codes are used: **S9379**, **S9542**, and **S9810**.

In addition, for many therapies the set of per diem "S" codes provides a code we have labeled as "not otherwise classified", or NOC, in our code list in Section VI. Sometimes, these codes are used because provider and payer have signed an agreement to bill with these NOC codes, vs. the standard procedure of billing with a more detailed set of available codes. For example, such agreement might specify that PN be coded with **S9364**, whereas the alternative is to code with **S9365** (1 liter), **S9366** (>1 to 2 liters), etc.

For some of these NOC codes, they may also be used because there isn't an available code to more specifically define the therapy. For example if ½ liter of PN is provided daily **S9364** is used. Another example would be for an anti-infective drug that is administered once every 7 days, S9494 is used. When the NOC codes are used because a more specific code isn't available, entry of a note with the claim line in the X12N claim is advised, and permitted "at provider's discretion" in the X12N claim. Codes in this category are: **S9494**, **S9329**, **S9340**, **S9373**, **S9325**, and **S9364**.

The remaining NOC codes in Section VI not listed in this section are only used by provider-payer agreement and therefore a note on the claim line isn't needed on the X12N claim.

[11] See X12N 837 Professional standard, version 5010, **CMS Fact Sheet**

Selection of Specific Per diem "S" code. We provide guidance on choice of per diem "S" codes in the remainder of Section III and elsewhere throughout this document. In addition, billers should exercise care to select "S" codes that best describe the specific drug therapies provided. If a per diem "S" code description very specifically describes a drug therapy, it would normally be inappropriate to use a more generally described "S" code. For example, when solumedrol is infused then **S9490** (corticosteroid infusion) best describes the therapy and it would not normally be appropriate to use a less specific code such as **S9347** (uninterrupted, long-term, controlled rate.) Billers should be aware of any terms in provider-payer agreements (contracts) that could further specify the "S" code to be billed.

III.B. Anti-infective Therapies.

The per diem "S" codes are used to code the services associated with the provision of antibiotics, antifungals, and antivirals. The codes that specify frequency of administration (Q3H-Q24H) are used; except that the general code **S9494** is used if an "S" code is unavailable for the frequency (e.g., every 7 days as referenced above in III.A), or if **S9494** is required under provider-payer agreement. As with most other per diem "S" codes, all drugs and nursing visits are coded, billed and reimbursed separately.

III.C. Chemotherapy.

The per diem "S" codes are used to code the services associated with the provision of chemotherapy administered continuously or intermittently. The codes that specify continuity of administration are used; except that the general code **S9329** is used if required under provider-payer agreement. *Continuous administration* is defined as that which occurs without interruption over a period of 24 hours or more. *Intermittent administration* is for chemotherapy administered for a period of less than 24 hours. As with most other per diem "S" codes, all drugs and nursing visits are coded, billed and reimbursed separately.

III.D. Enteral Nutrition.

The per diem "S" codes are used to code the services associated with the provision of home enteral nutrition, administered via gravity, pump, or bolus. The codes that specify route of administration are used; except that the general code **S9340** is used if required under provider-payer agreement. As with most other per diem "S" codes, all nursing visits are coded, billed and reimbursed separately. All enteral formulae are also coded, billed and reimbursed separately.

III.E. Hydration Therapy.

The per diem "S" codes are used to code the services associated with the provision of hydration therapy. The codes that specify volume of fluid are used; except that the general code **S9373** is used if an "S" code is unavailable for the volume, or if **S9373** is required under provider-payer agreement. NHIA recommends that **S9373** be used for fluid volume of less than one liter. As with most other per diem "S" codes, all drugs and nursing visits are coded, billed and reimbursed separately.

III.F. Pain Management.

The per diem "S" codes are used to code the services associated with the provision of pain management administered continuously or intermittently. The codes that specify continuity of administration are used; except that the general code **S9325** is used if required under provider-payer agreement. *Continuous administration* is defined as administration occurring without interruption over a period of 24 hours or more. *Intermittent administration* is for pain medications administered for a period of less than 24 hours. As with most other per diem "S" codes, all drugs and nursing visits are coded, billed and reimbursed separately.

III.G. Parenteral Nutrition (PN).

The per diem "S" codes are used to code the services associated with the provision of PN. The codes that specify volume of fluid are used; except that the general code **S9364** is used if an "S" code is unavailable for the volume, or if **S9364** is required under provider-payer agreement. NHIA recommends that **S9364** be used for fluid volume of less than one liter. As with most other per diem "S" codes, nursing visits are coded, billed and reimbursed separately. Some components of the PN formula are included in the per diem as explained next, but all other drugs are coded, billed and reimbursed separately.

In this section, we provide extensive lists of PN components and additives that communicate well to clinicians and others to define the standard. While extensive, these lists cannot be all inclusive. Other products may appropriately be included in the categories of these lists. Further, we use trade names in these lists. Trade names are used to provide a standard that communicates well. Use of trade names is not a product recommendation or comment on extent of use in practice.

As distinguished from all other per diem "S" codes, the PN "S" codes include some drugs and other products in the per diem. Specifically, products used in a standard PN formula and included in the per diem are:

a) Non-specialty amino acids (e.g., Aminosyn®, FreAmine®, Travasol®)
b) Concentrated dextrose (e.g., D10, D20, D40, D50, D60, D70)
c) Sterile water
d) Electrolytes (e.g., CaCl2, KCL, KPO4, MgSo4, NaAc, NaCl, NaPO4)
e) Standard multi-trace element solutions (e.g., MTE4, MTE5, MTE7)

f) Standard multivitamin solutions (e.g., MVI-12 or MVI-13)

Not included in the PN per diem are the following items to be coded, billed and reimbursed separately:

a) Specialty amino acids for renal failure (e.g., Aminosyn-RF®, NephrAmine®)
b) Specialty amino acids for hepatic failure (e.g., HepatAmine®, Hepatasol ® 8%)
c) Specialty amino acids for high stress conditions (e.g., Aminosyn-HBC®, BranchAmin®, FreAmine HBC®, Premasol®, TrophAmine®)
d) Specialty amino acids with concentrations of 15% and above when medically necessary for fluid restricted patients (e.g., Aminosyn® 15%, Clinisol® 15%, Plenamine® 15%, Prosol® 20%)
e) Lipids (e.g., Intralipid®, Liposyn®, Smoflipid®, Omegaven®)
f) Added trace elements not from a standard multi-trace element solution (e.g., chromium, copper, iodine, manganese, selenium, zinc)
g) Added vitamins not from a standard multivitamin solution (e.g. folic acid, vitamin C, vitamin K)
h) Products serving non-nutritional purposes (e.g., heparin, insulin, L- Carnitine, iron dextran, Pepcid®, Sandostatin®)

Depending on stability and practice, some of the products in the lists above are compounded into the PN in the pharmacy, while others are dispensed separately for injection into the PN in the home.

III.H. Specialty Therapies.

The per diem "S" codes of this code set are used to code the services associated with the provision of *specialty* therapies. Specialty therapies may be infused, injected, aerosolized or transfused as described in the HCPCS "S" code descriptions, and range from anti-hemophilic factors to growth hormone to IVIG to infliximab and more (see the code list in Section VI HIPAA-Approved Code System). As with most other per diem "S" codes, all drugs and nursing visits are coded, billed and reimbursed separately. For blood products (**S9538**), all blood products, drugs and nursing visits are coded, billed and reimbursed separately.

III.I Not Otherwise Classified (NOC) Therapies.

The general code **S9379** is used for NOC infusion therapies (including NOC administration through an IV line, into an implanted pump, or "IV push" administration) and the general code **S9542** is used for NOC injectable therapies (including NOC subcutaneous or intramuscular administration). **S9379** or **S9542** are used only if a therapy is not otherwise described by other per diem "S" codes. Such use would typically be for emerging therapies, technologies and services in health care

or as newly provided in the home. Do not use **S9379** or **S9542** in provider-payer contracts for a single health service if this also prohibits its use for other services. Using **S9379** or **S9542** will require manual review by payer claims processors. Providers and payers who find they must use **S9379** or **S9542** are encouraged to submit requests to NHIA for recommendation of additional coding (see Section II.E New Code Requests). As with most other per diem "S" codes, all drugs and nursing visits are coded, billed and reimbursed separately.

III.J. Catheter Care.

The per diem "S" codes are used to code the services associated with the provision of catheter care only when provided as a standalone therapy, or during days not covered under per diem by another therapy. The codes can be used to specify the maintenance for single or multiple lumens in the catheter, as well as for an implanted access device (i.e., implanted port). The codes that specify single/multiple lumens or implanted access device are used; except that the general code **S5497** is used if required under provider-payer agreement.

Excluded from any per diem "S" code are supplies required for non-routine catheter procedures. They are always coded, billed and reimbursed separately using **S5517** for catheter declotting supplies and **S5518** for catheter repair supplies.

As with most other HCPCS per diem codes, all drugs and nursing visits are coded, billed and reimbursed separately for services associated with routine catheter care. In addition, non-routine catheter-insertion services are coded, billed and reimbursed separately: insertion by a nurse of a PICC line (**S5522**) and a midline (**S5523**).

III.K. Home Nursing Services for Infusion/Specialty Drug Administration.

Provision of infusion and specialty drug administration sometimes requires home nursing visits provided by an RN with special expertise.

CPT codes **99601** and **99602** are used to encode high-tech RN services--provided by a RN with special education, training and expertise in home administration of drugs via infusion, home administration of specialty drugs, and/or home nursing management of disease state and care management programs. Typical services include evaluation and assessment, education and training for the patient or caregiver, inspection and consultation of aseptic home environment, catheter insertion, and patient assessment.

Codes used for nursing services, with procedures for use, are:

> **Code nursing "per visit (up to 2 hours)"* with 99601.** This CPT code ("home infusion/specialty drug administration, per visit (up to 2 hours)" is used to code a high-tech RN visit.

--Code nursing "each additional hour"* with 99602. This CPT code ("each additional hour") is used to code additional time if needed beyond the two hours included in the **99601** visit code.

** Unlike nursing services delivered in a facility, a home infusion nurse must travel to the patient's home to meet their individual needs. The time needed for all nursing activities necessary for a home nurse visit—preparation, travel, time in the home, documentation, post-visit reporting, follow-up activities, etc.—should be included on a claim, unless a third-party payer's coverage policy differs from this standard.*

To illustrate the CPT coding with a brief example, if total time required for all activities involved for a nurse visit is 2 hours and 40 minutes, coding is:

99601 Billing Unit = 1

99602 Billing Unit = 1

III.K.1 Nursing -SD Modifier.

To these nursing visit codes, in some circumstances you append the **-SD** modifier ("specialized, highly technical home infusion") to qualify the services as being high-tech home infusion nursing that is *specialized*. A *specialized* high-tech home infusion nurse supports infusion to pediatric, obstetric, and oncology patients; provides infusion of blood products; performs implantable pump programming and/or refilling, and provides other specialty services. **–SD** is used if required under provider-payer agreement, or to distinguish the provider's fees for *specialized* high-tech home infusion nursing. If neither situation is the case, **-SD** is not used.

III.K.2. Catheter Care Insertion.

Insertion by a nurse of a PICC line (**S5522**) or midline (**S5523**) is always coded, billed and reimbursed separately from the other nursing visit codes, as well as separately from any other per diem "S" code. Also coded, billed and reimbursed separately are **S5520** for supplies to insert a PICC line, and **S5521** for supplies to insert a midline.

III.K.3. Nursing Services in Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS).

See Section III.Q for coding procedures.

III.K.4. Unusual or High Risk/Escort Travel.

Codes are available for submitting extra charges to compensate for extra costs sometimes incurred with a home visit, as may be applicable to the provider's usual and customary pricing structure or to provider-payer agreements.

99082 for "unusual travel". Unusual travel (eg, transportation and escort of a patient).

An example of home infusion therapy use would be when unusually expensive transportation expenses are incurred to visit a remote area.

S9381 for "high risk/escort". Delivery or service to high risk areas requiring escort or extra protection, per visit.

III.L. Other Specialized Home Services.

The per diem "S" codes are used to code the care management services associated with the provision of home obstetrical services. For these services, included in the per diem are care coordination activities that include extensive, specialized daily nursing management that are part of these services and provided in the offices of the provider.

Gestational Diabetes Management (**S9214**)
Gestational Hypertension Management (**S9211**)
Preeclampsia Management (**S9213**)
Postpartum Hypertension Management (**S9212**)
Preterm Labor Management (**S9208**)
Preterm Premature Rupture of Membranes (PPROM) (**S9209**)

Provision of these services sometimes requires home nursing visits provided by an RN with special expertise in provision of these services. The following RN visit codes are used for home services not related to home infusion therapies if a home nursing visit is provided:

For prenatal monitoring and assessment:

Code nursing per visit up to 2 hours* with 99500 ("home visit for prenatal monitoring and assessment, to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring")

--Code nursing each additional hour* with S9123 ("nursing care, in the home; by registered nurse, per hour")

For all other home services not related to home infusion therapies:

Code nursing per hour* with S9123 ("nursing care, in the home; by registered nurse, per hour")

** Unlike nursing services delivered in a facility, a home infusion nurse must travel to the patient's home to meet their individual needs. The time needed for all nursing activities necessary for a home nurse visit—preparation, travel, time in the home, documentation, post-visit reporting, follow-up activities, etc.—should be included on a claim, unless a third-party payer's coverage policy differs from this standard.*

To illustrate the coding with a brief example, if total time required for all activities involved for a prenatal monitoring and assessment nurse visit is 2 hours and 40 minutes, coding is:

99500 Billing Unit = 1

S9123 Billing Unit = 1

As another example, for any other home nurse visit not related to home infusion therapies requiring 2 hours and 40 minutes, coding is:

S9123 Billing Unit = 3

III.L.1. Unusual or High Risk/Escort Travel.

Codes are available for submitting extra charges to compensate for extra costs sometimes incurred with a home visit, as may be applicable to the provider's usual and customary pricing structure or to provider-payer agreements.

99082 for "unusual travel". Unusual travel (eg, transportation and escort of a patient)

An example of use for other specialized home services would be when unusually expensive transportation expenses are incurred to visit a remote area.

S9381 for "high risk/escort". Delivery or service to high risk areas requiring escort or extra protection, per visit.

III.M. Extra Services.

HCPCS and CPT provide codes for extra services that may be applicable to the provider's usual and customary pricing structure or to provider-payer agreements. Each code may be used in addition to the per diem "S" codes. See Section VI (Ref. # III.M) for codes available to bill for:

Disease management program, initial assessment and initiation
Disease management program, follow-up/reassessment
Disease management program, per diem
Disease management program, RN telephone calls, per month
Emergency services in the office
Emergency services out of the office

High risk/escort travel
Infusion device routine service
Infusion device repair
Nutritional counseling, dietitian visit
Unusual travel

III.N. THIS SECTION IS RESERVED FOR FUTURE USE

III.O. Professional Pharmacy Services.

All of the HCPCS "S" codes established in 2002 set a new national standard for coding for home professional pharmacy services. The per diem "S" code descriptions encompass most of the services performed to manage home patient care, including the pharmacists' clinical patient care services, care coordination, and a wide range of operational and administrative services. Accordingly, these codes include professional pharmacy services.

However, there are circumstances where it is necessary to bill for professional pharmacy services on a basis other than inclusion in the per diem addressed in this section or in addition to per diem billing.

III.O.1. Professional Pharmacy Services Code.

Setting a new precedent in 2002 was the availability of **S9810** as the first code found in a HIPAA-approved medical coding set to be a standalone code solely for coding professional pharmacy services:

> **S9810 for "professional pharmacy services"*.** "Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)"

As stated in the code definition, you are not to use this code if a per diem "S" code is also used, since the per diem includes all professional pharmacy services.

**Time needed for all activities necessary for a professional pharmacy service—including applicable travel, clinical cognitive activities, care coordination activities, compounding, packaging, documentation, and all other time the office or home—will be included on a claim.*

Next we list circumstances for use of this code:

1. **Pre-admission Services. S9810** is used to bill for pre-admission professional pharmacy services provided for patients referred for home infusion services, but where such services are not provided under a per diem relationship for billing. An example is where services are expended, but infusion services are not actually provided due to a change in patient care plan.

2. **Disease State Management**. Use of **S9810** may fit the clinical/business model established between an individual provider and payer for disease state management services provided by home pharmacies.

3. **Other Situations**. There are other situations where a per diem billing relationship is not established. An example is when a home health agency or physician office is the primary patient care manager/contracted entity submitting claims to the payer, the pharmacy dispenses the products, and the pharmacy submits claims to the agency or physician office. Another example is for provision of injectable drug therapies, where use of a non-per diem structure in contracts and on claims may fit the business/clinical model between an injectable drug pharmacy provider and payer. **S9810** is available to bill for the professional pharmacy services that are provided.

To illustrate the coding with a brief example, if total time required for all activities involved for a professional pharmacy service occurrence is 2 hours and 40 minutes, coding is:

S9810 Billing Unit = 3

III.O.2. After Hours, Emergency and Out of Office Services.

CPT provides codes to represent that the service has been provided outside of the normal weekday work window, on an emergency basis or out of the office, and they would be billed on charge lines separately from per diem "S" codes or S9810. These extra charge lines would be used when higher rates are to be billed, often needed to compensate for increased costs associated with providing these services, per provider-payer agreements or providers' usual and customary fees.

99050 for "in the office at times other than regularly scheduled office hours". Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service. Billed on a separate charge line.

99051 for "in the office during regularly scheduled evening, weekend, or holiday office hours". Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service. Billed on separate charge line.

99053 for "between 10:00 PM and 8:00 AM at 24-hour facility". Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service. Billed on separate charge line.

99056 for "provided out of the office at request of patient". Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service. Billed on separate charge line.

99058 for "provided on an emergency basis in the office". Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service. Billed on separate charge line.

99060 for "provided on an emergency basis, out of the office". Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service. Billed on separate charge line.

One or more of these CPT codes are used to specify additional charge for a single professional pharmacy service occurrence. For example, service "provided on an emergency basis in the office" that occur "in the office during regularly scheduled evening, weekend, or holiday office hours" would be billed on separate charge lines with **99058** and **99051**.

III.O.3. Unusual or High Risk/Escort Travel.

Codes are available for submitting extra charges to compensate for extra costs sometimes incurred with a home delivery or service, as may be applicable to the provider's usual and customary pricing structure or to provider-payer agreements.

99082 for "unusual travel". Unusual travel (eg, transportation and escort of a patient).

An example of home infusion therapy use would be when unusually expensive transportation expenses are incurred to deliver to, or for a pharmacy staff to visit, a patient in a remote area.

S9381 for "high risk/escort". Delivery or service to high risk areas requiring escort or extra protection, per visit.

III.P. Pediatric Services.

Some provider-payer agreements and some provider usual and customary fees prices may distinguish the higher level of services needed for pediatric patients through higher fees. Coding the claims will remain the same as for other non-pediatric claims. Since the birth date of a patient is part of the claim, that information is used by the payer to distinguish the higher rate structure.

III.Q. Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS).

Many home infusion therapy providers also operate a health care facility called the *Ambulatory Infusion Suite of the home infusion therapy provider, or AIS*. The Ambulatory Infusion Suite of the home infusion therapy provider is a setting where the clinical care provided pursuant to physician orders is managed and performed by RN's and registered pharmacists that are highly skilled in provision of infusion/specialty drug administration. National accrediting organizations (e.g., The Joint Commission) recognize these infusion suite settings as adjunct to the services of a home infusion therapy provider with supplemental accreditation standards.

This is one of three types of Ambulatory Infusion Centers (AICs):

- Ambulatory Infusion Suite of the home infusion therapy provider (AIS).
- Physician-based infusion clinic.
- Hospital-based infusion clinic.

