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1.0 Description of Service

The Home Infusion Therapy (HIT) program covers self-administered infusion therapy and enteral supplies provided to a Medicaid recipient residing in a private residence or an adult care home. Covered services include the following:

- a. Total parenteral nutrition (TPN)
- b. Enteral nutrition (EN)
- c. Intravenous chemotherapy
- d. Intravenous antibiotic therapy
- e. Pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy
- f. Tocolytic therapy (Refer to Clinical Coverage Policy # 3H-2 on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>. This policy is incorporated by reference.)

2.0 Eligible Recipients

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

Individuals approved for Medicaid receive a monthly Medicaid identification (MID) card as proof of their eligibility. The color of the MID card indicates eligibility coverage and restrictions that apply to the recipient.

2.1 Blue Medicaid Card

Recipients with a blue MID card are eligible for HIT services.

2.2 Pink Medicaid Card—Medicaid for Pregnant Women

Pregnant women with a pink MID card are eligible for HIT services if the service is required for a pregnancy-related condition. HIT services for these recipients must be prior approved.

Refer to sections 2 and 6 of the *Basic Medicaid Billing Guide* on the Division of Medical Assistance's (DMA) Web site at <http://www.ncdhhs.gov/dma/medbillcaguide.htm> for additional information on Medicaid eligibility and prior approval.

2.3 Buff MEDICARE AID Card (Medicare-Qualified Beneficiary)

Medicaid recipients with a buff MEDICARE AID card are not eligible for Medicaid-covered HIT services.

2.4 Managed Care Participation

The MID card will indicate if the recipient is enrolled in a managed care program under Medicaid. Recipients participating in a managed care program, including Medicaid health maintenance organizations and Community Care of North Carolina programs (Carolina

ACCESS and ACCESS II/III), must have authorization from their primary care physician (PCP) to receive HIT services. Refer to sections 2 and 4 of the Basic Medicaid Billing Guide for information on Medicaid eligibility and managed care.

2.5 Transfer of Assets

All recipients, except MPW recipients, must have a Transfer of Assets evaluation performed by the local department of social services (DSS) prior to receiving any home care service. Refer to Section 2 of the Basic Medicaid Billing Guide on the DMA Web site for further information on recipient eligibility for Medicaid.

2.6 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396(d)(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

EPSDT provider page: <http://www.ncdhhs.gov/dma/EPSDTprovider.htm>

3.0 When the Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

HIT services are covered when all criteria in **Sections 3.1, 3.2, and 3.3** are met in accordance with criteria for the specific therapy ordered.

- a. The service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
- b. The service can be furnished safely in the living environment.
- c. There is no equally effective and more conservative or less costly treatment available statewide.
- d. The service is not primarily provided for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Program Criteria

- a. The recipient's clinical status is stable as determined by the attending physician.
- b. The service is provided in the recipient's private residence or in an adult care home (such as a domiciliary care or family care home).
- c. The treatment is self-administered.
Note: "Self-administered" is defined as a recipient or an unpaid primary caregiver who is able and willing to administer the therapy following teaching and with monitoring.
- d. The home environment is conducive to the provision of the HIT therapy, i.e., clean environment with electricity, water, telephone access, refrigeration, and physical space to support HIT supplies.

3.3 Medical Necessity Criteria

HIT services must be medically necessary for the treatment of a recipient's illness, injury, or medical condition as documented by the physician who orders the service. The recipient must be under the care of the referring physician.

3.3.1 Drug Therapies

Drug therapy is covered when all criteria specified in **Sections 3.1, 3.2, and 3.3**, and the criteria listed below, are met.

- a. The treatment is self-administered.
- b. The recipient's medical condition supports the safe administration of the therapy in the home.
- c. The recipient has an available site for the administration of the therapy.
- d. The physician has determined that the need for HIT infusion of a drug is appropriate for at least one of the reasons stated below:
 1. HIT is more effective than oral or injectable administration.
 2. The medication is not available in an oral form.
 3. The medication cannot be tolerated orally.

3.3.2 Total Parenteral Nutrition Therapies

TPN is covered when all criteria specified in **Sections 3.1, 3.2, and 3.3**, and the criteria listed below, are met.

- a. The recipient has a medical condition that prohibits adequate oral intake of nutrients, including the inability to ingest, tolerate and absorb sufficient oral nourishment to maintain or improve health status.
- b. The recipient has an available site for the administration of the therapy.