Prior to 2005, there were "coding gaps" in HCPCS and CPT for billing of the services provided in the AIS[12]. In spite of this, commercial and Medicaid payers had recognized the AIS as a setting that may offer cost-effective care as compared to physician-based and hospital-based infusion clinics. Therefore codes used may not have been the most appropriate given code descriptions, but such coding was necessary to bill for these services. With addition of a new code modifier added late in 2004, transition to standardized HIPAA-compliant coding for AIS services has been underway starting in 2005.

[12] This is in contrast to infusion therapy provided as incident to physician services or provided to hospital outpatients where codes have existed.

To close the coding gaps, CMS added a modifier for the purpose of coding drug administration and other services provided in the AIS that became effective for use starting October 1, 2004:

-SS Home infusion services provided in the infusion suite of the IV therapy provider.

Modifiers released by CMS can be used to modify both HCPCS and CPT codes.

III.Q.1 All Services for Therapy Provided in the AIS.

Sometimes for a therapy, all of patient's treatment is performed in the AIS. The natures of these therapies and examples are provided next:

- Dosing interval is often infrequent, while the total regimen of therapy may last over long periods of time for chronic illnesses.
    - Examples: infliximab for rheumatoid arthritis or Crohn's disease, IVIG for hypogammaglobulinemia, methylprednisolone for multiple sclerosis, palivizumab for pediatric RSV, blood transfusion for various blood disorders, etc.
- Dosing interval may be more frequent, but the total length of therapy is brief.
    - Examples: methylprednisolone for multiple sclerosis, prophylactic premedications for patients with a history of endocarditis prior to dental work, etc.

- Clinical situations in which close monitoring is required by an RN for the duration of the drug administration or where stat laboratory results are used by the physician to order specific dosage
    - Examples: amphotericin B for systemic fungal infections where monitoring of vital signs, pulse, etc. are required; hydration fluids with additives such as for hyperemesis associated with pregnancy to ensure patient stabilization; calcium, magnesium, etc. for electrolyte imbalances where the patient is dosed based upon stat laboratory results and thus an extra home visit can be avoided; blood transfusion for various blood disorders, etc.

As in home infusion therapy, all drugs and nursing visits are coded, billed and reimbursed separately as required by the HCPCS per diem "S" code descriptions. See Example 7 for illustration of the procedures that follow in this section.

Coding for Nursing. When the patient is seen in the AIS, an RN will treat the patient. This is like treatment provided by a home infusion nurse in a visit to the patient's home, except that the patient is visiting the nurse in the AIS. Codes used for nursing services, with procedures for use, are:

Code nursing "per visit" (up to 2 hours of patient service in suite*) with 99601 -SS. This CPT code ("home infusion/specialty drug administration, per visit (up to 2 hours)" as modified by **–SS** is used to mean:

RN services in the ambulatory infusion/specialty drug administration suite of the home infusion therapy provider, per visit (up to 2 hrs patient service in suite)

--**Code nursing "each additional hour"* with 99602 –SS.** This CPT code ("each additional hour") is used to code additional time if needed beyond the two hours included in **99601 -SS**.

** Time recorded is for the duration of patient service in suite.*

To illustrate the CPT coding with a brief example, if time of duration of patient service in suite is 2 hours and 40 minutes, coding is:

99601 -SS Billing Unit = 1

99602 -SS Billing Unit = 1

Nursing -SD Modifier. To these nursing per diem, in some circumstances you append the **-SD** modifier ("specialized, highly technical home infusion") to qualify the services as being high-tech infusion nursing that is *specialized*. A *specialized* high-tech infusion nurse supports infusion to pediatric, obstetric, and oncology patients; provides infusion of blood products; performs implantable pump programming and/or refilling, and provides other specialty services. **–SD** is used if required under provider-payer agreement, or to distinguish the provider's fees for *specialized* high-tech home infusion nursing. If neither situation is the case, **-SD** is not used.

Catheter Care Insertion. Insertion by a nurse of a PICC line (**S5522**) or midline (**S5523**) is always coded separately from the other nursing visit codes, as well as separately from any other per diem "S" code. To each code is added the **–SS** modifier since the insertion has been performed in the AIS.

Coding for AIS Services (other than RN services). The **–SS** modifier is also used with any of the HCPCS per diem "S" codes for home infusion therapy including infusion, injection and other administrations, i.e. all per diem "S" codes listed in Section VI. Appending **-SS** therefore modifies the code descriptions to indicate the administration was provided in the AIS.

For example, if infliximab is administered then in addition to coding for the nursing, the other services provided in the AIS would be coded with:

S9359 -SS **"**Home infusion therapy, anti-tumor necrosis factor intravenous therapy; (e.g. infliximab); administrative services, professional pharmacy services, care coordination, and all necessary

supplies and equipment (drugs and nursing visits coded separately), per diem" as modified by "home infusion services provided in the infusion suite of the IV therapy provider"

Which means The infliximab administration was performed in the AIS.

Also As with home infusion therapy claims, the administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment involved with treatment of the patient are recognized in the per diem "S" code description through which they are billed and paid for. In addition, also included is payment for the use of the AIS facility.

And As with home infusion therapy claims, all drugs and nursing services are coded, billed and paid for separately.

A complete example for coding an infliximab claim is provided in Example 7.

Using the HCPCS "S" and CPT codes. The conclusion is that nearly all of the HCPCS "S" and CPT codes of Section VI may be used for coding when all services for a therapy are provided in the AIS.

For the per diem "S" codes, fee schedules established may reflect variations in providers' expenses to provide different therapies.

Especially important to recognize is that administration of different therapies has average drug administration times that vary greatly by therapy. For example, a typical administration of IVIG lasts up to 6 hours and therefore high cost is incurred since the patient is occupying the infusion space for a lengthy period.

In addition to HCPCS per diem "S" codes, other HCPCS and CPT codes may be used and should be modified with **–SS** when services are performed or products are used in the AIS. For example, professional pharmacy services provided in the AIS

may be coded with **S9810 –SS** if per diem coding is not being used (see Section III.O Professional Pharmacy Services). As another example, **99058 –SS** may be coded for emergency services provided in the AIS (see Section III.Q.3 After Hours, Emergency and Out of Office Services).

Coding Drugs and Blood Products. All drugs and blood products are coded, billed and reimbursed separately, with coding modified with **–SS** to indicate administration was provided in the AIS[13].

III.Q.2. Occasional Occurrence of Treatment in the AIS.

Sometimes for a therapy that is administered in the home, a particular nursing encounter is provided in the AIS. An example would be to provide a first dose of medication to a patient in a controlled setting with necessary monitoring equipment and emergency medication readily available, often at a location close to a hospital should additional care be needed. Or, when close monitoring of patient technique for delivery of medication is needed with immediate availability of different drug delivery systems, such as when there may be ongoing issues with operation of the medication delivery system at the home. Or, to perform catheter replacement, dressing change, and/or catheter declotting, since the nurse may be more readily available in the AIS and more timely service may be provided than in the home.

The Patient is a Home Infusion Therapy Patient. While an occasional nursing encounter occurs in the AIS for purposes of clinical monitoring or access to care, this is an extension of the continuity of care for a home patient. Stating again, on these occasions the service performed in the AIS is a continuation of the service provided to the home infusion therapy patient. Drugs associated with the ongoing provision of the therapy (e.g. antibiotic, sterile water for reconstitution, diluent, heparin/saline for catheter flush, etc.) are prepared and dispensed by the pharmacy in batch for home use. As a practical matter of providers' ability to correctly code claims, as well as payers' ability to correctly adjudicate them, for the drugs associated with the ongoing provision of the therapy the **–SS** modifier isn't used for coding of the drugs.

However, the **–SS** modifier is used for coding of specific nursing encounters performed within the AIS, such as with **99601** -**SS** (infusion/specialty drug administration). **–SS** is also used to modify coding of drugs or products provided by the pharmacy for use in an AIS nursing procedure, other than drugs and products prepared in batch for home use that are associated with the ongoing provision of the therapy.

[13] Use –SS for coding, billing and reimbursement for all enteral formulae and products billed separately with PN (see Section III.G) when all services for enteral or PN therapies are performed in the infusion suite (unlikely).

For example, **–SS** would be used for billing drugs and products used for insertion of a PICC line in the AIS because the drugs and products are provided by the pharmacy specifically for use in an AIS procedure. Whereas, drugs associated with the ongoing provision of the home therapy (e.g. antibiotic, sterile water for reconstitution, the diluent, heparin/saline for catheter flush, etc.) are prepared and dispensed by the pharmacy in batch for home use, and **–SS** isn't used even though there may be occasional occurrence of use in the AIS.

The coding rules for when **–SS** is used are clarified through the procedures that follow and via the examples for coding a claim for home infusion therapy with occasional occurrence of treatment in the AIS in Examples 8A and 8B. Home infusion therapy providers providing AIS services and payers should understand the coding procedures as specified in this document via provider-payer agreement or other communication by the provider to the payer.

HINT: If you are reading this material for the first time, we recommend you review Examples 8A and 8B before continuing on with the remaining material of this section.

Coding with HCPCS per diem "S" codes. In all these instances, the patient is a home infusion therapy patient. Existing HCPCS per diem "S" coding is used to code for the therapy provided by the home infusion therapy provider, including for days in which a nursing intervention may be provided in the AIS. All drugs and nursing visits are coded, billed and reimbursed separately as required per the descriptions of the per diem "S" codes.

Coding for Nursing. When the patient is seen in the AIS, an RN will treat the patient. This is like treatment provided by a home infusion nurse in a visit to the patient's home, except that the patient is visiting the nurse in the AIS. Codes used for nursing services, with procedures for use, are:

> **Code nursing "per visit" (up to 2 hours of patient service in suite*) with 99601 -SS.** This CPT code ("home infusion/specialty drug administration, per visit (up to 2 hours)" as modified by **–SS** is used to mean:
>
> > **RN services in the ambulatory infusion/specialty drug administration suite of the home infusion therapy provider, per visit (up to 2 hrs patient service in suite)**

--**Code nursing "each additional hour"* with 99602 –SS.** This CPT code ("each additional hour") is used to code additional time if needed beyond the two hours included in **99601 -SS**.

> ** Time recorded is for the duration of patient service in suite.*

To illustrate the CPT coding with a brief example, if time of duration of patient service in the AIS is 2 hours and 40 minutes, coding is:

99601 -SS Billing Unit = 1

99602 -SS Billing Unit = 1

Observe that the nursing coding procedure just presented is identical to the procedure of Section III.Q.1. Also, coding procedures for when a patient is treated by an RN in the home are provided in Section III.K.

Nursing -SD Modifier. To these nursing per diem, in some circumstances you append the **-SD** modifier ("specialized, highly technical home infusion") to qualify the services as being high-tech infusion nursing that is *specialized*. A *specialized* high-tech infusion nurse supports infusion to pediatric, obstetric, and oncology patients; provides infusion of blood products; performs implantable pump programming and/or refilling, and provides other specialty services. **–SD** is used if required under provider-payer agreement, or to distinguish the provider's fees for *specialized* high-tech home infusion nursing. If neither situation is the case, **-SD** is not used.

Claim Lines Coded with –SS Modifier. –SS is used to code specific professional procedures that are coded separately from the per diem when they are performed in the AIS, e.g. nursing procedures performed in the AIS. In addition, when drugs and product used in such procedures are billed separately, they are appended with **–SS**. See the coding of the next rules illustrated in Examples 8A and 8B.

1. **Use –SS to modify all per diem used for coding specific professional procedures that are coded separately from the per diem when they are performed in the AIS.**

   These are procedures performed by RNs, dietitians, and registered pharmacists.

   Examples when service provided in the AIS: **99601 –SS**, infusion/specialty drug administration.

   S5522 -SS, PICC line insertion. **S9470 -SS**, nutritional counseling, dietitian visit. **99058 –SS**, emergency office services. **99050 –SS**, after office hours. Etc.

2. **Use –SS to modify codes for drugs and other products used in the procedures of item #1.**

Examples when service provided in the AIS: **S5000 –SS with NDC#**, generic prescription drug. **S5520 -SS**, PICC line kit. **S5517 –SS**, declot supply kit. Etc.

Claim Lines Coded Without –SS Modifier. See the coding of the next rules illustrated in Examples 8A and 8B.

A. Do not use –SS with the per diem "S" codes.

Do not split out with **–SS** modifier separate claim lines for per diem billing days in which drugs are infused in the AIS from days where infusion occurs in the home[14]. This is because the patient is a *home infusion therapy patient*.

B. Do not use –SS with coding of drugs or any other products associated with but billed separately from per diem.

For example, let's look at a situation in which a first dose of a home infusion therapy is provided in the AIS. As required by the descriptions of the per diem "S" codes, all drugs are coded, billed and reimbursed separately. Do not split out with **–SS** modifier separate claim lines for drugs infused during the first dose, from drugs infused for all remaining doses in the home[15]. Because the patient is a *home infusion therapy* patient, all units of each drug provided for the therapy are coded on a single claim line for the date span of therapy being claimed, just like for any home infusion therapy patient.

C. Do not use –SS with coding of nurse or other professional visits to, or procedures in, the home.

Examples when service provided in the home: **99601**, home infusion/specialty drug administration (up to 2 hours). **S5522** PICC line insertion. **S9470** nutritional counseling, dietitian visit. **99082** unusual travel. Etc.

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[14] We should note there would be situations where infusion would occur both in the infusion suite and at home on a single day. Therefore, to split out per diem codes using –SS would result in billing of two per diems on a single day, which isn't the intent of per diem billing for a single home infusion therapy.

[15] Attempts to split out would result in multiple lines for same products with same dates. This would be extremely difficult for providers to accomplish without error on claims, and would result in payer denial for duplicate claim lines.

Do not use –SS with coding of drugs and other products used in the visits or procedures of item C.

Examples when service provided in the home: **S5000 with NDC#**, generic prescription drug. **S5520**, PICC line kit. **S5517**, declot supply kit. Etc

III.Q.3. After Hours, Emergency and Out of Office Services. CPT provides codes to represent that the service has been provided outside of the normal weekday work window, on an emergency basis or out of the office, and they would be billed on charge lines separately from per diem "S" codes or S9810. These extra charge lines would be used when higher rates are to be billed, often needed to compensate for increased costs associated with providing these services, per provider-payer agreements or providers' usual and customary fees. The CPT codes are appended with the –SS modifier since such office services would be performed in the AIS

99050 for "in the office at times other than regularly scheduled office hours". Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service. Billed on a separate charge line.

99051 for "in the office during regularly scheduled evening, weekend, or holiday office hours". Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service. Billed on separate charge line.

99053 for "between 10:00 PM and 8:00 AM at 24-hour facility". Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service. Billed on separate charge line.

99056 for "provided out of the office at request of patient". Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service. Billed on separate charge line.

99058 for "provided on an emergency basis in the office". Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service. Billed on separate charge line.

99060 for "provided on an emergency basis, out of the office". Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service. Billed on separate charge line.

One or more of these CPT codes are used to specify additional charge for a single professional pharmacy service occurrence. For example, service "provided on an emergency basis in the office" that occur "in the office during regularly scheduled evening, weekend, or holiday office hours" would be billed on separate charge lines with **99058** and **99051**.

III.Q.4. Coding for Place of Service[16].

Proper use of Place of Service Code (POS) is important to ensure payers process the claim properly as some payers will use POS found on claims to determine the benefit. For example, many payers will have a benefit for services in the home (POS=12) that is different from services provided in other locations as denoted by different POS codes. So, for some payers it will be important to accurately provide the place of service on claims in accordance with the benefit structure put in place for AIS services by the health plan. Providers should determine from the health plan covering the service the POS code to be used when drug administration or other services are provided in the AIS. We recommend the provider document the instructions on POS provided by the health plan.

Common practices have been in place (per instruction from health plans) to use Place of Per diem "12" or "49". While POS=49 provides the best description for place of service (see description that follows), use of "12" or possibly other POS codes is also appropriate as explained next.

From available POS codes, use:

Use Place of Service Code 12 ("location, other than a hospital or other facility, where the patient receives care in a private residence") for drug administration or other services that are provided in the AIS.

Because coding of drug administration provided in the AIS includes use of the **–SS** modifier, the modifier itself indicates the location of service is in the AIS and therefore use of POS=12 as directed by the health plan is appropriate.

OR

[16] The Place of Service code list can be accessed at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Use Place of Service Code 49 ("a location, not part of a hospital and not described by any other Place of Service Code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients, only") for drug administration or other services that are provided in the AIS.

While unlikely, it is possible that the health plan will direct that POS codes other than "49 or "12" be used which would be appropriate since the modifier itself indicates the location of services is in the AIS.

Stated again, providers should determine from the health plan covering the service the POS code to be used when drug administration or other services are provided in the AIS. We recommend the provider document the instructions on POS provided by the health plan.

III.R. Modifiers.

Section III.K Home Nursing Services for Infusion/Specialty Drug Administration, provides the standard for using the **-SD** modifier for "specialized, highly technical home infusion" nursing. Section III.Q Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS), provides the standard for using the -**SS** modifier for coding of drug administration and other services provided in the AIS.

In addition, two situationally used modifiers allow specification of second, third or more therapies provided on the same dates of service:

-SH Second concurrently administered therapy.

-SJ Third or more concurrently administered therapy.

-SH *and* ***-SJ*** *may be used if distinction is needed per provider-payer agreement on per diem rates or to distinguish the provider's usual and customary fees. Additionally, these modifiers may be used to indicate that a therapy is a distinct administered therapy not to be denied as duplicate billing.*

An example would be where a second anti-infective drug therapy is provided in a separately compounded IV bag for infusion over a service period for some of the same days as for a first anti-infective drug therapy. If the provider-payer agreement specifies that the per diem rate for the second anti-infective therapy is to be paid at a rate other than the normal per diem rate, the payer will need to recognize such situations on claims. To accomplish that, the provider-payer agreement may require the provider append -**SH** to the anti-infective per diem "S" code associated with the second therapy for the overlapping per diem service days.

Another example would be to distinguish multiple per diems billed on the same dates of service as being distinct administered therapies which shouldn't be denied by the payer as a duplicate per diem billing. If there were four per diems to be billed on the same dates of service (unusual but not improbable,) the four per diems may be billed respectively with no modifier, **-SH**, **-SJ** and **-SJ**. While we recommend this approach to payers that might otherwise install edits in their adjudication systems to deny multiple per diems billed on the same dates of service, we do not encourage such claim edits because provision of multiple, concurrent infusion therapies is sometimes needed to treat patients.

The following modifiers may be appended to HCPCS codes to specify the route of administration where unspecified in the HCPCS code description:

-JA Administered intravenously.

-JB Administered subcutaneously.

Use of -JA or -JB will be rare. *Do not use -JA or -JB when the HCPCS per diem code description already specifies the same route of administration.* For example, -JA would never be used with a code having in its description "home infusion therapy" and -JB would never be used with a code having in its description "home injectable therapy". An example for using such a modifier might be to code with -JA for a pediatric patient's infusion therapy when normally the drug is injected intermittently.

The following modifier may be used to qualify HCPCS per diem "S" codes when a more complex/high level of care is provided than might otherwise be assumed in a per diem "S" code, to be used only as specified per provider-payer agreement or to distinguish the provider's usual and customary fees:

-TG Complex/high level of care

An example could be to qualify the not otherwise classified per diem codes **S9379** and **S9542** when particular therapies require a more complex/high level of care than others.

IV. Claim Coding Examples

NHIA provides a comprehensive set of examples to illustrate best use of the National Coding Standard. Regarding codes used, most home infusion services and products are encoded with billing codes from the HCPCS Level II code set, the "S" codes. As required under HIPAA regulation (see Section VIII), nursing visits and all drugs are coded, billed and reimbursed separately. For this purpose, nursing visits are coded with CPT and HCPCS codes (see Section III.K). HCPCS codes used in the next examples were in effect in 2011. We discuss coding of drugs next.

IV.A. Coding for Billing of Drugs

In February 2003, the U.S. Department of Health and Human Services (HHS) released its rule modifications to 45 CFR Part 162, Modifications to Electronic Data Transaction Standards and Code Sets. We call it the "Modified TCS Rule". While HHS has written that they repealed setting the standard as NDC number for drug coding on the X12N electronic claim, it is the X12N electronic claim standard that allows drugs to be coded on X12N claims with NDC numbers although HCPCS codes are also included. Custom and "local" coding for drugs is not allowed.

- Terminology Note. Most but not all drug codes in HCPCS begin with the letter "J". Commonly, HCPCS drug codes are called "j-codes". We will use this convention at times, but be aware that there are other HCPCS drug codes starting with different letters including drug code A4216 which is used in our examples.

IV.B. Coding Drugs with NDC Numbers is Superior for Home Infusion Claims

For home infusion claims, coding drugs with NDC numbers has many specific advantages over HCPCS:

1. **NDCs exist for all prescription drugs because they are assigned by the FDA when a drug is approved.**

   - In contrast, the HCPCS code set is incomplete because assigned drug codes tend to be those for which Medicare Part A or B will pay under certain circumstances. This means that for some infusion drugs there are no specific HCPCS codes assigned. Therefore, HCPCS unclassified drug codes must sometimes be used for billing, and that leads to costly manual claim processing by payers, with resultant delay in payment to providers. Adding to the confusion is that there are multiple unclassified HCPCS drug codes to select from. We use J3490 ("unclassified drugs") in our examples because it is the most generally stated unclassified code.
   - As compared to the immediate assignment of NDC numbers, establishing HCPCS drug codes takes much longer. If a j-code is established at all, the result from the process of submitting requests for new HCPCS is that code assignment can take from 12 to 24 months or more, after the new drug is approved by the FDA.

2. **A NDC uniquely identifies each drug, including its manufacturer, strength, dosage form, formulation and package size.**

- NDC coding gives payers the data necessary to facilitate potential "drug rebate" agreements with manufacturers. This is especially important for Medicaid health plans where federal law authorizes them to establish such agreements, and may be applicable for commercial insurance.
- The detail provided by NDC coding also enables payers to analyze usage of and payments for specific drugs from specific manufacturers.
- The detail provided by NDC coding enables payers to establish drug and manufacturer specific fee schedules that may reasonably take into account the provider's acquisition costs.

3. Specifying of billing units is simpler with NDC coding and results in fewer errors.

- For home infusion claims, with NDCs the billed units equal the containers used, e.g. number of vials, number of bags, etc.
- This methodology for billing unit is simple and well understood, and it is an approach that is already well established processing home infusion paper claims submitted on the CMS 1500 form[17].
- In contrast, bill units for j-codes are different for each code, and written into the code description. For example, billing for seven ceftriaxone 2 gram vials in HCPCS requires a billing unit of 56 because the J0696 HCPCS code description is for "per 250 mg". If billed with NDC number, determining the billing unit is simple—it's a count of 7, the number of vials used for compounding of the prescription.
- As illustrated in this ceftriaxone example, billing the quantity used with NDCs on home infusion claims is simple and easily understood by non-clinicians, i.e. the provider's billers. Assignment of billing units with NDCs is easier to automate in home infusion computer systems. All this means there is less error, less re-work, and less potential for undetected billing errors resulting in inaccurate payments on claims.
- For payers, the situation is similar. It is easier for their claims processing computer systems to automate processing with NDC numbers, and simpler for their claims processing staff to adjudicate the drug claims should manual review be necessary. There is less potential for error.

4. HCPCS billing units in the code descriptions frequently do not match the commonly available drug packaging sizes from the manufacturer.

[17] Formerly called the HCFA 1500 form.

- For NDC coding of home infusion claims, it is simple: billed units equal the containers used, e.g. number of vials, number of bags, etc.

5. **In HCPCS, providers may have multiple HCPCS codes to select from <u>for the same drug</u> and there is lack of clarity as to which one to use.**

   - There is no possibility of multiple codes in NDC.

6. **Some HCPCS drug code descriptions encompass different prescription drugs. Also, some drugs which come in different package sizes map to a single HCPCS code. Both occurrences can result in claims being denied in error as "duplicate".**

   - These claim processing errors will not occur when NDCs are used for adjudication.

Because of these reasons, the practice for home infusion is that NDCs are used to code drugs on the majority of home infusion therapy claims, although HCPCS drug codes are also provided for reference. NHIA strongly encourages that home infusion drug coding and reimbursement be based upon NDC coding and units because of the past precedence and for the reasons listed here.

IV.C. Primer on NDC Numbers

NDC numbers are assigned by the FDA, and they have different formats for their numeric content with dashes to separate the numbers:

1234-0123-01 4-4-2 format

01234-123-01 5-3-2 format

01234-0123-1 5-4-1 format

While these formats appear on the drug packaging, each of them is easily mapped into the "11 digit", 5-4-2 format used in computer systems by adding leading zeros, as seen next:

1234-0123-01 4-4-2 format becomes 01234-0123-01 (5-4-2 format)

01234-123-01 5-3-2 format becomes 01234-0123-01 (5-4-2 format)

01234-0123-1 5-4-1 format becomes 01234-0123-01 (5-4-2 format)

According to the FDA, for these formats:

- The left segment is a **labeler code**. Assigned by the FDA, a labeler is any firm that manufactures, repacks or distributes a drug product.
- The middle segment is a **product code**. It identifies a specific strength, dosage form, and formulation for the drug for a particular firm.
- The right segment is the **package code**. It identifies package sizes.

More information is found at **www.fda.gov/cder/ndc/database/default.htm**.

IV.D. Using NDC Coding for Reimbursement

Recognizing there may be differences in approach, we provide information to further educate on what NHIA understands to be the most common practice.

For each specific NDC number, providers and payers make use of commercially available pricing databases. Historically, the prevailing practice has been to use a pricing methodology called Average Wholesale Price (AWP), but other methodologies exist. NHIA is aware of the following commercial database sources that include benchmark fee schedules for every NDC:

- Medi-Span®
- RED BOOK™

This product list is provided only to complete this primer on NDCs. Listing them is not a product recommendation or comment on extent of use in practice.

IV.E. Coding of Drugs in the X12N 837 Electronic Claim

Under HIPAA, the X12N 837 Professional claim (837P) electronic format is the equivalent of the CMS 1500 paper claim form, and within 837P the data structures accommodate billing of home infusion claims with NDC number. The examples of this section that follow illustrate the key data elements. Specifically, for billing of drugs in the X12N electronic claim:

- A HCPCS code is always required.
- If drugs are also coded with an NDC number, then in the electronic claim the NDC is entered in what is called the "2410 loop"—see the X12N 837P standard[18] and the X12N 837 Professional claim example we provide (later).
- For both the HCPCS code and NDC number, the 837P standard requires billed quantity. For this reason, our examples show billed quantity units for both the HCPCS and NDC. This is why you see two billed quantities (under the Days or Units column) on each claim line in the examples.
- For each NDC number billed on the claim, in the 2410 loop a unit of measure code for the quantity billed is required. For most home infusion claims, the unit of measure code will be UN (for "unit"), which means that the drug quantity billed is the number of drug containers on which the NDC number is labeled (vials, bags, etc)[19]. For example, seven vials of a drug are billed as 7 UN.
- For CMS 1500 paper claims, the National Uniform Claim Committee's 1500 claim form instruction manual[20] uses a similar convention. For example, 7 vials of a drug are billed as UN7.
- While we have omitted showing the unit of measure code (UN) to reduce clutter in the examples, for each NDC number billed an actual claim would include the unit of measure code for the quantity billed.

Data is Sufficient: The following data provided on electronic claim lines for drugs is 100% sufficient for billing and processing of the claim.

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[18] Obtain from **www.wpc-edi.com**.

[19] An exception is for drugs or biologics where strength varies in the manufacturing process. "International units" are billed with unit of measure code F2.

[20] Full name of document is *NUCC 1500 Health Insurance Claim Form Reference Instruction Manual*. Obtain at **www.nucc.org**.

1) Date(s) of Service*
2) Place of Service
3) CPT/HCPCS (or, for drugs, NDC)*
4) Diagnosis
5) $ Charges
6) Days or Units*
7) Unit of measure code for NDC quantity billed

* Field provided in solutions to our examples.

In 1–6 above, we used data labels that are seen in Box 24 of the CMS-1500 paper claim form. Fields <u>not</u> listed above are seldom, if ever, used for billing of drugs on the electronic claim. The NUCC's 1500 claim form instruction manual provides an example of a drug billing that might be found in a 1500 claim[21]:

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
N45914801665 UN1												
10	01	05	10	01	05	11		J0400		1	250 00	40

<u>A Note on Other Prescription Information</u>. On paper, in some cases it has been the practice to provide such data elements as drug name, dosing frequency, strength of drug provided, number of total doses, etc. as comments for each drug line. None of this information is necessary for billing and processing of home infusion electronic claims.

[21] Illustration from *NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 08/05*, July 2010 Version 6.0 07/10 © 2010 American Medical Association.

Accordingly, in the 837P, there are no data elements present to submit such information—simply because the information is not relevant to billing or processing the professional pharmacy claim.

A Note on Rx Number. In our examples, we do not show an Rx number for drugs. In the 837P standard, Rx number is required when drugs are coded with NDC number. This requirement facilitates identification of drugs that are elements of compounds and coded with NDC number, and enables adjudication that may include payment of a "compounding fee" used by some Medicaid health plans. This is the only circumstance in 837P where Rx number is provided.

A Note on Providing Information in Claim Notes. There may be desire to use the 837P standard to replicate data practices for paper claims. The developers of the 837P standard have carefully analyzed information necessary, and not necessary, to place in a health care claim. The standard reflects their analysis and use of claim notes is limited.

- There may be a temptation for payers to require submission of information for drug claim lines in the 837P data field in a claim line note. In fact, this is prohibited in the 837P standard. Specifically, the claim note is required to be used only if the submitter of the claim used a "not otherwise classified" (NOC) procedure code on the service line or at provider's discretion.

- As shown in the Addendum Examples, frequently the unclassified drug code J3490 is used. NHIA recommends the following be placed in the 837P claim line note when J3490 is used:

    - Positions 1-4: "NDC:"

    - Position 5: space

    - Positions 6-18: NDC number in eleven digit format, with dashes, e.g. 01234-0678-01

    - Position 19: space

    - Positions 20-54: product name (use trade name if brand drug is used, generic name if generic drug is used)

    - Position 55: space

- Position 56-61: "Units="
- Position 62 and on: Enter billed quantity, no leading zeros; followed by a space; and then the unit of measure code (usually UN)[22]

- Actual NDC number, billed quantity and unit of measure code are also provided in 837P's 2410 loop, so the payer's claims processing system may obtain the information either from the claim line note or the 2410 loop. If the payer's claims processing information system extracts this data from the 2410 loop, manual intervention of the claim to interpret the content of the note can be minimized.

- Entering information in claim notes often results in setting apart claims for manual processing, at higher cost to payers with delays in payment to providers. This is why the developers of the 837P standard have severely restricted their use.

In an Addendum example which follows later, we provide an example of a home infusion therapy claim illustrated as a HIPAA-compliant X12N 837 Professional claim that is useful for information technology and other professionals. Most electronic claims for home infusion therapy are submitted to payers using the 837P claim format.

IV.F. Claiming of Nursing Visits May or May Not Be on Same Claim.

In some examples, the home infusion provider also provides the high-tech RN services. Therefore, the provider's claims include both the comprehensive pharmacy-related services and the nursing services. In practice, this is sometimes the case. However, in other cases the nursing is provided by an organization separate from the home infusion provider and, therefore, nursing may be submitted on a separate claim. Our examples are not a recommendation or comment on frequency of either practice.

IV.G. Claims Are for Submission of Charges.

In the examples, the columns contain key data elements for claim charge lines to be submitted. While charges are not shown in the examples, *the standard is that every charge line submitted will have charges for an amount greater than zero,*

[22] Five unit of measures code are available: UN for Unit, F2 for International Unit, GR for Gram, ME for Milligram, and ML for Milliliter.

and no lines are submitted with a zero charge amount. Any services or products not charged for are not itemized on the claim.

IV.H. Importance of Electronic Claim Submission.

We have labeled the columns in our examples to have names found on the paper CMS 1500 form's Box 24 charge lines for convenience of illustrated examples. However, NHIA strongly encourages submission of electronic X12N 837 professional claims to achieve the many benefits from associated administrative simplification:

Paper claims are processed more slowly.

Speed of payment is faster for electronic claims.

Payers and providers reduce their administrative costs through electronic claiming.

Electronic health care is the future of health care.

IV.I. Use of Trade Names and NDC Numbers.

In some examples, we use trade names. In all examples, we use real NDC numbers for drugs (assigned when examples written), and those familiar with NDC may recognize the company that is the labeler. We do this to provide examples that communicate well. Use of trade names and NDC numbers is not a product recommendation or comment on extent of use in practice.

IV.J. Examples Build Upon Each Other.

Subsequent examples we provide are often similar to earlier examples presented. They build upon each other. Certain examples that are highly similar have a number example number suffixed with A, B, C, etc., e.g. Example 1A, Example 1B, Example 1C, etc. When using this document for the first time, we recommend you read all the examples in sequence.

Example 1A ANTI-INFECTIVE THERAPY FOR ONE WEEK; NO NURSING

Provided is Rocephin® (ceftriaxone), 2 gm IV, q24h over 7 days for gravity infusion through PICC line. 20mls sterile water is the diluent for reconstitution of the Rocephin which is compounded into 100ml saline IV mini-bags. Also provided are all administration supplies and the pole necessary for the Rocephin infusion. Additionally provided are the flushing solutions (sodium chloride and heparin) prepackaged by the manufacturer in pre-filled syringes. As with all pre-filled syringes, each syringe is labeled with an NDC number. As nursing is provided by a home health agency that is a different organization from the home infusion provider, nursing charges are not included on the claim from the home infusion provider. The PICC line is in place and functioning properly.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	S9500		7	Anti-infective q24h per diem. HCPCS per diem "S" code.
2/1/YY	2/7/YY	J0696		56	HCPCS code is "injection, ceftriaxone, sodium, per 250 mg".
		00004-1965-01		7	Rocephin 2 gram vials
2/1/YY	2/7/YY	A4216		14	HCPCS code is "sterile water, saline and/or dextrose, diluent/flush, 10 ml".
		63323-0249-10		14	Sterile water, 10ml vials.
2/1/YY	2/7/YY	J7050		3	HCPCS code is "infusion, normal saline solution, 250 cc".
		00338-0049-38		7	Sod chl 0.9% 100ml IV mini-bags.
2/1/YY	2/7/YY	A4216		14	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".
		08290-0330-10		14	0.9% Sod chl 10ml pre-filled syringes. For flushing.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	J1642		350	HCPCS code is "injection, heparin sodium, (heparin lock flush), per 10 units".
	Drug Billed with NDC	08290-0380-05		7	Heparin Lock 100u/ml 5ml pre-filled syringes. For flushing.

Comment: As with other HCPCS per diem "S" codes, the provider's charges for administrative services, professional pharmacy services, care coordination services, supplies, and DME are coded in the per diem line. Since the anti-infective per diem covers the entire service period, a per diem charge for catheter care is not submitted, although the flushing drugs are coded, billed and reimbursed separately.

Conforming to the HCPCS per diem "S" code descriptions, all drugs are coded, billed and reimbursed separately for billing to the payer. Failure to use this approach would be a violation of HIPAA regulation. Drugs and nursing visits cannot be included in the per diem fee that is claimed.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent. For example, the provider may choose to code 100ml mini-bags of normal saline with J3490 in this example.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service, such as with A4216 in this example. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Box 24 Coding: For this example, we illustrate how the data elements of the example would be coded on Box 24 of the CMS-1500 claim form. For the coding of drug information with NDC number, we note that the "N4" seen on the beginning of each NDC line is a "qualifier" to indicate that what follows is an eleven position NDC number. In addition, the billed quantity for the NDC-specified drug follows the "UN" seen to the right of the NDC number. "UN" defines the unit of measure for billing of home infusion drugs. While not illustrated, adding the provider's charges to column F would be necessary.

Our Section IV.E. Coding of Drugs in the X12N 837 Electronic Claim provides additional information on coding of drugs for the X12N 837 electronic claim and on the CMS-1500 claim form.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS
1	02	01	10	02	07	10	12		S9500		1		7
2	N400004196501 UN7												
	02	01	10	02	07	10	12		J0696		1		56
3	N463230249 10 UN14												
	02	01	10	02	07	10	12		A4216		1		14
4	N400338004938 UN7												
	02	01	10	02	07	10	12		J7050		1		3
5	N408290033010 UN14												
	02	01	10	02	07	10	12		A4216		1		14
6	N408290038005 UN7												
	02	01	10	02	07	10	12		J1642		1		350

Example 1B ANTI-INFECTIVE THERAPY FOR ONE WEEK; NO NURSING

Provided is Merrem® IV (meropenem), 1 gm IV, q8h over 7 days via a disposable pump through a PICC line. 20mls sterile water is the diluent for reconstitution of the Merrem which is compounded into 30ml saline in a disposable pump. Also provided are all administration supplies and flushing solutions (sodium chloride and heparin) prepackaged by the manufacturer in pre-filled syringes. As with all pre-filled syringes, each syringe is labeled with an NDC number. As nursing is provided by a home health agency that is a different organization from the home infusion provider, nursing charges are not included on the claim from the home infusion provider. The PICC line is in place and functioning properly.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	S9502		7	Anti-infective q8h per diem. HCPCS per diem "S" code.
2/1/YY	2/7/YY	J2185		210	HCPCS code is "injection, meropenem, 100 mg".
	Drug Billed with NDC	00310-0321-30		21	Merrem 1 gram vials.
2/1/YY	2/7/YY	A4216		42	HCPCS code is "sterile water, saline and/or dextrose, diluent/flush 10 ml".
	Drug Billed with NDC	63323-0249-10		42	Sterile water, 10mls vials.
2/1/YY	2/7/YY	J7030		1	HCPCS code is "infusion, normal saline solution, 1,000 cc".
	Drug Billed with NDC	00338-0049-04		1	Sod chl 0.9% 1000ml IV bag. (Used 630mls for fill)
2/1/YY	2/7/YY	A4216		42	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".
	Drug Billed with NDC	00264-1400-00		42	Sodium chloride 10ml pre-filled syringe. For flushing.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	J1642		1050	HCPCS code is "injection, heparin sodium, (heparin lock flush), per 10 units".
		08290-0390-05		21	Heparin Lock 100u/ml 5ml pre-filled syringe. For flushing.

Comment: As with other HCPCS per diem "S" codes, the provider's charges for administrative services, professional pharmacy services, care coordination services, supplies, and DME are coded in the per diem line. Since the anti-infective per diem covers the entire service period, a per diem charge for catheter care is not submitted, although the flushing drugs are coded, billed and reimbursed separately.

Conforming to the HCPCS per diem "S" code descriptions, all drugs are coded, billed and reimbursed separately for billing to the payer. Failure to use this approach would be a violation of HIPAA regulation. Drugs and nursing visits cannot be included in the per diem fee that is claimed.