3.3.3 Enteral Nutrition Therapies

EN is covered when all criteria specified in **Sections 3.1, 3.2, and 3.3**, and the criteria listed below, are met.

- a. The recipient has a functioning gastrointestinal tract but with the inability to physically ingest or tolerate adequate oral intake of nutrients to maintain or improve health status.
- b. The recipient has an available site for the administration of the therapy.

Note: Oral nutrition and supplements are not covered under this policy.

4.0 When the Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

HIT services are not covered when the eligibility criteria identified in Section 2.0 and the criteria for coverage specified in Section 3.0 are not met.

HIT services are not covered when:

- a. the service duplicates another provider's service;
- b. the service is experimental, investigational, or part of a clinical trial;
- c. the drug therapy is provided for services other than chemotherapy, antibiotic therapy or pain management; and/or
- d. the recipient is receiving Medicare-covered home health nursing services.

Note: Medicaid reimburses drug therapy at a per diem rate that includes both the nursing component and the drug therapy component. Reimbursement for EN and TPN services does not include a nursing charge.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Drug Therapies

Drug therapy services include equipment, supplies, delivery of these items, and any nursing services needed to teach, monitor, and assist the recipient. The drug is reimbursed separately through the Medicaid Outpatient Pharmacy program as a prescription drug. The drug therapies covered by the program include the following:

- a. intravenous chemotherapy;
- b. intravenous antibiotic therapy; and
- c. pain management therapy, including subcutaneous, epidural, intrathecal, and intravenous pain management therapy.

5.1.1 Infusion Nursing Services

The infusion nursing services component of drug therapies includes

- a. assessing the recipient for the appropriateness of HIT;
- b. monitoring the recipient;
- c. teaching the recipient and/or primary caregiver about the HIT administration;
- d. changing intravenous (IV) sites and dressings;
- e. drawing blood for laboratory analysis; and
- f. supervising the first dose as specified in **Section 7.1.1.1**.

5.1.2 Pharmacy Services

The pharmacy component of drug therapies includes

- a. monitoring the drug therapy to ensure that the drugs and related fluids are dispensed according to the physician's plan of care (POC) and standards of practice;
- b. developing a medication history and recipient profile;
- c. consulting with physicians and nurses on the therapy;
- d. providing drug use evaluations;
- e. providing quality assurance; and
- f. procuring drugs and maintaining the inventory, reconstituting drugs, preparing dosage(s), labeling drugs, and delivering to a recipient's residence.
The reimbursement for the drug is not included as a HIT service.

5.1.3 Medical Equipment and Supplies

Drug therapies include medical equipment and supplies needed for the therapy according to the POC and standards of practice.

5.1.4 Training

Training, including educational and counseling services, must be provided to ensure the safe and effective administration of HIT. The services are provided through a combination of verbal and written instructions.

5.1.5 Enteral Nutrition and Total Parenteral Nutrition Therapies

Nutrition therapy services include

- a. the rental or purchase of pumps used for EN and TPN and the IV pole ordered by the physician;
- b. formulae/solutions ordered by the physician;
- c. medical supplies ordered by the physician; and
- d. the cost of delivery of supplies and items to the recipient's residence.

Note: Nursing services are not covered.

Note: Refer to the Medicaid Home Infusion Therapy Fee Schedule for a list of covered formulae/solutions and medical supplies.

5.2 Prior Approval

There are no prior approval requirements for HIT services unless the recipient is covered under the Medicaid for Pregnant Women (MPW) category.

Note: MPW recipients can be identified by a pink MID card for pregnancy-related services. Refer to sections 2 and 6 of the Basic Medicaid Billing Guide on the DMA Web site at <http://www.ncdhhs.gov/dma/medbillcaguide.htm> for additional information on Medicaid eligibility and requirements for obtaining prior approval.

5.3 Amount of Service

HIT services are limited to what is medically reasonable and necessary to treat the recipient's disease, injury, illness, or condition and what is ordered by the physician.

5.4 Physician's Order

The recipient's physician identifies the need for HIT and provides signed, written orders that detail the needed services. The order for services must clearly document medical necessity, the starting date for care, the expected duration of the therapy, and the amount and type(s) of services required. The orders must be on the appropriate form as indicated below.