As compared to Example 1A, the concepts of coding for this case are identical. Differences include that S9502 is used for the q8hr frequency per diem coding, and that drugs and quantities of drugs billed are different to reflect the case.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service, such as with A4216 in this example. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 2A ANTI-INFECTIVE THERAPY FOR ONE WEEK WITH HIGH-TECH NURSING

Provided is cefazolin, 1.5 gm IV, q8h over 7 days for gravity infusion through PICC line. 10mls sterile water is the diluent for reconstitution of cefazolin that is compounded into 100ml saline IV bags. Also provided are all administration supplies and the pole necessary for the cefazolin infusion, as well as supplies and solutions (sodium chloride and heparin) for the catheter flush. The home infusion organization also provides high-tech home nursing, with 3 nursing visits. On day of the first dose, the RN visit includes activities of assessment and training requiring 3 hours in total. The follow-up visit on day 2 and the visit on day 7 for discontinuing of therapy required up to 2 hours. Time recorded to provide these RN visits includes preparation, travel, time in the home, documentation, post-visit reporting, follow-up activities, etc. The PICC line is in place and functioning properly.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	S9502		7	Anti-infective q8h per diem. HCPCS per diem "S" code.
2/1/YY	2/7/YY	J0690		64	HCPCS code is "injection, cefazolin sodium, 500 mg".
		63323-0237-65		32	Cefazolin 1 gram vials.
2/1/YY	2/7/YY	A4216		21	HCPCS code is "sterile water, saline and/or dextrose, diluent/flush 10 ml".
		63323-0249-10		21	Sterile water, 10mls vials.
2/1/YY	2/7/YY	J7050		9	HCPCS code is "infusion, normal saline solution, 250 cc".
		00338-0049-38		21	Sod chl 0.9% 100ml IV mini-bags.
2/1/YY	2/7/YY	A4216		30	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
	Drug Billed with NDC	00074-1966-07		10	Sod chl 0.9% 30ml bact vials. For flushing.
2/1/YY	2/7/YY	J1644		15	HCPCS code is "injection, heparin sodium, per 1000 units".
	Drug Billed with NDC	00074-1152-78		5	Heparin 100u/ml 30ml vials. For flushing.
2/1/YY	2/1/YY	99601		1	High-tech RN visit. CPT code.
2/1/YY	2/1/YY	99602		1	High-tech RN visit, extra hour. CPT code.
2/2/YY	2/2/YY	99601		1	High-tech RN visit. CPT code.
2/7/YY	2/7/YY	99601		1	High-tech RN visit. CPT code.

Comment: As with other HCPCS per diem "S" codes, the provider's charges for administrative services, professional pharmacy services, care coordination services, supplies, and DME are coded in the per diem line. Since the anti-infective per diem covers the entire service period, a per diem charge for catheter care is not submitted, although the flushing drugs are coded, billed and reimbursed separately.

Conforming to the HCPCS per diem "S" code descriptions, drugs and nursing visits are coded, billed and reimbursed separately for billing to the payer. Failure to use this approach would be a violation of HIPAA regulation. Drugs and nursing visits cannot be included in the per diem fee that is claimed. 99601 is used to specify the home nursing visit charges up to 2 hours, whereas 99602 is used to code the additional hour for the first visit.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-

specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent. For example, the provider may choose to code 100ml mini-bags of normal saline with J3490 in this example.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service, such as with A4216 in this example. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Coding When Multiple Container Sizes Are Used for Same Drug: Suppose in the example instead of using 32 "single dose" vials of cefazolin, the infusion provider used three 10 gram vials ("multi-dose" vials) and two single dose vials of 2 grams each. As shown here, the coding is done with both NDC numbers coded, billed and reimbursed. Such billing is entirely correct. When NDC coding is used on claims, payers expect providers to code the specific drug packages used, i.e. each NDC number, since correct adjudication (e.g. based on AWP), and manufacturer drug rebates for state Medicaid plans, are dependent on such coding. Payers accepting X12N infusion claims should expect such occurrences and adjudicate appropriately, because use of multi-dose vials by infusion providers may be more cost-effective and is a common practice.

In stark contrast, when retail pharmacy drug claims are submitted through the NCPDP claim, in some cases a rejection included in prescription benefit manager payers' adjudication systems is to reject the second drug line billed as a duplicate, as recognized from both NDC numbers being cross referenced to the same drug (e.g. both are cefazolin). While this may be appropriate for retail drug claims, such as for dispense of oral meds, you can observe that for home infusion claims such rejection would create major problems for provider and payer.

Here is how the cefazolin would be billed on the claim with the two different vial sizes:

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	J0690		60	HCPCS code is "injection, cefazolin sodium, 500 mg".
	Drug Billed with NDC	63323-0238-61		3	Cefazolin 10 gram vials.
2/1/YY	2/7/YY	J0690		4	HCPCS code is "injection, cefazolin sodium, 500 mg".
	Drug Billed with NDC	63323-0237-65		2	Cefazolin 1 gram vials.

Example 2B ANTI-INFECTIVE FOR ONE WEEK WITH HIGH-TECH NURSING WITH SERVICE REQUIRING SECURITY ESCORT

The services and products provided are identical to Example 2A, excepting that the nurse was provided with a security escort due to travel in an usually high crime area when a patient problem resulted in a nurse visit for up to 2 hours that occurred starting at 1 AM on 2/3/YY.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	S9502		7	Anti-infective q8h per diem. HCPCS per diem "S" code.
2/1/YY	2/7/YY	J0690		64	HCPCS code is "injection, cefazolin sodium, 500 mg".
		63323-0237-65		32	Cefazolin 1 gram vials.
2/1/YY	2/7/YY	A4216		21	HCPCS code is "sterile water, saline and/or dextrose, diluent/flush 10 ml".
		63323-0249-10		21	Sterile water, 10mls vials.
2/1/YY	2/7/YY	J7050		9	HCPCS code is "infusion, normal saline solution, 250 cc".
		00338-0049-38		21	Sod chl 0.9% 100ml IV mini-bags.
2/1/YY	2/7/YY	A4216		30	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".
		00074-1966-07		10	Sod chl 0.9% 30ml bact vials. For flushing.
2/1/YY	2/7/YY	J1644		15	HCPCS code is "injection, heparin sodium, per 1000 units".
		00074-1152-78		5	Heparin 100u/ml 30ml vials. For flushing.

Date(s) of Service	Days or CPT/HCPCS	Modifier	Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY2/1/YY	99601		1	High-tech RN visit. CPT code.
2/1/YY2/1/YY	99602		1	High-tech RN visit, extra hour. CPT code.
2/2/YY2/2/YY	99601		1	High-tech RN visit. CPT code.
2/3/YY2/3/YY	99601		1	High-tech RN visit. CPT code.
2/3/YY2/3/YY	S9381		1	"High risk/escort" charge.
2/7/YY2/7/YY	99601		1	High-tech RN visit. CPT code.

Comment: The charge for the security escort is coded with S9381.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent. For example, the provider may choose to code 100ml mini-bags of normal saline with J3490 in this example.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service, such as with A4216 in this example. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 2C ANTI-INFECTIVE FOR ONE WEEK WITH HIGH-TECH NURSING; PICC LINE INSERTED

The services and products provided are identical to Example 2A, plus a supplemental nursing procedure is performed. The patient was discharged from the hospital with a peripheral access device. The physician ordered insertion of a PICC line in the home to facilitate the anti-infective administration expected to last 3 to 4 weeks. The PICC insertion procedure that is performed by the home infusion organization's high-tech home RN is coded, billed and reimbursed separately, in addition to other infusion start-up nursing services that are billed per visit (as in Example 2A). For this procedure, items that are often packaged in a kit are used, such as sterile drape, syringe, gloves, etc., and these are coded, billed and reimbursed separately outside of the anti-infective per diem code, S9502. The prescription drugs used for the PICC insertion procedure are also coded, billed and reimbursed separately.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	S9502		7	Anti-infective q8h per diem. HCPCS per diem "S" code.
2/1/YY	2/7/YY	J0690		64	HCPCS code is "injection, cefazolin sodium, 500 mg".
		63323-0237-65		32	Cefazolin 1 gram vials.
2/1/YY	2/7/YY	A4216		21	HCPCS code is "sterile water, saline and/or dextrose, diluent/flush 10 ml".
		63323-0249-10		21	Sterile water, 10mls vials.
2/1/YY	2/7/YY	J7050		9	HCPCS code is "infusion, normal saline solution, 250 cc".
		00338-0049-38		21	Sod chl 0.9% 100ml IV mini-bags.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	A4216		33	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".
	Drug Billed with NDC	00074-1966-07		11	Sod chl 0.9% 30ml bact vials. 10 vials for flushing. 1 vial for PICC line insert.
2/1/YY	2/7/YY	J1644		18	HCPCS code is "injection, heparin sodium, per 1000 units".
	Drug Billed with NDC	00074-1152-78		6	Heparin 100u/ml 30ml vials. 5 vials for flushing. 1 vial for PICC line insert.
2/1/YY	2/1/YY	99601		1	High-tech RN visit. CPT code.
2/1/YY	2/1/YY	99602		1	High-tech RN visit, extra hour. CPT code.
2/2/YY	2/2/YY	99601		1	High-tech RN visit. CPT code.
2/7/YY	2/7/YY	99601		1	High-tech RN visit. CPT code.
2/1/YY	2/1/YY	S5522		1	Home nursing procedure to insert PICC line. HCPCS "S" code.
2/1/YY	2/1/YY	S5520		1	Catheter and all supplies for PICC line insertion. HCPCS "S" code.
2/1/YY	2/1/YY	J3490		1	HCPCS code is "unclassified drugs".
	Drug Billed with NDC	00168-00357-55		1	Lidocaine and prilocaine cream 2.5%\2.5%, 5 grams. For PICC line insert.

Comment: The solution is that provided in Example 2A with three additional lines and two drug lines with different units billed. HCPCS provides the S5522 code for the procedure of PICC insertion in the home by the high-tech infusion nurse, and it is always coded, billed and reimbursed separately (see Section III.K.2 Catheter Care Insertion). The HCPCS S5520 code is used to charge for the PICC catheter and other supplies necessary to perform the procedure, and it is always coded, billed and reimbursed separately outside of any other per diem (see Section III.J Catheter Care). Also, the following drugs used for PICC line insertion are added: 1 vial sod chl 0.9% 30ml bact, 1 vial heparin 100u/ml 30ml, and 1 tube lidocaine and prilocaine cream 2.5%\2.5%, 5 grams.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used. In this example, such is the case for the lidocaine and prilocaine cream.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent. For example, the provider may choose to code 100ml mini-bags of normal saline with J3490 in this example.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service, such as with A4216 in this example. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 3 IVIG INFUSION, ONE DOSE EVERY THREE WEEKS, WITH EXTENDED LENGTH HIGH-TECH NURSING

Provided is IVIG 25 grams infused via a pole mounted pump through peripheral line. Used for the IVIG are two 100ml bottles of Gamunex® 10 % (i.e. 10gms per bottle) and one 50 ml bottle of Gamunex 10% (i.e. 5gms). Also provided are all administration supplies and the pump and pole necessary for the IVIG infusion, as well as supplies and solutions (sodium chloride and heparin) for the catheter insertion and flush. The home infusion organization also provides high-tech home nursing, with 1 nursing visit that lasts 5 hours each time the IVIG is infused. Time recorded to provide these RN visits includes preparation, travel, time in the home, documentation, post-visit reporting, follow-up activities, etc. The therapy repeats every three weeks indefinitely. The peripheral IV catheter is inserted for each dose and then removed after the dose is done.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/1/YY	S9338		1	Immunomodulating agent per diem. HCPCS per diem "S" code.
2/1/YY	2/1/YY	J1561		40	HCPCS code is "injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg".
	Drug Billed with NDC	00026-0654-71		2	Gamunex 10 % 100ml vials.
2/1/YY	2/1/YY	J1561		10	HCPCS code is "injection, immune globulin, (Gamunex), intravenous, non-lyophilized (e.g. liquid), 500 mg".
	Drug Billed with NDC	00026-0654-20		1	Gamunex 10 % 50ml vial.
2/1/YY	2/7/YY	A4216		6	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".
	Drug Billed with NDC	00074-1966-07		2	Sod chl 0.9% 30ml bact vials. For flushing.
2/1/YY	2/7/YY	J1644		6	HCPCS code is "injection, heparin sodium, per 1000 units".

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
		00074-1152-78		2	Heparin 100u/ml 30ml vials. For flushing.
2/1/YY	2/1/YY	99601		1	High-tech RN visit. CPT code.
2/1/YY	2/1/YY	99602		3	High-tech RN visit, extra hours. CPT code.

Comment: As with other HCPCS per diem "S" codes, the provider's charges for administrative services, professional pharmacy services, care coordination services, supplies, and DME are coded in the per diem line. Because the high tech home infusion nurse visit required is of extended length and well beyond the two hours included in the description of code 99601, this means 99602 is added to the claim for the additional three hours required. Because the peripheral IV catheter is inserted for each dose and then removed, no catheter care per diem charge is needed for the remaining six days each week.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 4A **CHEMOTHERAPY CONTINUOUS OVER FOUR DAYS EACH WEEK; CATHETER CARE PER DIEM CODED; NO NURSING; CLAIM IS FOR ONE WEEK**

Provided is Adrucil® (5-FU), 1920mg at 5mg/ml IV over 4 days at 4 ml/hr continuously, one dose a week for an extended time period, via infusion pump through a PICC line already in place. Also provided are all administration supplies including pump tubing, pump and a pole necessary for the infusion. Also provided are flushing solutions (sodium chloride and heparin). The catheter is flushed before and after administration on days 1 and 4. On days 5, 6 and 7, with the absence of other medication delivery the catheter used requires flushing to maintain patency. As nursing is provided by a home health agency that is a different organization from the home infusion provider, nursing charges are not included on the claim from the home infusion provider. The claim is for a service period of one week.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	S9330		4	Chemotherapy, continuous, per diem. HCPCS per diem "S" code.
2/1/YY	2/7/YY	J9190		4	HCPCS code is "injection, fluorouracil, 500 mg".
	Drug Billed with NDC	00013-1036-91		4	Adrucil 50mg/ml, 10ml vials.
2/1/YY	2/7/YY	J7050		2	HCPCS code is "infusion, normal saline solution, 250 cc".
	Drug Billed with NDC	00264-7800-20		2	Sod chl 0.9% 250ml bag.
2/1/YY	2/7/YY	S5498		3	Catheter care, single lumen, per diem. HCPCS per diem "S" code.
2/1/YY	2/7/YY	A4216		6	HCPCS code is "water, saline and/or dextrose, diluent/flush," 10 ml".
	Drug Billed with NDC	00074-1966-07		2	Sod chl 0.9% 30ml bact vials. For flushing.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	J1644		6	HCPCS code is "injection, heparin sodium, per 1000 units".
		00074-1152-78		2	Heparin 100u/ml 30ml vials. For flushing.

Comment: As with other HCPCS per diem "S" codes, the provider's charges for administrative services, professional pharmacy services, care coordination services, supplies, and DME are coded in the per diem lines for chemotherapy and catheter care. Since the chemotherapy per diem covers only 4 days of the week, a per diem charge for catheter care is submitted for the remaining 3 days, with the flushing solutions coded, billed and reimbursed separately. Because the chemotherapy dosing is over a period of 24+ hours, the S9330 per diem code is used for *continuous* administration. If in chemotherapy administration a dosing period is less than 24 hours, the S9331 per diem code is used for *intermittent* administration. Likewise, the S5498 per diem code is used for *simple (single lumen)* catheter care in the example, whereas if it was two or more lumen catheter care, then the S5501 *complex (more than one lumen)* is used.

If you are an experienced biller, you may have already realized some payers might deny the claim in this example for "overlapping dates". Please see Example 4C for explanation of how you would change the service from/to dates for these payers. Alternatively, some payers may accept use of modifiers **-SH** or **-SJ** to distinguish more than one per diem "S" codes that are coded on the same dates as distinct therapies; see Section III.R for coding procedures. NHIA encourages payers to remove such overlapping date edits for home infusion codes as a way to simplify processing of home infusion therapy claims.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 4B **CHEMOTHERAPY CONTINUOUS OVER FOUR DAYS EACH WEEK; CATHETER CARE PER DIEM CODED; NO NURSING; CLAIM IS FOR FOUR WEEKS**

The services and products provided are identical to Example 4A, except that claim is for a service period of four weeks. Compounding and delivery is done weekly.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/28/YY	S9330		16	Chemotherapy, continuous, per diem. HCPCS per diem "S" code.
2/1/YY	2/28/YY	J9190		16	HCPCS code is "injection, fluorouracil, 500 mg".
		00013-1036-91		16	Adrucil 50mg/ml, 10ml vials.
2/1/YY	2/28/YY	J7050		8	HCPCS code is "infusion, normal saline solution, 250 cc".
		00264-7800-20		8	Sod chl 0.9% 250ml bags.
2/1/YY	2/28/YY	S5498		12	Catheter care, single lumen, per diem. HCPCS per diem "S" code.
2/1/YY	2/28/YY	A4216		24	HCPCS code is "water, saline and/or dextrose, diluent/flush,"
		00074-1966-07		8	Sod chl 0.9% 30ml bact vials. For flushing.
2/1/YY	2/7/YY	J1644		24	HCPCS code is "injection, heparin sodium, per 1000 units".
		00074-1152-78		8	Heparin 100u/ml 30ml vials. For flushing.

Comment: The coding is similar to that presented in Example 4A, except that the date ranges and quantities are for a 4-week service period. Unfortunately, some payers may deny this claim, or a portion of it, due to "overlapping dates"

associated with the chemotherapy S9330 and catheter care S5498 per diem codes. Their claims processing systems may have logic to edit out overlapping dates on certain per diem codes. The provider may need to break out the chemotherapy and catheter care per diem lines, as illustrated in Example 4C. Alternatively, some payers may accept use of modifiers **-SH** or **-SJ** to distinguish more than one per diem "S" codes that are coded on the same dates as distinct therapies; see Section III.R for coding procedures. NHIA encourages payers to remove such overlapping date edits for home infusion per diem codes as a way to simplify processing of these claims.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 4C **CHEMOTHERAPY CONTINUOUS OVER FOUR DAYS EACH WEEK; CATHETER CARE PER DIEM CODED; NO NURSING; CLAIM IS FOR FOUR WEEKS; AVOID "OVERLAPPING DATES"**

The services and products provided are identical to Example 4A, except that claim is for a service period of four weeks. Compounding and delivery is done weekly. This approach avoids "overlapping dates" edits that may be present in some payers' claim processing systems for the HCPCS per diem "S" codes.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/4/YY	S9330		4	Chemotherapy, continuous, per diem. HCPCS per diem "S" code.
2/8/YY	2/11/YY	S9330		4	Chemotherapy, continuous, per diem. HCPCS per diem "S" code.
2/15/YY	2/18/YY	S9330		4	Chemotherapy, continuous, per diem. HCPCS per diem "S" code.
2/22/YY	2/25/YY	S9330		4	Chemotherapy, continuous, per diem. HCPCS per diem "S" code.
2/1/YY	2/28/YY	J9190		16	HCPCS code is "injection, fluorouracil, 500 mg".
		00013-1036-91		16	Adrucil 50mg/ml, 10ml vials.
2/1/YY	2/28/YY	J7050		8	HCPCS code is "infusion, normal saline solution, 250 cc".
		00264-7800-20		8	Sod chl 0.9% 250ml bags.
2/5/YY	2/7/YY	S5498		3	Catheter care, single lumen, per diem. HCPCS per diem "S" code.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/12/YY	2/14/YY	S5498		3	Catheter care, single lumen, per diem. HCPCS per diem "S" code.
2/19/YY	2/21/YY	S5498		3	Catheter care, single lumen, per diem. HCPCS per diem "S" code.
2/26/YY	2/28/YY	S5498		3	Catheter care, single lumen, per diem. HCPCS per diem "S" code.
2/1/YY	2/28/YY	A4216		24	HCPCS code is "water, saline and/or dextrose, diluent/flush," 10 ml".
	Drug Billed with NDC	00074-1966-07		8	Sod chl 0.9% 30ml bact vials. For flushing.
2/1/YY	2/7/YY	J1644		24	HCPCS code is "injection, heparin sodium, per 1000 units".
	Drug Billed with NDC	00074-1152-78		8	Heparin 100u/ml 30ml vials. For flushing.

Comment: Of course, this results in a longer claim. For electronic submission, that is not a big issue. However, it will result in a longer Explanation of Benefits (EOB) statement delivered to patients. NHIA encourages payers to remove such overlapping date edits for home infusion codes as a way to simplify processing of these claims. (If you are an experienced biller, you may have already realized some payers might deny the claim in Example 4A for "overlapping dates". As an exercise, consider in Example 4A how you would change the service from/to dates.)

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-

specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 5 **PN WITH NON-SPECIALTY AMINO ACIDS FOR 7 DAY PERIOD; NO NURSING**

Provided is 1 liter of PN 3-1 compounded from Aminosyn® that is infused daily over 7 days through an ambulatory pump. 200mls of Liposyn® II 20% is compounded into each of the 7 bags of PN. Also included in the PN compound are concentrated dextrose (D70), sterile water, 5 electrolytes, and standard multi-trace element solution MTE5. The patient also receives 7 vials of Pepcid® 4ml and 7 vials of MVI-12 10ml to be added to the PN at the home. Also provided are all administration supplies necessary for the PN infusion, as well as supplies and solutions (sodium chloride and heparin) for the catheter flush. No nursing was required during the period.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	S9365		7	1 liter PN per diem, 7 days. HCPCS per diem "S" code.
2/1/YY	2/7/YY	J3490		3	HCPCS code is "unclassified drugs".
		00074-9791-03		3	Liposyn III 20% 500ml containers (2.8 rounded to 3)
2/1/YY	2/7/YY	J3490		7	HCPCS code is "prescription drug, brand name".
		00006-3541-14		7	Pepcid 10mg/ml 4ml vials.
2/1/YY	2/7/YY	A4216		24	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".
		00074-1966-07		8	Sod chl 0.9% 30ml bact vials. For flushing.
2/1/YY	2/7/YY	J1644		15	HCPCS code is "injection, heparin sodium, per 1000 units".
		00074-1152-78		5	Heparin 100u/ml 30ml vials. For flushing.

Comment: As with other HCPCS per diem "S" codes, the provider's charges for administrative services, professional pharmacy services, care coordination services, supplies, and DME are coded in the per diem line. For PN, many "standard PN products" are included in the PN per diem. Such products include the Aminosyn, D70, sterile water, electrolytes, MTE5, and MVI-12. Since Pepcid is not part of the standard PN formula, it is coded for separate charge. Since the PN per diem covers the entire service period, a per diem charge for catheter care is not submitted, although the flushing solutions are coded, billed and reimbursed separately.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used. In this example, such is the case for the Liposyn III and Pepcid.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service, such as with J3490. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 6 **MULTIPLE ANTI-INFECTIVE THERAPIES; SECOND THERAPY MODIFIER**

Provided is Fortaz® (ceftazidime) 2 gm IV, q8h and tobramcyin 120mg IV, q12h over 7 days for pump infusion through PICC line. 10mls sterile water is the diluent for reconstitution of Fortaz. Each is compounded into 100ml saline IV bags and given by a pole-mounted pump. Also provided are all administration supplies including pump tubing, a pump and pole necessary for the infusions. Additionally provided are supplies and flushing solutions (sodium chloride and heparin) for the catheter flush. As nursing is provided by a home health agency that is a different organization from the home infusion provider, nursing charges are not included on the claim from the home infusion provider. The PICC line is in place and functioning properly. The provider-payer contract specifies that the per diem rate for the second anti-infective therapy is to be paid at a rate that is different from the single-therapy per diem rate. To implement this on the claim, the payer requires the provider to append the **-SH** modifier to the second therapy per diem charge line.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	S9502		7	Anti-infective q8h per diem. HCPCS per diem "S" code.
2/1/YY	2/7/YY	S9501	SH	7	Anti-infective q12h per diem. Second concurrent drug. HCPCS per diem "S" code.
2/1/YY	2/7/YY	J0713		84	HCPCS code is "injection, ceftazidime, per 500 mg".
	Drug Billed with NDC	00173-0379-34		21	Fortaz 2 gram vials.
2/1/YY	2/7/YY	J3260		21	HCPCS code is "injection, tobramycin sulfate, up to 80 mg".
	Drug Billed with NDC	00074-3255-03		21	Tobramycin 80mg vials.
2/1/YY	2/7/YY	A4216		21	HCPCS code is "sterile water, saline and/or dextrose, diluent/flush 10 ml".
	Drug Billed with NDC	63323-0249-10		21	Sterile water, 10mls vials.

2/1/YY	2/7/YY	J7050	14	HCPCS code is "infusion, normal saline solution, 250 cc".
		00338-0049-38	35	Sod chl 0.9% 100ml IV mini-bags.
2/1/YY	2/7/YY	A4216	60	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".
		00074-1966-07	20	Sod chl 0.9% 30ml bact vials. For flushing.
2/1/YY	2/7/YY	J1644	30	HCPCS code is "injection, heparin sodium, per 1000 units".
		00074-1152-78	10	Heparin 100u/ml 30ml vials. For flushing.

Comment: In the rare occurrence where even a third or more anti-infective is provided over some or all of the same time period, and assuming the provider-payer agreement requires distinction of that, -SJ would be used. Another observation is that the example illustrates that necessary supplies and *equipment* are included in HCPCS per diem "S" codes; that includes the pump, pump sets and pole.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent. For example, the provider may choose to code 100ml mini-bags of normal saline with J3490 in this example.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service, such as with A4216 in this example. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 7 **ALL SERVICES FOR A THERAPY PROVIDED IN THE**

AMBULATORY INFUSION SUITE OF THE HOME INFUSION THERAPY PROVIDER (AIS)

REMICADE® (INFLIXIMAB) INFUSION, ONE DOSE AT 0, 2 AND 6 WEEKS FOLLOWED

BY A MAINTENANCE REGIMEN OF ONE DOSE EVERY 8 WEEKS

HIGH-TECH NURSING PROVIDED IN THE AIS

CLAIM IS FOR THE FIRST DOSE

Provided for each dose is Remicade, 475 mg infused via a pole mounted pump through peripheral line. Used for the infusion are five 100 mg vials of Remicade reconstituted with 50ml (10ml per vial Remicade) preservative free sterile water and added to 250 ml normal saline for the infusion. Also provided are all administration supplies and the pump and pole necessary for the infusion, as well as supplies and solution (sodium chloride) for the catheter insertion and flush. The home infusion organization also provides nursing services, including infusion suite preparation, patient care, documentation, post-visit reporting, follow-up activities, etc. The patient time in the AIS for each administration is 2.5 hours. The peripheral IV catheter is inserted for each dose, then flushed and removed after the dose is done.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/1/YY	S9359	SS	1	AIS services, anti-tumor necrosis factor, per diem. HCPCS per diem "S" code. –SS modifier.
2/1/YY	2/1/YY	J1745	SS	50	HCPCS code is "injection, infliximab, 10 mg". –SS modifier.
	Drug Billed with NDC	57894-0030-01		5	Remicade 100mg vial.
2/1/YY	2/7/YY	J7050		1	HCPCS code is "infusion, normal saline solution, 250 cc".

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
	Drug Billed with NDC	00074-1966-07		1	Sod chl 0.9% 250ml bag.
2/1/YY	2/1/YY	A4216	SS	6	HCPCS code is "sterile water, saline and/or dextrose, diluent/flush, 10 ml". –SS modifier.
	Drug Billed with NDC	00074-4887-20		3	Sterile water, preservative free inj, 20ml vial.
2/1/YY	2/7/YY	A4216		6	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".
	Drug Billed with NDC	00074-1966-07		2	Sod chl 0.9% 30ml bact vials. For flushing.
2/1/YY	2/1/YY	99601	SS	1	RN services in the AIS. CPT code. –SS modifier.
2/1/YY	2/1/YY	99602	SS	1	RN services in the AIS, extra hour. CPT code. –SS modifier.

Comment: As with other HCPCS per diem "S" codes, the provider's charges for administrative services, professional pharmacy services, care coordination services, supplies, and DME are coded in the per diem line. Coding of the nursing services with two lines of 99601 and 99602 reflects the 2.5 hours of total patient time in the AIS. The -SS modifier denotes that services are performed and products are provided in the AIS.

Place of Service Code: While not shown, the provider determined from the health plan the Place of Service Coding, documenting the POS instructions received from the plan. See Section III.Q.4 Coding for Place of Service for discussion of alternatives for assigning POS codes to the claim lines.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-

specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service, such as with A4216 in this example. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 8A **OCCASIONAL OCCURRENCE OF TREATMENT IN THE**

AMBULATORY INFUSION SUITE OF THE HOME INFUSION THERAPY PROVIDER (AIS)

HOME INFUSION ANTI-INFECTIVE THERAPY FOR ONE WEEK

HIGH-TECH NURSING PROVIDED IN THE AIS

The services and products provided are similar to Example 2A, but here the first dose and subsequent nurse services are performed in the AIS. Provided is cefazolin, 1.5 gm IV, q8h over 7 days for gravity infusion through PICC line. 10ml sterile water is the diluent for reconstitution of cefazolin that is compounded into 100ml saline IV bags. Also provided are all administration supplies and the pole necessary for the cefazolin infusion, as well as supplies and solutions (sodium chloride and heparin) for the catheter flush. The home infusion organization provides the first dose, including all necessary skilled nursing services in the organization's AIS. On the day of the first dose, RN services include activities of documentation preparation, infusion suite preparation, assessment, training and observation of the patient for potential first-dose adverse reactions. Because the patient is ambulatory and making a visit to the physician on days 2 and 7 of the treatment, follow-up RN services on day 2 for IV site assessment and follow-up training, and day 7 for discontinuing of therapy, are also provided in the home infusion organization's AIS. For these occurrences, the patient's time in the suite was up to 2 hours. These RN services included infusion suite preparation, patient care, documentation, post-visit reporting, follow-up activities, etc. The PICC line was in place and functioning properly prior to start of therapy.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	S9502		7	Anti-infective q8h per diem. HCPCS per diem "S" code.
2/1/YY	2/7/YY	J0690		64	HCPCS code is "injection, cefazolin sodium, 500 mg".
		63323-0237-65		32	Cefazolin 1 gram vials.
2/1/YY	2/7/YY	A4216		32	HCPCS code is "sterile water, saline and/or dextrose, diluent/flush 10 ml".

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
	Drug Billed with NDC	63323-0249-10		32	Sterile water, 10mls vials.
2/1/YY	2/7/YY	J7050		9	HCPCS code is "infusion, normal saline solution, 250 cc".
	Drug Billed with NDC	00338-0049-38		21	Sod chl 0.9% 100ml IV mini-bags.
2/1/YY	2/7/YY	A4216		30	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".
	Drug Billed with NDC	00074-1966-07		10	Sod chl 0.9% 30ml bact vials. For flushing..
2/1/YY	2/7/YY	J1644		15	HCPCS code is "injection, heparin sodium, per 1000 units".
	Drug Billed with NDC	00074-1152-78		5	Heparin 100u/ml 30ml vials. For flushing.
2/1/YY	2/1/YY	99601	SS	1	RN services in the AIS. CPT code. –SS modifier.
2/2/YY	2/2/YY	99601	SS	1	RN services in the AIS. CPT code. –SS modifier.
2/7/YY	2/7/YY	99601	SS	1	RN services in the AIS. CPT code. –SS modifier.

Comment: As with other HCPCS per diem "S" codes, the provider's charges for administrative services, professional pharmacy services, care coordination services, supplies, and DME are coded in the per diem line. Since the anti-infective per diem covers the entire service period, a per diem charge for catheter care is not submitted, although the flushing drugs are coded, billed and reimbursed separately.

Conforming to the HCPCS per diem "S" code descriptions, drugs and nursing visits are coded, billed and reimbursed separately for billing to the payer. Failure to use this approach would be a violation of HIPAA regulation. Drugs and nursing visits cannot be included in the per diem fee that is claimed. 99601 is used to specify nursing service charges up to 2 hours, whereas 99602 is used to code the additional hour for the first visit. The -SS modifier added to coding of the RN services denotes that the services were performed in the AIS.

Place of Service Code: While not shown, the provider determined from the health plan the Place of Service Coding, documenting the POS instructions received from the plan. See Section III.Q.4 Coding for Place of Service for discussion of alternatives for assigning POS codes to the claim lines.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent. For example, the provider may choose to code 100ml mini-bags of normal saline with J3490 in this example.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service, such as with A4216 in this example. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers as duplicates.

Example 8B **OCCASIONAL OCCURRENCE OF TREATMENT IN THE**

AMBULATORY INFUSION SUITE OF THE HOME INFUSION THERAPY PROVIDER (AIS)

HOME INFUSION ANTI-INFECTIVE THERAPY FOR ONE WEEK OF 3-4 WEEK DURATION

HIGH-TECH NURSING PROVIDED IN THE AIS

PICC LINE INSERTION PERFORMED IN THE AIS

CLAIM IS FOR FIRST WEEK

The services and products provided are similar to Example 8A including RN services in the suite on days 1 and 2. As the patient was discharged from the hospital with a peripheral access device, the physician ordered insertion of a PICC line to facilitate the anti-infective administration expected to last 3 to 4 weeks. Hence, a PICC insertion was performed by the RN in the AIS. The RN performs a PICC dressing change in the infusion suite on day 7 and weekly thereafter. The PICC insertion procedure that is performed by the home infusion organization's RN in the home infusion provider's AIS is coded, billed and reimbursed separately, in addition to other infusion start-up nursing services that are billed per visit (as in Example 8A). For this procedure, items that are often packaged in a PICC insertion kit (tray) are used, such as sterile drape, syringe, gloves, etc., and these are coded, billed and reimbursed separately outside of the anti-infective per diem code, S9502. The prescription drugs used for the PICC insertion procedure are also coded, billed and reimbursed separately.

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
2/1/YY	2/7/YY	S9502		7	Anti-infective q8h per diem. HCPCS per diem "S" code.
2/1/YY	2/7/YY	J0690		64	HCPCS code is "injection, cefazolin sodium, 500 mg".
	Drug Billed with NDC	63323-0237-65		32	Cefazolin 1 gram vials.
2/1/YY	2/7/YY	A4216		32	HCPCS code is "sterile water, saline and/or dextrose, diluent/flush 10 ml".

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
	Drug Billed with NDC	63323-0249-10		32	Sterile water, 10mls vials.
2/1/YY	2/7/YY	J7050		9	HCPCS code is "infusion, normal saline solution, 250 cc".
	Drug Billed with NDC	00338-0049-38		21	Sod chl 0.9% 100ml IV mini-bags.
2/1/YY	2/7/YY	A4216		30	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".
	Drug Billed with NDC	00074-1966-07		10	Sod chl 0.9% 30ml bact vials. For flushing..
2/1/YY	2/7/YY	J1644		15	HCPCS code is "injection, heparin sodium, per 1000 units".
	Drug Billed with NDC	00074-1152-78		5	Heparin 100u/ml 30ml vials. For flushing.
2/1/YY	2/1/YY	99601	SS	1	RN services in the AIS. CPT code. –SS modifier.
2/2/YY	2/2/YY	99601	SS	1	RN services in the AIS. CPT code. –SS modifier.
2/7/YY	2/7/YY	99601	SS	1	RN services in the AIS. CPT code. –SS modifier.
2/1/YY	2/1/YY	S5522	SS	1	Nursing procedure to insert PICC line. HCPCS "S" code. –SS modifier.
2/1/YY	2/1/YY	S5520	SS	1	Catheter and all supplies for PICC line insertion. HCPCS "S" code. –SS modifier.
2/1/YY	2/1/YY	A4216	SS	3	HCPCS code is "water, saline and/or dextrose, diluent/flush, 10 ml".

Date(s) of Service		CPT/HCPCS	Modifier	Days or Units	Explanation for Example, but Excluded from Electronic Claim.
	Drug Billed with NDC	00074-1966-07		1	Sod chl 0.9% 30ml bact vial. For PICC line insert.
2/1/YY	2/1/YY	J1644	SS	3	HCPCS code is "injection, heparin sodium, per 1000 units".
	Drug Billed with NDC	00074-1152-78		1	Heparin 100u/ml 30ml vial. For PICC line insert.
2/1/YY	2/1/YY	J3490	SS	1	HCPCS code is "unclassified drugs".
	Drug Billed with NDC	00168-00357-55		1	Lidocaine and prilocaine cream 2.5%\2.5%, 5 grams. For PICC line insert.

Comment: The solution is that provided in Example 8A with five additional lines. HCPCS provides the S5522 code for the procedure of PICC insertion in the home by the high-tech infusion nurse, and it is always coded, billed and reimbursed separately (see Section III.K.2 Catheter Care Insertion). The HCPCS S5520 code is used to charge for the PICC catheter and other supplies necessary to perform the procedure, and it is always coded, billed and reimbursed separately outside of any other per diem (see Section III.J Catheter Care). The drugs used for the PICC line insertion are also added to the claim. The -SS modifier denotes that the services were performed and supplies used in the AIS.

Place of Service Code: While not shown, the provider determined from the health plan the Place of Service Coding, documenting the POS instructions received from the plan. See Section III.Q.4 Coding for Place of Service for discussion of alternatives for assigning POS codes to the claim lines.

Coding Drugs: All drugs are coded, billed and reimbursed separately. Drugs are coded with HCPCS codes and NDC numbers. Payers should use NDC numbers and NDC billing quantities to determine reimbursement amounts. A pair of drug-specific HCPCS and NDC must sometimes be billed with different quantities of units. If a drug does not have a specific assigned HCPCS code, code J3490 "unclassified drugs" is used. In this example, such is the case for the lidocaine and prilocaine cream.

A provider may use J3490 when it determines that there is not a good match of a specific HCPCS code with the drug dispensed, which may occur when (1) the HCPCS billing unit differs from the size of the manufacturer's drug packaging, or (2) the HCPCS code description is not specific enough to facilitate establishing fee schedules to accommodate differences in the provider's drug acquisition costs that are packaging dependent. For example, the provider may choose to code 100ml mini-bags of normal saline with J3490 in this example.

Note that it may be necessary to code more than one line with the same HCPCS code for the same dates of service, such as with A4216 and J1644 in this example. Payers should not reject multiple occurrences of HCPCS codes distinguished by different NDC numbers or modifier -SS as duplicates.

ADDENDUM EXAMPLE: HIPAA-Compliant X12N 837 Professional Home Infusion Therapy Claim

Introduction

Conforming to HIPAA regulations[23] for submission of professional pharmacy claims, home infusion therapy providers submit claims for all services, products and drugs using the ASC ANSI X12N 837 electronic transaction. Per HIPAA regulations published on January 16, 2009, a deadline of January 1, 2012 was established for conversion of the X12N set of health insurance transactions to version 5010. HHS authorized an enforcement discretion period through June 30, 2012. During this time, CMS did not initiate enforcement action against any covered entity that was not compliant with the undated Version 5010 standards. The only HIPAA-compliant X12N professional claim transaction in 20120 is the ASC ANSI X12N 837 Professional ("837P") version 5010 standard. Software developers and others may purchase the version 5010 837P standard from Washington Publishing Company at **www.wpc-edi.com/**. Among many other clearing houses, Emdeon has a helpful website regarding HIPPA 5010, NCPDP D.0, ICD-10 and other HIPAA regulations, http://www.emdeon.com/hipaasimplified/

In this addendum, we provide an example of a home infusion therapy claim illustrated as a HIPAA-compliant version 5010 837P that is useful for information technology and other professionals. Of particular interest to many information technology professionals of payers, providers, and clearinghouses is the accommodation in the 837P for billing of drugs, including provision of NDC numbers. The 837P contains all of the data elements necessary for billing of drugs within home infusion therapy claims and more information is provided in Section IV.E. In the example that follows, we have bolded the lines within the 837P that pertain to billing of drugs for the home infusion therapy claim.