- a. Drug therapies and TPN orders must be documented on the Plan of Care form such as CMS-485 or similar form.
- b. EN orders can be documented either on the Plan of Care form (CMS-485) or the Certificate of Medical Necessity/Prior Approval (CMN/PA) Form used by durable medical equipment (DME) providers.

Note: If the CMS-485 is not used, the following information must be documented in accordance with agency policy and all applicable state and federal licensure rules:

- a. Patient's name
- b. Birthdate
- c. Medicaid number
- d. Patient's address and telephone number
- e. Provider number
- f. Provider name, address, and telephone number
- g. Attending physician name, address, and telephone number
- h. ICD-9 CM and other pertinent diagnosis date
- i. Objective information to substantiate medical necessity
- j. Physician signature and date

5.5 Recipient Assessment

After receiving the referral/order from the physician, the agency must assess the recipient to ensure that HIT services are appropriate and that the agency can provide all of the services needed. The HIT agency must assess the recipient, the recipient's environment, and availability of caregivers, if needed. The agency should not accept a referral if it cannot provide all components of the needed service either directly or through an arrangement. A registered nurse (RN) representing the HIT agency makes an initial visit to assess the recipient. During the assessment, the RN must determine that:

- a. the therapy can be administered successfully and in accordance with the physician's orders;
- b. the recipient and/or responsible caregiver are motivated to use HIT, understand the purpose of the therapy, are capable of self-administration, are able to adhere to a disciplined medical regimen, and are realistic in coping with issues involved with treatment in the home;
- c. the condition of the recipient, the available support, and the recipient's home environment are conducive to safe and effective care; and
- d. other services that the recipient is receiving do not conflict with, interfere with, or duplicate HIT services.

5.6 Recipient/Caregiver Training

The HIT agency provides the necessary training to carry out the therapy according to the physician's orders. Responsibilities for training differ with each type of therapy.

5.6.1 Drug Therapy Training

The HIT RN ensures that the recipient and/or caregiver has received proper training. The pharmacist may also be involved in the training. The recipient/caregiver should understand the following:

- a. how to administer the therapy;
- b. how to care for the supplies, equipment, and drugs;
- c. the responsibilities of the recipient/caregiver and the agency; and
- d. the symptoms and conditions that need immediate action and the actions required in each situation, including emergency procedures.

The agency must provide the recipient/caregiver with written instructions that include provisions for emergency situations and a telephone number to contact the agency 24 hours a day.

The HIT nurse should monitor the first dose given at home and provide any needed follow-up training and supervision as specified in **Section 7.1.1.1**.

5.6.2 Enteral Nutrition and Total Parenteral Nutrition Training

Because nursing services are not covered for EN and TPN therapy, a referral should be made for home health services if the recipient/caregiver requires intensive training for the administration of the therapy.

The HIT provider must make sure that the recipient and/or caregiver understands the following:

- a. how to care for supplies, equipment, and formulae; and
- b. the responsibilities of the agency and the responsibilities of the recipient/caregiver.

The agency must provide the recipient/caregiver with written instructions, including provisions for emergency situations and a telephone number to contact the agency 24 hours a day.

6.0 Providers Eligible to Bill for the Service

6.1 Agency Requirements

HIT services are provided by an agency licensed by the Division of Health Service Regulation (DHSR) as a home care agency and approved to provide infusion nursing services pursuant to 10A NCAC 13J (adopted by reference). Providers who meet the Medicaid qualifications for participation shall be enrolled with the N.C. Medicaid program to provide this service.

6.2 Staff Qualifications

The agency staff must be properly trained and capable of providing the needed services. Services requiring licensed personnel must be provided by staff members who are currently licensed by the appropriate North Carolina licensure board(s).

Outpatient pharmacy services must be provided by a registered pharmacist.

Infusion nursing services must be provided by a licensed nurse, in accordance with the North Carolina Nurse Practice Act, who is directly employed and/or contracted by the HIT agency.

- a. The staff member cannot be the recipient's spouse, child, parent, grandparent, grandchild, or sibling, or be a person with an equivalent step- or in-law relationship to the recipient.
- b. The agency must make services available 24 hours a day, seven days a week.

7.0 Additional Requirements

7.1 Monitoring Care

Monitoring responsibilities depend on the type of therapy (drug or nutrition) provided.

7.1.1 Drug Therapy Monitoring

The amount and type of monitoring must be appropriate for the drug administered, the individual recipient, and the success or effectiveness of the training provided. The recipient's physician and the HIT agency must ensure sufficient monitoring to protect the health and well-being of the recipient.