We will not attempt to explain the technical details of the 837P here and consequently we expect that you will already be familiar with the 837P standard if you are using the information in this addendum.

It is necessary to include charges in order to complete this example of an 837P claim. The dollar amounts are hypothetical and not a comment on actual marketplace charges.

The example next is the same as Example 1A found earlier in this section.

[23] See Section VII.

Example 1A, HIPAA-Compliant X12N 837 Professional Claim

ANTI-INFECTIVE THERAPY FOR ONE WEEK; NO NURSING

Provided is ceftriaxone, 2 gm IV, q24h over 7 days for gravity infusion through PICC line to treat an acute upper respiratory infection. 20mls sterile water is the diluent for reconstitution of the ceftriaxone which is compounded into 100ml saline IV mini-bags. Also provided are all administration supplies and the pole necessary for the ceftriaxone infusion. Additionally, provided are all administration supplies, and flushing solutions (sodium chloride and heparin) prepackaged by the manufacturer in pre-filled syringes. As with all pre-filled syringes, each syringe is labeled with an NDC number. As nursing is provided by a home health agency that is a different organization from the home infusion provider, nursing charges are not included on the claim from the home infusion provider. The service is provided over a date span from 2/1/2004 to 2/7/2004 for prescriptions that the physician prescribed on 1/30/2004.

Drug service lines in this example begin after submission of a daily per diem charge of $200 per day of therapy, coded with HCPCS S9500 in the LX*1 service line. Drugs are coded with HCPCS and NDC numbers with unit quantities appropriate for the respective codes. For NDC coding, the practice used for infusion therapy claims is to provide a count of containers used, e.g. number of vials, number of bags, etc.

Best practices (see Section IV.B) are when the health plan adjudicates drug claim lines using the NDC in the 2410 LIN segment, quantity and unit of measure in the 2410 CPT segment, and charges in the 2400 SV1 segment. For example, in the LX*2 service line, 7 units of ceftriaxone (NDC of 00004-1965-01 which is for Rocephin®) is billed by the provider for total charge amount of $1421.84. We note that as 00004-1965-01 Rocephin comes in a physical container of 2gm vials, this means that the provider's charge per vial of Rocephin is $97.50.

Service lines LX*2, LX*3 and LX*4 contain the drugs that are elements of the compound. Service lines LX*5 and LX*6 are for non-compounded prescription drugs.

Here is the example of the claim presented in a HIPAA-compliant X12N 837 Professional claim (837P) version 5010 electronic transaction, in which drug billing is bolded, and labels (in CAPS) and blank lines are inserted for ease of reading:

X12N 837P HEADER

ST*837*0711*005010X222A1~

BHT*0019*00*0013*20100301*1200*CH~

NM1*41*2*Quality Billing Service Corporation*****46*587654321~

PER*IC*Bud Holly*TE*8017268899~

NM1*40*2*Union Mutual of Oregon*****46*369852758~

BILLING/PAY-TO PROVIDER DETAIL

HL*1**20*1~

NM1*85*2*Professional Home IV, LLC*****XX*1012345678~

N3*1500 Industrial Drive~

N4*Libertyville*IL*600481532~

REF*EI*650215922~

SUBSCRIBER AND PATIENT DETAIL

HL*2*1*22*0~

SBR*P*18*GRP01020102******CI~

NM1*IL*1*Smith*Steve*A***MI*MBRID01234~

N3*15210 Juliet Lane~

N4*Libertyville*IL*60048~

DMG*D8*19430501*M~

NM1*PR*2*Union Mutual of Oregon*****PI*PLANID12345~

N3*123 W Main St~

N4*Malvern*PA*19355~

CLAIM HEADER INFORMATION

CLM*CLMNO12345*3122.7***12:B:1*Y*A*Y*Y~

HI*BK:4659~

CLAIM CHARGE LINE DETAIL INFORMATION

LX*1~

SV1*HC:S9500*1400*UN*7***1~

DTP*472*RD8*20100201-20100207~

NM1*DK*1*Welby*Marcus****XX*1112223333~

LX*2~

SV1*HC:J0696*1421.84*UN*56*1~**

DTP*472*RD8*20100201-20100207~

LINN4*00004196501~**

CTP**7*UN~**

REF*XZ*2530001~

NM1*DK*1*Welby*Marcus****XX*1112223333~

LX*3~

SV1*HC:A4216*30.24*UN*14*1~**

DTP*472*RD8*20100201-20100207~

LINN4*63323024910~**

CTP**14*UN~**

REF*XZ*2530001~

NM1*DK*1*Welby*Marcus****XX*1112223333~

LX*4~

SV1*HC:J7050*135.38*UN*3*1~**

DTP*472*RD8*20100201-20100207~

LINN4*00338004938~**

CTP**7*UN~**

REF*XZ*2530001~

NM1*DK*1*Welby*Marcus****XX*1112223333~

LX*5~

SV1*HC:A4216*114.24*UN*14*1~**

DTP*472*RD8*20100201-20100207~

LINN4*08290033010~**

CTP**14*UN~**

REF*XZ*2530002~

NM1*DK*1*Welby*Marcus****XX*1112223333~

LX*6~

SV1*HC:J1642*21*UN*350*1~**

DTP*472*RD8*20100201-20100207~

LINN4*08290038005~**

CTP**7*UN~**

REF*XZ*2530003~

NM1*DK*1*Welby*Marcus****XX*1112223333~

X12N 837P TRAILER

SE*61*0711~

V. National Definition of Per diem

National Home Infusion Association
National Definition of Per diem

I. **Executive Summary**. The standardization of pertinent and relevant definitions is inherently advantageous to all stakeholders within the health care delivery system. Such standardization reduces the chance of differing expectations amongst stakeholders, encourages benchmarking and analysis that is based upon comparable data sets, and generally fosters communication and cooperation between the various entities responsible for providing medically necessary health care services. With infusion therapy, reimbursement is often based upon a per diem approach, yet frequently this term is left undefined. Accordingly, as the national organization representing infusion services, the National Home Infusion Association (NHIA) presents the following definition of the term "per diem."

II. **Per diem Definition**. As related to reimbursement, the term "per diem" represents each day that a given patient is provided access to a prescribed therapy, beginning with the day the therapy is initiated and ending with the day the therapy is permanently discontinued. The term "permanently" shall not be construed to infer that a therapy shall never again be initiated, but rather that continuation of the therapy is simply not predicted or anticipated at the time of cessation. The expected course and duration of the treatment shall be determined by the plan of care as prescribed by the ordering physician.

It shall not be necessary for the patient to receive an actual drug infusion each and every day in order to be considered covered under an existing per diem, so long as additional infusions are anticipated in the near future as prescribed in the physician plan of care. The fact that the health care provider anticipates continued responsibility for the patient and incurs costs related to such responsibilities, remains accountable for the provision of such anticipated care, and is responsible for the acquisition and allocation of resources that will be necessary to meet these obligations, shall deem the existing per diem to be current, valid, and in force.

This definition is valid for per diem therapies of duration of up to and including every 72 hours. Therapies provided beyond this range (weekly, monthly, etc.) fall outside of the per diem structure, and should have separate reimbursement rates that are specified on a contractual or other basis.

III. Examples: For purpose of demonstration, the following examples are provided:

Prescribed Therapy	Units of Service
Infusion every 4 hours for 14 days	14
Infusion every 8 hours for 14 days	14
Infusion every 12 hours for 14 days	14
Infusion every 24 hours for 14 days	14
Infusion every 48 hours for 14 days	14
Infusion every 72 hours for 14 days	14
Infusion once per week	1 (per week)
Infusion once per month	1 (per month)

IV. Cost Reconciliation. Costs associated with therapies that are of a more infrequent nature (72 hours, 48 hours, etc.) are less than those that are more frequent, and decreased reimbursement for such services is thereby appropriate. Using the above as an example, it is expected that the "Every 72 hours" per diem would be reimbursed at lesser daily rate than the "Every 4 hours" per diem, and that the units of service would remain identical.

V. Products and Services Included in the Definition. Per diem reimbursement is intended to compensate for costs plus a fair return, i.e. the excess of revenues over expenses needed to ensure continued access to these therapies, for the following services, products and other support costs of an infusion therapy provider:

(i) Professional Pharmacy Services

(a) Dispensing

Medication profile set-up and drug utilization review

Monitoring for potential drug interactions

Sterile procedures including intravenous admixtures, clean room upkeep, vertical and horizontal laminar flow hood certification, and all other biomedical procedures necessary for a safe environment

USP-797 compliant sterile compounding of medications

Patient counseling as required under OBRA 1990

(b) Clinical Monitoring

Development and implementation of pharmaceutical care plans

Pharmacokinetic dosing

Review and interpretation of patient test results

Recommending dosage or medication changes based on clinical findings

Initial and ongoing pharmacy patient assessment and clinical monitoring

Measurement of field nursing competency with subsequent education and training

Other professional and cognitive services as needed to clinically manage the patient pharmacy care

(c) Care Coordination

Patient admittance services, including communication with other medical professionals, patient assessment, and opening of the medical record

Patient/caregiver educational activities, including providing training and patient education materials

Clinical coordination of infusion services care with physicians, nurses, patients, patient's family, other providers, caregivers and case managers

Clinical coordination of non-infusion related services

Patient discharge services, including communication with other medical professionals and closing of the medical record

24 hours/day, 7 days/week availability for questions and/or problems of a dedicated infusion team consisting of pharmacist(s), nurse(s) and all other medical professionals responsible for clinical response, problem solving, trouble shooting, question answering, and other professional duties from pharmacy staff that do not require a patient visit

Development and monitoring of nursing care plans

Coordination, education, training and management of field nursing staff (or sub-contracted agencies)

Delivery of medication, supplies and equipment to patient's home

(d) Supplies and Equipment

DME (pumps, poles and accessories) for drug and nutrition administration

Equipment maintenance and repair (excluding patient owned equipment)

Short peripheral vascular access devices

Needles, gauze, non-implanted sterile tubing, catheters, dressing kits and other necessary supplies for the sale and effective administration of infusion, specialty drug and nutrition therapies

(e) Multiple Categories of Pharmacy Professional Services

Maintaining comprehensive knowledge of vascular access systems

Continuing education to professional pharmacy staff

Removal, storage and disposal of infectious waste

Maintaining accreditation, including:

Outcomes assessments and analysis

Ongoing staff development and competency assessment

Continuous quality assessment and performance improvement programs

All other policies and procedures necessary to remain in compliance with The Joint Commission, Community Health Accreditation Program (CHAP), Accreditation Commission for HealthCare (ACHC), and other professional accreditation standards

Certification fees and expenses

Other applicable accreditation expenses

Maintaining the substantial insurance requirements (e.g. liability), including compliance with all state and federal regulations related to minimal insurance coverage

(ii) Administrative Services

Administering coordination of benefits with other insurers

Determining insurance coverage, including coverage for compliance with all state and federal regulations

Verification of insurance eligibility and extent of coverage

Obtaining certificate of medical necessity and other medical necessity documentation

Obtaining prior authorizations

Performing billing functions

Performing account collection activities

Internal and external auditing and other regulatory compliance activities

Retrieval and storage of medical and reimbursement records

Maintaining inventories of drugs, equipment, administration supplies and office supplies

Maintaining physical plant and offices, including building, equipment and furnishings, utilities, telephone, pagers, office supplies, etc.

Maintaining computer clinical and administrative information systems

Postage and shipping

Design and production of patient education materials

Quality assessment and improvement activities

Continuing education to administrative staff

Legal and accounting services

Licensing application activities and fees

(iii) Other Support Costs

Wages, salaries, benefits, payroll taxes, FICA, unemployment insurance, and workers compensation premiums

Property taxes

Asset depreciation

Inventory carrying costs

Accounts receivable carrying costs associated with carrying of large accounts receivable balances

Costs of insurance coverage per state regulations

Costs of maintaining accreditation (The Joint Commission, CHAP, ACHC, etc.)

New product research and development

Sales, advertising, and marketing

Community commitment and charitable donations

Cost of bad debt (uncollectible accounts receivable)

Other applicable overhead and operational expenses

VI. Products and Services Not Included in the Definition of Per diem

- All drugs*, biologicals, enteral formulae and blood products

Nursing services provided directly to patients in their residences or other alternate sites

Other services provided directly to patients in their residences or other alternate sites by provider's staff or representatives (e.g. dietician for nutritional counseling)

PICC and Midline insertion procedures and associated supplies

Surgically implanted central vascular access devices

Invasively placed digestive tract access devices for enteral therapy, including G tubes, NG tubes, J tubes, etc.

Services and products not considered part of the per diem compensation as may be agreed to by provider and payer (e.g. delivery to high risk areas with escort or extra protection, wound care supplies and devices for sites other than IV catheter insertion sites, etc.)

Services and products that may be provided at request of the patient that are considered by provider to be not medically necessary and beyond the scope of inclusion in the per diem

All services and products provided when not otherwise paid for through per diem coding for a therapy episode.

* Except that components which are part of a standard PN formula are included in the per diem: (a) non-specialty amino acids (e.g., Aminosyn®, FreAmine®, Travasol®), (b) concentrated dextrose (e.g., D10, D20, D40, D50, D60, D70), (c) sterile water, (d) electrolytes (e.g., CaCl2, KCL, KPO4, MgSo4, NaAc, NaCl, NaPO4), (e) standard multi-trace element solutions (e.g., MTE4, MTE5, MTE7), and (f) standard multivitamin solutions (e.g., MVI-12 or MVI-13). Excluded from per diem reimbursement and reimbursed separately are other drugs associated with PN therapy: (a) specialty amino acids for renal failure (e.g.,Aminosyn-RF®, NephrAmine®), (b) specialty amino acids for hepatic failure (e.g., HepatAmine®, Hepatasol® 8%), (c) specialty amino acids for high stress conditions (e.g., Aminosyn-HBC®, BranchAmin®, FreAmine HBC®, Premasol®, TrophAmine®), (d) specialty amino acids with concentrations of 15% and above when medically necessary for fluid restricted patients (e.g., Aminosyn® 15%, Clinisol® 15%, Plenamine® 15%, Prosol® 20%), (e) lipids (e.g., Intralipid®, Liposyn®, Omegaven®, Smoflipid®), (f) added trace elements not from a standard multi-trace element solution (e.g. chromium, copper, iodine, manganese, selenium, zinc), (g) added vitamins not from a standard multivitamin solution (e.g. folic acid,

vitamin C, vitamin K), and (h) products serving non-nutritional purposes (e.g., heparin, insulin, L-Carnitine, iron dextran, Pepcid®, Sandostatin®). (Please note: trade names are used to provide a definition of per diem that communicates well; however, use of trade names is not a product recommendation or comment on extent of use in practice.)

VII. Summary. As the national standardization of relevant and pertinent definitions is deemed inherently advantageous to all stakeholders; and as NHIA is the national organization representing infusion services and standards, it is hereby established that the preceding definition of the phrase "per diem" is the national standard for purposes associated with infusion therapy reimbursement.

VI. HIPAA-Approved Code System for Per diem Coding of Home Infusion Therapy

Ref. #	*Codes and Modifiers*	*Summary Description*	*HIPAA-Compliant Code Description*
III.B		**Anti-Infective Therapies (antibiotics/ antifungals/ antivirals)**	
1	**S9497**	**Q3 hours**	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 3 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
2	**S9504**	**Q4 hours**	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
3	**S9503**	**Q6 hours**	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
4	**S9502**	**Q8 hours**	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
5	**S9501**	**Q12 hours**	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.B		**Anti-Infective Therapies (antibiotics/ antifungals/ antivirals)**	
6	**S9500**	**Q24 hours**	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
7	**S9494***	**NOC**	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately) , per diem (do not use with home infusion codes for hourly dosing schedules S9497-S9504)
		* Code Use Limited:	Used only if more specific "S" code is unavailable or if the not otherwise classified (NOC) code is required for use under provider-payer agreement

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.C		**Chemotherapy**	
1	**S9330**	**Continuous***	Home infusion therapy, continuous (twenty-four hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
		* Code Use Procedure: *Continuous* defined as 24 hours or more	
2	**S9331**	**Intermittent***	Home infusion therapy, intermittent (less than twenty-four hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
		* Code Use Procedure: *Intermittent* defined as less than 24 hours	
3	**S9329***	**NOC**	Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code with S9330 or S9331)
		* Code Use Limited: Used only if the not otherwise classified (NOC) code is required for use under provider-payer agreement	

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.D		**Enteral Nutrition**	
1	**S9343**	**Bolus therapy administration**	Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
2	**S9341**	**Gravity therapy administration**	Home therapy; enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
3	**S9342**	**Therapy administration via pump**	Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
4	**S9340***	**NOC**	Home therapy; enteral nutrition; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem
		* Code Use Limited: Used only if the not otherwise classified (NOC) code is required for use under provider-payer agreement	

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.E		**Hydration Therapy**	
1	**S9374**	**1.0 liter**	Home infusion therapy, hydration therapy; one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
2	**S9375**	**>1.0 to 2.0 liters**	Home infusion therapy, hydration therapy; more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
3	**S9376**	**>2.0 to 3.0 liters**	Home infusion therapy, hydration therapy; more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
4	**S9377**	**>3.0 liters**	Home infusion therapy, hydration therapy; more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies (drugs and nursing visits coded separately), per diem
5	**S9373***	**NOC**	Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use with hydration therapy codes S9374-S9377 using daily volume scales)
		* Code Use Limited: Used only if more specific "S" code is unavailable or if the not otherwise classified (NOC) code is required for use under provider-payer agreement	

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.F		**Pain Management**	
1	**S9326**	**Continuous***	Home infusion therapy, continuous (twenty-four hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
		* Code Use Procedure: *Continuous* defined as 24 hours or more	
2	**S9327**	**Intermittent***	Home infusion therapy, intermittent (less than twenty-four hours) pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
		* Code Use Procedure: *Intermittent* defined as less than 24 hours	
3	**S9328**	**Implanted pump**	Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
4	**S9325***	**NOC**	Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (do not use this code with S9326, S9327 or S9328)
		* Code Use Limited: Used only if the not otherwise classified (NOC) code is required for use under provider-payer agreement	

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.G		**Parenteral Nutrition ***	
		*Procedures for PN Coding:	1. Standard PN formula includes the following components: non-specialty amino acids, concentrated dextrose, sterile water, electrolytes, standard multi-trace element solutions and standard multivitamin solutions.
			2. Components not included in standard PN formula are specialty amino acids, lipids, trace elements not from a standard multi-trace element solution, vitamins not from a standard multivitamin solution, and products serving non-nutritional purposes. Such components are billed on claims with NDC number addition to the PN per diem "S" code.
1	**S9365**	**1.0 liter**	Home infusion therapy, parenteral nutrition (PN); one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard PN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
2	**S9366**	**>1.0 – 2.0 liter**	Home infusion therapy, parenteral nutrition (PN); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard PN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
3	**S9367**	**>2.0 -3.0 liter**	Home infusion therapy, parenteral nutrition (PN); more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard PN formula (lipids, specialty amino acids, drugs other than in standard formula and nursing visits coded separately), per diem

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.G		**Parenteral Nutrition ***	
4	**S9368**	**> 3.0 liter**	Home infusion therapy, parenteral nutrition (PN); more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard PN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem
5	**S9364***	**NOC**	Home infusion therapy, parenteral nutrition (PN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard PN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (do not use with home infusion codes S9365-9368 using daily volume scales)
		* Code Use Limited: Used only if more specific "S" code is unavailable or if the not otherwise classified (NOC) code is required for use under provider-payer agreement	

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.H		**Specialty Therapy Per diems**	
1	**S9061**	**Aerosolized drug (e.g. pentamidine)**	Home administration of aerosolized drug therapy (e.g., pentamidine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
2	**S9346**	**Alpha-1 proteinase inhibitor (e.g. Prolastin®): infusion**	Home infusion therapy, alpha-1-proteinase inhibitor (e.g. Prolastin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
3	**S9336**	**Anti-coagulant (e.g. heparin): continuous infusion**	Home infusion therapy, continuous anticoagulant infusion therapy (e.g. heparin), administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
4	**S9372**	**Anti-coagulant (e.g. heparin): intermittent injection**	Home therapy; intermittent anticoagulant injection therapy (e.g. heparin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code for flushing of infusion devices with heparin to maintain patency)
5	**S9351**	**Anti-emetic: continuous or intermittent infusion**	Home infusion therapy, continuous or intermittent anti-emetic infusion therapy; administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.H		**Specialty Therapy Per diems**	
6	**S9370**	**Anti-emetic: intermittent injection**	Home therapy, intermittent anti-emetic injection therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
7	**S9345**	**Anti-hemophilic agent (e.g. Factor VIII): infusion**	Home infusion therapy, anti-hemophilic agent infusion therapy (e.g. Factor VIII); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
8	**S9363**	**Anti-spasmotic: infusion**	Home infusion therapy, anti-spasmotic therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
9	**S9359**	**Anti-tumor necrosis factor (e.g. infliximab): intravenous infusion**	Home infusion therapy, anti-tumor necrosis factor intravenous therapy; (e.g. infliximab); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
10	**S9538**	**Blood product transfusion**	Home transfusion of blood product(s); administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (blood products, drugs, and nursing visits coded separately), per diem
11	**S9355**	**Chelation: infusion**	Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.H		**Specialty Therapy Per diems**	
12	**S9490**	**Corticosteroid: infusion**	Home infusion therapy, corticosteroid infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
13	**S9361**	**Diuretic: intravenous infusion**	Home infusion therapy, diuretic intravenous therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
14	**S9357**	**Enzyme replacement (e.g. imiglucerase): intravenous infusion**	Home infusion therapy, enzyme replacement intravenous therapy; (e.g. imiglucerase); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
15	**S9558**	**Growth hormone: injectable**	Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
16	**S9537**	**Hematopoietic hormone (e.g. erythropoietin, G-CSF, GM-CSF): injection**	Home therapy; hematopoietic hormone injection therapy (e.g. erythropoietin, G-CSF, GM-CSF); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
17	**S9560**	**Hormonal (e.g. leuprolide, goserelin): injectable**	Home injectable therapy; hormonal therapy (e.g.; leuprolide, goserelin), including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.H		**Specialty Therapy Per diems**	
18	**S9338**	**Immunotherapy (e.g. immunoglobulin): infusion**	Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination; and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
19	**S9348**	**Inotropic/sympath-omimetic (e.g. dobutamine): infusion**	Home infusion therapy, sympathomimetic/inotropic agent infusion therapy (e.g. dobutamine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
20	**S9353**	**Insulin: continuous infusion**	Home infusion therapy, continuous insulin infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
21	**S9559**	**Interferon: injectable**	Home injectable therapy; interferon, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
22	**S9590**	**Irrigation (e.g. of an organ or anatomical cavity): injectable**	Home injectable therapy, irrigation therapy (e.g. sterile irrigation of an organ or anatomical cavity); including administrative services, professional pharmacy services, coordination of care, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
23	**S9562**	**Palivizumab (e.g. Synagis®): injectable**	Home injectable therapy, palivizumab, including administrative services, professional pharmacy services, coordination of care, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Ref. #	*Codes and Modifiers*	*Summary Description*	*HIPAA-Compliant Code Description*
III.H		**Specialty Therapy Per diems**	
24	**S9339**	**Peritoneal dialysis**	Home therapy; peritoneal dialysis, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
25	**S9349**	**Tocolytic: infusion**	Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
26	**S9347**	**Uninterrupted, long term, controlled rate (e.g. epoprostenol): intravenous or subcutaneous infusion**	Home infusion therapy, uninterrupted, long-term, controlled rate intravenous or subcutaneous infusion therapy (e.g. epoprostenol); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.I		**Not Otherwise Classified (NOC) Therapy** **Per diems**	
1	**S9379***	**NOC Infusion Therapy** **Per diem**	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
		* Code Use Limited: Used only for miscellaneous infusion therapies not otherwise described by more specific per diem "S" codes.	
2	**S9542***	**NOC Injectable Therapy** **Per diem**	Home injectable therapy; not otherwise classified, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
		* Code Use Limited: Used only for miscellaneous non-infusion therapies not otherwise described by more specific per diem "S" codes.	

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.J		**Catheter Care**	
1	**S5498***	**Catheter care maintenance - single lumen**	Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem
		* Code Use Procedure: Used when catheter care provided as a standalone therapy, or during days not covered under per diem by another therapy	
2	**S5501***	**Catheter care maintenance - more than 1 lumen**	Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
		* Code Use Procedure: Used when catheter care provided as a standalone therapy, or during days not covered under per diem by another therapy	
3	**S5502***	**Catheter care maintenance-interim (implanted access device)**	Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use)
		* Code Use Procedure: Used when catheter care provided as a standalone therapy, or during days not covered under per diem by another therapy	

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.J		**Catheter Care**	
4	**S5517***	**Catheter declotting supply kit**	Home infusion therapy, all supplies necessary for restoration of catheter patency or declotting
		* Code Use Procedure: Supplies required for non-routine catheter procedures are coded, billed and reimbursed separately from other per diem "S" codes.	
5	**S5518***	**Catheter repair supply kit**	Home infusion therapy, all supplies necessary for catheter repair
		* Code Use Procedure: Supplies required for non-routine catheter procedures are coded, billed and reimbursed separately from other per diem "S" codes.	
6	**S5497***	**NOC**	Home infusion therapy, catheter care/maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
		* Code Use Limited: Used only if required for use under provider-payer agreement; otherwise, codes S5498, S5501 and S5502 are used.	

Ref. #	*Codes and Modifiers*	*Summary Description*	*HIPAA-Compliant Code Description*
III.K		**Home Nursing**	Provision of home infusion, specialty drug administration and/or associated nursing services and procedures by high tech or specialized high tech registered nurse.
		^^ Code Use Procedure for 99601 and 99602:	Time needed for all nursing activities necessary for a nurse visit—preparation, travel, time in the home, documentation, post-visit reporting, follow-up activities, etc.— *should be included on a claim, unless a third-party payer's coverage policy differs from this standard.*
1	**99601^^**	**High-tech RN services per visit up to 2 hours**	Home infusion/specialty drug administration, per visit (up to 2 hours)
2	**99601^^ --SD***	**Specialized high-tech RN services per visit up to 2 hours**	Home infusion/specialty drug administration, per visit (up to 2 hours)
		* Code Use Procedure:	Use if required under provider-payer agreement, or to distinguish the provider's fees for specialized high-tech home infusion nursing.
3	**99602^^**	**High-tech RN services each additional hour**	Each additional hour (List separately in addition to primary procedure) (Use 99602 in conjunction with code 99601)
4	**99602^^ -SD***	**Specialized high-tech RN services each additional hour**	Each additional hour (List separately in addition to primary procedure) (Use 99602 in conjunction with code 99601)

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.K		**Home Nursing**	Provision of home infusion, specialty drug administration and/or associated nursing services and procedures by high tech or specialized high tech registered nurse.
		* Code Use Procedure:	Use if required under provider-payer agreement, or to distinguish the provider's fees for specialized high-tech home infusion nursing.
5	**S5522***	**PICC line insertion w/o supplies**	Home infusion therapy, insertion of peripherally inserted central venous catheter (PICC), nursing services only (no supplies or catheter included)
		* Code Use Procedure:	Coded separately from 99601 and 99602, as well as separately from any other per diem "S" code.
6	**S5520***	**PICC line catheter kit**	Home infusion therapy, all supplies (including catheter) necessary for a peripherally inserted central venous catheter (PICC) line insertion
		* Code Use Procedure:	Supplies required for non-routine catheter procedures are coded, billed and reimbursed separately from other per diem "S" codes.
7	**S5523***	**Midline insertion w/o supplies**	Home infusion therapy, insertion of midline venous catheter, nursing services only (no supplies or catheter included)
		* Code Use Procedure:	Coded separately from 99601 and 99602, as well as separately from any other per diem "S" code.
8	**S5521***	**Midline catheter kit**	Home infusion therapy, all supplies (including catheter) necessary for midline catheter insertion

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.K		**Home Nursing**	Provision of home infusion, specialty drug administration and/or associated nursing services and procedures by high tech or specialized high tech registered nurse.
		* Code Use Procedure:	Supplies required for non-routine catheter procedures are coded, billed and reimbursed separately from other per diem "S" codes.
9	**99082***	**Unusual travel**	Unusual travel (eg, transportation and escort of a patient)
		* Code Use Procedure:	Used to charge for unusual travel per provider-payer agreement or to distinguish provider's usual and customary fees.
10	**S9381***	**High risk/escort**	Delivery or service to high risk areas requiring escort or extra protection, per visit
		* Code Use Procedure:	Used to charge for visit to high risk areas requiring escort or extra protection per provider-payer agreement or to distinguish provider's usual and customary fees.

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.L		**Other Specialized Home Services**	
1	**S9214**	**Gestational diabetes management**	Home management of gestational diabetes, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any home infusion per diem code)
2	**S9211**	**Gestational hypertension management**	Home management of gestational hypertension, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any home infusion per diem code)
3	**S9213**	**Preeclampsia management**	Home management of preeclampsia, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any home infusion per diem code)
4	**S9212**	**Postpartum hypertension management**	Home management of postpartum hypertension, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately); per diem (do not use this code with any home infusion per diem code)
5	**S9208**	**Preterm labor management**	Home management of preterm labor, including administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.L		**Other Specialized Home Services**	
6	**S9209**	**Preterm premature rupture of membranes (PPROM) management**	Home management of preterm premature rupture of membranes (PPROM), including administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment (drugs and nursing visits coded separately), per diem (do not use this code with any home infusion per diem code)
		^^ Code Use Procedure for 99500 and S9123:	Time needed for all nursing activities necessary for a nurse visit—preparation, travel, time in the home, documentation, post-visit reporting, follow-up activities, etc.—will be included on a claim.
7	**99500^^**	**RN services per visit up to 2 hours (not to be used for home infusion therapy)**	Home visit for prenatal monitoring and assessment to include fetal heart rate, non-stress test, uterine monitoring, and gestational diabetes monitoring
8	**S9123* ^^**	**RN services per hour (not to be used for home infusion therapy)**	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99600 can be used)
		* Code Use Procedure:	Use S9123 for each additional hour for 99500, or as a standalone per hour nursing code for other specialized home services that are different from the service described by 99500.
9	**99082***	**Unusual travel**	Unusual travel (eg, transportation and escort of a patient)

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.L		**Other Specialized Home Services**	
		* Code Use Procedure:	Used to charge for unusual travel per provider-payer agreement or to distinguish provider's usual and customary fees.
10	**S9381***	**High risk/escort**	Delivery or service to high risk areas requiring escort or extra protection, per visit
		* Code Use Procedure:	Used to charge for visit to high risk areas requiring escort or extra protection per provider-payer agreement or to distinguish provider's usual and customary fees.

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.M		**Extra Services**	
1	**S0315***	**DMP, initial assessment and initiation**	Disease management program; initial assessment and initiation of the program
2	**S0316***	**DMP, follow-up/reassessment**	Disease management program, follow-up/reassessment
3	**S0317***	**DMP, per diem**	Disease management program; per diem
4	**S0320***	**DMP, RN telephone calls, per month**	Telephone calls by a registered nurse to a disease management program member for monitoring purposes, per month
5	**99058***	**Provided on an emergency basis in the office**	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service
6	**99060***	**Provided on an emergency basis, out of the office**	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service
7	**S9381***	**High risk/escort**	Delivery or service to high risk areas requiring escort or extra protection, per visit
		* Code Use Procedure:	Coded separately from other per diem "S" codes.

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.M		**Extra Services**	
8	**S5035***	**Infusion device routine service**	Home infusion therapy, routine service of infusion device (e.g. pump maintenance)
9	**S5036***	**Infusion device repair**	Home infusion therapy, repair of infusion device (e.g. pump repair)
10	**S9470***	**Nutritional counseling**	Nutritional counseling, dietitian visit
11	**99082***	**Unusual travel**	Unusual travel (eg, transportation and escort of a patient)
		* Code Use Procedure:	Coded separately from other per diem "S" codes.

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.O		**Professional Pharmacy Services**	
		^^ Code Use Procedure for S9810:	Time needed for all activities necessary for a professional pharmacy service—including applicable travel, clinical cognitive activities, care coordination activities, compounding, packaging, documentation, and all other time in the office or home—will be included on a claim.
1	**S9810* ^^**	**Pharmacy service, not otherwise classified, per hour**	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code)
		* Code Use Procedure:	Do not use if a per diem "S" code is also used that includes professional pharmacy services.
2	**99050***	**In the office at times other than regularly scheduled office hours**	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
3	**99051***	**In the office during regularly scheduled evening, weekend, or holiday office hours**	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
4	**99053***	**Between 10:00 PM and 8:00 AM at 24-hour facility**	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.O		**Professional Pharmacy Services**	
		* Code Use Procedure:	Used to charge per provider-payer agreement or to distinguish provider's usual and customary fees. One or more codes are used if applicable.
5	**99056***	**Provided out of the office at request of patient**	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
6	**99058***	**Provided on an emergency basis in the office**	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service
7	**99060***	**Provided on an emergency basis, out of the office**	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service
		* Code Use Procedure:	Used to charge per provider-payer agreement or to distinguish provider's usual and customary fees. One or more codes are used if applicable.
8	**99082***	**Unusual travel**	Unusual travel (eg, transportation and escort of a patient)
		* Code Use Procedure:	Used to charge for unusual travel per provider-payer agreement or to distinguish provider's usual and customary fees.
9	**S9381***	**High risk/escort**	Delivery or service to high risk areas requiring escort or extra protection, per visit

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.O		**Professional Pharmacy Services**	
		* Code Use Procedure:	Used to charge for visit to high risk areas requiring escort or extra protection per provider-payer agreement or to distinguish provider's usual and customary fees.

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.Q		**Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS)**	
		^^ Code Use Procedure for 99601 and 99602:	Time recorded is for the duration of patient service in suite.
1	**99601^^ -SS***	**High-tech RN services in AIS per visit up to 2 hours**	Home infusion/specialty drug administration, per visit (up to 2 hours) -SS: Home infusion services provided in the infusion suite of the IV therapy provider
		*Code Use Procedure:	Use for: RN services in the infusion/specialty drug administration suite of the home infusion therapy provider, per visit (up to 2 hrs patient service in suite).
2	**99602^^ -SS***	**High-tech RN services in AIS each additional hour**	Each additional hour (List separately in addition to primary procedure) (Use 99602 in conjunction with code 99601) -SS: Home infusion services provided in the infusion suite of the IV therapy provider

Ref. #	*Codes and Modifiers*	*Summary Description*	*HIPAA-Compliant Code Description*
III.Q		**Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS)**	
		*Code Use Procedure:	Use for: RN services in the infusion/specialty drug administration suite of the home infusion therapy provider (each additional hour).
3	**99601^^ -SS* -SD****	**Specialized high-tech RN services in AIS per visit up to 2 hours**	Home infusion/specialty drug administration, per visit (up to 2 hours) -SS: Home infusion services provided in the infusion suite of the IV therapy provider
		*Code Use Procedure:	Use for: RN services in the infusion/specialty drug administration suite of the home infusion therapy provider, per visit (up to 2 hrs patient service in suite).
		**Code Use Procedure:	Use if required under provider-payer agreement, or to distinguish the provider's fees for specialized, high-tech infusion nursing.
		^^ Code Use Procedure for 99602:	Time recorded is for the duration of patient service in suite.
4	**99602^^ -SS***	**Specialized high-tech RN services in AIS each additional hour**	Each additional hour (List separately in addition to primary procedure) (Use 99602 in conjunction with code 99601)

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.Q		**Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS)**	
	-SD**		-SS: Home infusion services provided in the infusion suite of the IV therapy provider
		*Code Use Procedure:	Use for: RN services in the infusion/specialty drug administration suite of the home infusion therapy provider (each additional hour).
		**Code Use Procedure:	Use if required under provider-payer agreement, or to distinguish the provider's fees for specialized, high-tech infusion nursing.
5	**S5522** **-SS***	**PICC line insertion in AIS w/o supplies**	Home infusion therapy, insertion of peripherally inserted central venous catheter (PICC), nursing services only (no supplies or catheter included) -SS: Home infusion services provided in the infusion suite of the IV therapy provider
		* Code Use Procedure:	Coded separately from 99601 and 99602, as well as separately from any other per diem "S" code.
6	**S5523** **-SS***	**Midline insertion in AIS w/o supplies**	Home infusion therapy, insertion of midline venous catheter, nursing services only (no supplies or catheter included)

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.Q		**Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS)**	
			-SS: Home infusion services provided in the infusion suite of the IV therapy provider
		* Code Use Procedure:	Coded separately from 99601 and 99602, as well as separately from any other per diem "S" code.
7	**Per diem S-codes -SS ***	**Per diem coding when all services provided in AIS**	Typical per diem S-code description: Home…therapy;…administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem -SS: Home infusion services provided in the infusion suite of the IV therapy provider
		*Code Use Procedure:	Use for: Services in the infusion/specialty drug administration suite of the home infusion therapy provider, including administrative services, professional pharmacy services, care coordination, use of facility, and all necessary supplies and equipment (drugs and nursing service coded separately), per diem. Use when all of the patient's services for a therapy are provided in the AIS. Do not use the –SS modifier when there is occasional occurrence of treatment of a home infusion therapy patient that is provided in the AIS.

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.Q		**Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS)**	
8	**Per diem S-codes***	**Per diem coding when occasional occurrence of treatment in AIS**	Typical per diem S-code description: Home…therapy;…administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
		*Code Use Procedure:	*As patient is a home infusion therapy patient, the HCPCS per diem "S" codes are used, including for days in which a nursing intervention may be provided in the AIS. –SS modifier is not used.
		^^ Code Use Procedure for S9810:	Time needed for all activities necessary for a professional pharmacy service—including applicable travel, clinical cognitive activities, care coordination activities, compounding, packaging, documentation, and all other time in the office—will be included on a claim.
9	**S9470 -SS***	**Nutritional counseling**	Nutritional counseling, dietitian visit -SS: Home infusion services provided in the infusion suite of the IV therapy provider
		*Code Use Procedure:	Coded separately from other per diem "S" codes.

Ref. #	*Codes and Modifiers*	*Summary Description*	*HIPAA-Compliant Code Description*
III.Q		**Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS)**	
10	**S9810^^ -SS***	**Pharmacy service in AIS, not otherwise classified, per hour**	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour (do not use this code with any per diem code) -SS: Home infusion services provided in the infusion suite of the IV therapy provider
		* Code Use Procedure:	Do not use if a per diem "S" code is also used that includes professional pharmacy services.
11	**99050***	**In the office at times other than regularly scheduled office hours**	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
12	**99051***	**In the office during regularly scheduled evening, weekend, or holiday office hours**	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
13	**99053***	**Between 10:00 PM and 8:00 AM at 24-hour facility**	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service

Ref. #	*Codes and Modifiers*	*Summary Description*	*HIPAA-Compliant Code Description*
III.Q		**Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS)**	
14	**99056***	**Provided out of the office at request of patient**	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
		* Code Use Procedure:	Used to charge per provider-payer agreement or to distinguish provider's usual and customary fees. One or more codes are used if applicable.
15	**99058***	**Provided on an emergency basis in the office**	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service
16	**99060***	**Provided on an emergency basis, out of the office**	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service
		* Code Use Procedure:	Used to charge per provider-payer agreement or to distinguish provider's usual and customary fees. One or more codes are used if applicable.
17	**12***	**Place of Service Code (home)**	Location, other than a hospital or other facility, where the patient receives care in a private residence
18	**49***	**Place of Service Code (independent clinic)**	A location, not part of a hospital and not described by any other Place of Service Code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients, only

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.Q		**Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS)**	
		* Code Use Procedure:	May use "12" or "49" for drug administration or other services that are provided in the AIS. Provider should determine from the health plan covering the service which POS code(s) should be used and then document the plan's instructions in provider's file. While unlikely, the health plan may direct that POS codes other than "12" or "49" be used. See Section III.Q.4.

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.R		**Modifiers**	
1	**-SD***	**"Specialized" high-tech nursing**	Services provided by registered nurse with specialized, highly technical home infusion training
2	**-SH***	**2nd Therapy**	Second concurrently administered infusion therapy
3	**-SJ***	**3rd Therapy**	Third or more concurrently administered infusion therapy
		* Code Use Limited:	May be used if distinction is needed per provider-payer agreement on per diem rates, to distinguish the provider's usual and customary fees, or to indicate that the therapy is a distinct administered therapy.
4	**-SS**	**Ambulatory Infusion Suite of the Home Infusion Therapy Provider (AIS)**	Home infusion services provided in the infusion suite of the IV therapy provider
5	**-JA***	**Administered intravenously**	Administered intravenously
6	**-JB***	**Administered subcutaneously**	Administered subcutaneously
		* Code Use Limited:	Use will be rare. Do not use –JA or –JB when the HCPCS per diem code description already specifies the same route of administration.

Ref. #	Codes and Modifiers	Summary Description	HIPAA-Compliant Code Description
III.R		**Modifiers**	
7	**-TG***	**Complex/high tech**	Complex/high tech level of care
		* Code Use Limited	Used only if distinction is needed per provider-payer agreement or to distinguish provider's usual and customary fees.

VII. HIPAA Regulations on Requiring Standard Coding and Electronic Claim Transactions

NHIA provides the National Coding Standard to assist your organization in complying with and converting to HIPAA standardized coding requirements. The overriding objective set by the US Congress for HIPAA simplification is to save substantial health care administrative costs through setting standards for insurance transactions—both in electronic formats and use of standardized codes. It is also with this objective in mind that NHIA educates in this document on consistency in coding, billing and reimbursement of home infusion services[24].

For the home infusion provider and payer health segment, particularly important are standardization of (1) billing codes and (2) the electronic claim transaction. In this section, presented are HIPAA regulations and directives by the US Department of Health and Human Services (HHS) and its Centers for Medicare & Medicaid Services (CMS, which enforces most HIPAA regulations). These HIPAA regulations and directives support consistency for home infusion claims in a question and answer format.

VII.A. Can HCPCS or CPT code descriptions be changed by payers or providers, i.e. use the code with a different meaning?

No. A goal for HIPAA administrative simplification was to end "custom coding", including prohibiting changing the meanings assigned to what would otherwise be standardized codes. The HIPAA regulations are very clear in this area.

Of course, the law is the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. The relevant HIPAA regulations are found in 45 CFR Part 162 and were released as part of the August 17, 2000 Transactions and Coding Standards Rule. There are two separate parts of these regulations prohibiting change of code descriptions.

[24] NHIA's efforts in the Coding Standard exclude addressing any specific pricing rates for these services. Rates are determined by providers, under contract between providers and payers, or by administrators of government health plans under appropriate law and regulations.

The first part is actually a composite of different regulation sections. Taken together, they do the following:

1. The regulations require use of HCPCS and CPT-4 codes sets.
2. A code set includes the descriptors.
3. Descriptor means the text defining a code.
4. Therefore, no changes to code descriptions are allowed.

Next are the specific regulations:

> Sec. 162.103 Definitions.
>
> *Code set means any set of codes used to encode data elements*, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A *code set includes the codes and the descriptors of the codes*.
>
> *Descriptor means the text defining a code.*
>
> Sec. 162.1000 General requirements.

When conducting a transaction covered by this part, a covered entity must meet the following requirements: (a) *Medical data code sets. Use the applicable medical data code sets described in Sec. 162.1002* as specified in the implementation specification adopted under this part that are valid at the time the health care is furnished.

Sec. 162.1002 *Medical data code sets*.

> *The Secretary adopts the following…code sets as the standard medical data code sets:…e) The combination of…HCPCS…and CPT-4…for physician services and other health care services…(f)…HCPCS…for all other substances, equipment, supplies, or other items used in health care services.*

While the first part just cited stands on its own as sufficient prohibition of changing code descriptions, there is yet a second part in Sec. 162.915 that addresses the "Trading Partner Agreements" necessary for electronic claims which states the following:

> *A covered entity must not enter into a trading partner agreement that would do any of the following: (a) Change the definition, data condition, or use of a data element or segment in a standard.* (b) Add any data elements or segments to the maximum defined data set. (c) Use any code or data elements that are either marked "not used"' in the standard's implementation specification or are not in the standard's implementation specification(s). (d) Change the meaning or intent of the standard's implementation specification(s).

With even more clarity, HHS writes the following on their HIPAA FAQ web page at **https://aspe.hhs.gov/report/frequently-asked-questions-about-electronic-transaction-standards-adopted-under-hipaa#stipulatecodes:**Q: May health plans stipulate the codes or data values they are willing to accept and process in order to simplify implementation?

> A: The simplest implementation is the one that is identical to all others. If the standard adopted stipulates that HCPCS codes will be used to describe procedures, *then the health plan must abide by the instructions for the use of HCPCS codes*.

The italics are added above to highlight importance. Words are omitted where marked with "…" for brevity and clarity, but the omissions do not change the meaning.

VII.B. Must providers and payers break out coding for all of the dispensed drugs, including even diluents, flushing solutions, D5W, etc. in claims? Or, could they agree to include some drugs as part of the per diem when the HCPCS per diem "S" codes are used?

Under HIPAA rule, providers, payers and clearinghouses may not change the meanings of HCPCS or CPT descriptions within an electronic claim. See the previous question and answer on the relevant regulations. Therefore, because most of the HCPCS per diem "S" codes for home infusion therapy specify "drugs and nursing visits coded separately", drugs cannot be included in the per diem. To do otherwise would be an enforceable violation of HIPAA law. Thus, drugs are coded, billed and reimbursed separately.

Excluded from the per diem are all non-compounded drugs (e.g. injectables, flushing solutions) as well as all the drugs used within a compound including the primary drug, the diluent, and the solution compounded into. Put another way, all drugs requiring an Rx (often called legend drugs in state law) are excluded.

Note also that enteral formulae are coded separately when using the enteral per diem "S" codes. An exception is for PN per diem "S" codes where standard PN formula drugs are not coded separately (see Section III.G).

VII.C. Must providers and payers break out coding for home infusion nursing visits? Or, could they agree to include some home nursing as part of the per diem when the HCPCS per diem "S" codes are used?

Under HIPAA rule, providers, payers and clearinghouses may not change the meanings of HCPCS or CPT descriptions within an electronic claim. See the earlier question and answer on the relevant regulations. Therefore, because most of the HCPCS per diem "S" codes for home infusion therapy specify "drugs and nursing visits coded separately", home infusion nurse visits cannot be included in the per diem. To do otherwise would be an enforceable violation of HIPAA law. Thus, nursing visits are coded, billed and reimbursed separately.

VII.D. Through which electronic format are home infusion therapy claims submitted under HIPAA: X12N Professional or NCPDP Retail Pharmacy?

Home infusion therapy claims will be submitted electronically only with the ASC X12N 837 electronic claim format. This direction is provided by the Centers for Medicare & Medicaid Services (CMS) with two FAQs first posted in March of 2003 on CMS's HIPAA web site and a subsequent letter written to NHIA. CMS's direction applies to home infusion therapy claims submitted to all payers, including charges for drugs that are part of their claims. In October 2003, CMS updated these FAQs to address some questions that had arisen, including:

- What does this mean if the home infusion provider is licensed as a "retail pharmacy" in some states?

What does this mean if a home infusion therapy provider also has a retail pharmacy business line?

According to CMS, "Although Home Infusion Therapy providers may be licensed as retail pharmacies in some states, their model for dispensing drugs and biologics for infusion, injection, or inhalation using a nebulizer, as well as dispensing total parenteral and enteral nutrition, is very different from that of traditional retail pharmacies". And, "The ASC X12N 837 claim standard must be used for billing the drugs, biologics, parenteral nutrition and enteral nutrition that are provided by the pharmacy, and usually billed along with

the service, supply, and equipment components of Home Infusion Therapy, i.e. comprising a total claim for Home Infusion Therapy".

On April 8, 2003, CMS's Director of its Office of HIPAA Standards wrote a letter to NHIA to further confirm the direction CMS has set. Significantly, the Director wrote "a requirement to bill home infusion drugs using the NCPDP format would fail to meet the administrative, clinical, coordination or care, and medical necessity requirements for home drug infusion therapy claims."

- We note that for paper claims, most payers accept home infusion therapy claims on the CMS 1500 form (formerly called the HCFA 1500 form). Payers are unlikely to have separate claims processing systems--one for electronic and a second system for paper claims. Hence, home infusion therapy electronic claims will be routed through the X12N 837 Professional claim standard as it is the equivalent to the CMS 1500 form.

While a letter NHIA wrote to CMS in December of 2002 asked for clarification about home infusion claims that are submitted to Medicare, you should realize that CMS's direction in its FAQs and April 8 letter apply to claims submitted to all payers. That is because it's unlikely the CMS Office of HIPAA Standards would issue directives unique to type of payer since HIPAA regulations, generally, are not unique to payer. Notably, this CMS office which issued the direction is responsible for the enforcement of HIPAA regulations for health care claim transactions.

In conclusion, all of this means that under HIPAA, there will be no "split billing" of HIT drugs submitted through the NCPDP retail pharmacy format to a DME MAC or any other payer, and that all components of claims from a home infusion pharmacy provider--services, supplies, DME, drugs, biologicals, PN, and enteral nutrition--are submitted through the X12N 837 claim format.

Read next the directive from CMS's Office of HIPAA Standards on this subject, as first posted on March 31, 2003 in the form of an FAQ on their HIPAA website, and then updated on October 10, 2003. This CMS office has responsibilities for many areas of HIPAA, including developing regulations and enforcing the transactions and code sets, security, and identifier rules.

Short version of question: Are prescription drugs billed by Home Infusion Therapy Providers considered retail pharmacy drug claims?

Long version of question: Under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA), is the billing for drugs by a Home Infusion Therapy provider considered a retail pharmacy drug claim transaction that would require billing the drugs and biologics using the National Council for Prescription Drug Programs (NCPDP) formats, and billing for other Home Infusion Therapy components, such as supplies and services, using the ASC X12N 837 format?

A. No. When a patient receives Home Infusion Therapy, the episode of Home Infusion Therapy typically has components of professional services and products that include ongoing clinical monitoring care coordination, supplies and equipment, and the drugs and biologics administered – all supplied by the Home Infusion Therapy provider. For this encounter, the drugs and biologics are billed on a claim for Home Infusion Therapy services as one of numerous components that comprises the claim.

Although Home Infusion Therapy providers may be licensed as retail pharmacies in some states, their model for dispensing drugs and biologics for infusion, injection, or inhalation using a nebulizer, as well as dispensing total parenteral and enteral nutrition, is very different from that of traditional retail pharmacies. While the NCPDP claim format works well for the typical drug-dispensing activities performed by traditional retail pharmacies, it does not meet the administrative, clinical, coordination of care, and medical necessity requirements for Home Infusion Therapy claims. The ASC X12N 837 is the required standard format for claims for the provision of Home Infusion Therapy. Claims for Home Infusion Therapy care include the drugs, biologics, and nutrition components of the total Home Infusion Therapy encounter.

Examples:

1-A licensed retail pharmacy's business is providing Home Infusion Therapy. Supplied by the pharmacy are professional services, products, and supplies and equipment, that include ongoing clinical monitoring and care coordination. Also supplied are the drugs and biologics administered by infusion, injection, or inhalation using a nebulizer, as well as total parenteral and enteral nutrition products and care. The ASC X12N 837 claim standard must be used for billing the drugs, biologics, parenteral nutrition and enteral nutrition that are provided by the pharmacy, and usually billed along with the service, supply, and equipment components of Home Infusion Therapy, i.e. comprising a total claim for Home Infusion Therapy.

2-A licensed retail pharmacy has multiple lines of business, one of which is a traditional retail pharmacy, such as a walk-in community pharmacy, and a second of which is to provide Home Infusion Therapy as described in Example 1. The NCPDP

claim standard must be used for billing drugs and biologics that are dispensed by the line of business performing the traditional single event filling of prescriptions, without also supplying the ongoing clinical monitoring and care coordination involved with an episode of Home Infusion Therapy. However, the ASC X12N 837 claim standard must be used for billing the drugs, biologics, parenteral nutrition and enteral nutrition that are provided by the pharmacy, and usually billed along with the service, supply, and equipment components of Home Infusion Therapy, i.e. comprising a total claim for Home Infusion Therapy.

3-A licensed retail pharmacy could dispense drugs used for home infusion therapy during its normal course of business dispensing traditional retail drug prescriptions, but the pharmacy does not provide the ongoing clinical monitoring and care coordination involved with an episode of Home Infusion Therapy. In this situation, the NCPDP claim format must be used for billing the home infusion therapy drugs. This is because a licensed retail pharmacy that happens to fill a prescription for a drug used in Home Infusion Therapy is not supplying the service components of the Home Infusion Therapy episode of care, and the NCPDP format is the adopted standard for retail pharmacy drug claims.

2020 NHIA Quick Coding Reference for Home Infusion Therapy

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Thanks to the generous sponsorship from Innovatix, a Premier Inc. company, NHIA members can now access the 2020 NHIA Quick Coding Reference for Home Infusion Therapy directly on the *NHIA IVHub mobile app at* www.nhia.org/NHIAIVHub/ *or in PDF format at* www.nhia.org/quickcode

This is an essential reference for anyone coding home infusion and alternate-site infusion claims:

- ✓ Quickly find codes and procedures for per diem billing of infusion services.
- ✓ Use its detailed list of products included/excluded in standard PN formula.

If you are not currently a member of NHIA and would like to learn more about the Quick Coding Reference—and about the many other benefits of joining NHIA—please call our office at 703-549-3740 or e-mail Ashlan Olberholtzer at: ashlan.olberholtzer@nhia.org

The NHIA Model Contract Addenda

Easy-to-use contract language specific to home infusion therapy

The NHIA Model Contract Addenda is now available as a NHIA member-only benefit at www.nhia.org/modelcontract. While this tool has not been updated in nearly a decade it is a significant historical reference and contains important contracting concepts and strategies that are still relevant today. The NHIA Model Contract Addenda was developed by NHIA's Home Infusion EDI Coalition to help you:

- Establish the best possible contracts.
- Address critical missing ingredients and problematic clauses in contracts.
- Obtain contract language that clearly defines per diem, nursing and drug reimbursement.
- Establish appropriate definitions for key infusion service terminology.
- Develop proactive provider-payer relationships that minimize disputes.

The Addenda contains detailed contract language for proposing new contracts and renegotiating to improve existing contracts. It's not generic language for any health care organization, but rather language that is highly specific for provision of home infusion therapy services:

- **A set of very best contract language.** Starting with contributions of contract template language obtained from national, regional and local home infusion organizations, NHIA's PAR Committee experts analyzed these contributions, selected from the best ones and significantly enhanced language and terms given their multi-company assessment of the most critical opportunities and issues for home infusion.
- **A major enhancement to the presentation and organization of HCPCS and CPT billing codes as compared to the *NHIA National Coding Standard for Home Infusion Claims under HIPAA*.** Your marketing, billing or claims processing staff will find it to be extremely easy to understand and quick to implement the compendia of codes and fee schedules.

NHIA Model Contract Addenda Table of Contents and Sample Language

To provide a better understanding of what you will obtain, next is the complete table of contents from the Model Contract Addenda, with excerpts from it (and some explanatory comments are listed in italic):

INTRODUCTION

The National Home Infusion Association developed the NHIA Model Contract Addenda to be of service to the home infusion community with several purposes in mind. First and of high importance, this document serves home infusion providers and payers as an additional educational resource on home infusion services coding, complimenting NHIA's *National Coding Standard for Home Infusion Claims under HIPAA*.

ADDENDUM A

I. BACKGROUND

A. THE HOME INFUSION PROVIDER

B. A STRUCTURE FOR REIMBURSEMENT FOR PROVISION OF HOME INFUSION SERVICES

II. DEFINITIONS

A. PER DIEM

B. DRUG

For purposes of coding, billing and reimbursing separately from per diem rates as required by the HCPCS per diem code descriptions, and as referenced elsewhere in this addendum, PROVIDER and PAYER agree the definition of a drug (also called medication) as obtained from the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)) ("The Act") is….

The rest of this definition is found in the Model Contract Addenda.

III. SERVICES AND PRODUCTS THAT ARE PART OF THE PER DIEM

(i) PHARMACY PROFESSIONAL SERVICES

(ii) ADMINISTRATIVE SERVICES

The detail lists are thorough and itemized by the "professional pharmacy services", "care coordination" and "administrative services" you provide as encoded in the federal HCPCS per diem "S" code descriptions.

IV. SERVICES AND PRODUCTS THAT ARE CODED, BILLED AND REIMBURSED SEPARATELY FROM PER DIEM REIMBURSEMENT

V. AVERAGE WHOLESALE PRICE (AWP)

This section specifies that provider and payer agree to the source of AWP for drug pricing. Its objective removes much of the uncertainty from reimbursement for drugs, thus enabling both parties to more accurately project the reimbursement for drug billings under the terms of their contract. The next two sections further support the objective of this section.

VI. CHANGES IN PUBLISHED AWP SOURCE

VII. CHANGES IN AWP OR DRUG REIMBURSEMENT METHODOLOGY

VIII. DRUG SHORTAGE / LIMITED AVAILABILITY

IX. WASTAGE POLICY

This section suggests contract language that helps to ensure the provider is reimbursed for dispensed medications in the event that the orders are modified. The delivery schedule for all supplies and medications shall be based primarily on the stability of the prescribed medication. The responsibility for communication regarding medication changes and cuts and cuts lies with the physician, patient and care giver. Up to seven (7) days of supplies and

medication which have been prepared and/or delivered in good faith by Provider shall be reimbursed by PAYER at the full Agreement rate.

Medications supplied in vials labeled for single dose use (containing no preservatives nor approved for multiple dose use), for which only a portion is prepared for the patient, shall be reimbursed by PAYER at the full Agreement rate for the entire contents of the opened vial.

X. PAYMENTS BY PLAN MEMBERS

XI. THERAPIES NOT LISTED

XII. PERIODIC RATE ADJUSTMENT

The parties agree that on the initial and subsequent anniversary dates of the Agreement, the rates contained in this Addendum shall be subject to periodic adjustment, which adjustment shall be a percentage increase…*see rest of this clause in the Model Contract Addenda*.