7.1.1.1 Administering the First Dose

The physician determines if the first dose is to be administered in the physician's office, hospital, or the recipient's home, including an adult care home. The HIT nurse must always monitor the administration of the first dose when administered in the recipient's home or an adult care home. The term "first dose" does not apply if the drug was previously administered by another route or an IV medication that the recipient has received in the past 60 days.

7.1.1.2 Monitoring Subsequent Doses

Subsequent doses are monitored as needed to ensure quality care. The recipient's/caregiver's performance in administering the therapy should be monitored as needed and according to agency protocol.

7.1.1.3 Monitoring Amphotericin B

Nursing services for monitoring the administration of Amphotericin B may be billed separately from the HIT per diem for services that exceed two hours. The first two hours are included in the per diem.

7.1.1.4 Monitoring for Continuing Need and Appropriateness

Throughout the duration of the therapy, the HIT agency must review and monitor the administration of the drug to ensure that the need for treatment continues to meet the criteria for coverage listed in **Section 3.0**.

7.1.2 Enteral Nutrition and Total Parenteral Nutrition Monitoring

The HIT agency and the physician must ensure sufficient monitoring to protect a recipient's health and well-being. The physician may order other services, such as home health skilled nursing visits, if needed by the recipient receiving EN or

TPN. HIT agency responsibilities for monitoring EN and TPN include ensuring provision of the supplies, equipment, and formulae, as well as documenting and reporting problems and concerns.

7.2 Coordinating Care

HIT services must be coordinated with other home care services to avoid duplication.

7.2.1 Home Health Services

7.2.1.1 Drug Therapies

Medicaid home health nursing services may be provided if unrelated to infusion therapy.

7.2.1.2 Enteral Nutrition or Total Parenteral Nutrition

HIT nursing services are not covered for recipients receiving EN or TPN. The recipient should be referred for home health services when skilled nursing care (training or monitoring) is required.

7.2.2 Private Duty Nursing

- a. HIT drug therapy is not allowed for Medicaid recipients receiving private duty nursing.
- b. The private duty nurse or the caregiver will provide the care needed if the recipient is receiving only EN or TPN.

7.2.3 Personal Care Services

Drug therapy, EN, and/or TPN may be provided for the recipient receiving personal care services.

7.2.4 Community Alternatives Programs

If the recipient participates in a Community Alternatives Program (CAP), the case manager shall be contacted. CAP participants have a two-letter code in the CAP block of the MID card. CAP recipients have a cost limit for Medicaid home and community-based services that may affect their ability to receive HIT services.

7.2.5 Home Infusion Therapy Services in the Adult Care Home

The agency and the recipient's physician must coordinate the provision of HIT with the facility operator to ensure that the setting is appropriate and that there is adequate support to successfully administer the service as well as to provide for the health and safety of the recipient.

7.2.6 Medicare Part D

For medications covered under Medicare Part D, the HIT provider can bill Medicaid the applicable therapy code.

7.3 Providing Multiple Drug Therapies

If the recipient requires multiple drug therapies, the therapies must be provided by the same agency.

7.4 Drug and Nutrition Therapies Provided for the Same Recipient

The IV pole for the nutrition therapy cannot be billed if a recipient receives a nutrition therapy with a drug therapy.

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 1998

Revision Information:

Date	Section Revised	Change
09/01/06	Section 1.0	Tocolytic therapy was added to the list of covered services.
12/1/06	Section 2.6	The special provision related to EPSDT was revised.
12/1/06	Sections 3.0, 4.0, and 5.0	A note regarding EPSDT was added to these sections.
4/1/07	Attachment A, Section D	HCPCS procedure code E0781, erroneously omitted, was added.
4/1/07	Sections 2.6, 3.0, 4.0, and 5.0	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age
8/1/07	Section 5.1.5	Added a note that nursing services are not covered.
8/1/07	Section 6.1	Changed the name of Division of Facility Services (DFS) to Division of Health Service Regulation (DHSR).
8/1/07	Attachment A, letter C, #3	Deleted instructions regarding billing some codes in a specific order.
8/1/07	Attachment A, letter D; Attachment C	Added a note that E0781 can only be billed with the RR modifier.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid requirements, including obtaining appropriate referrals for recipients enrolled in Medicaid managed care programs.

A. Claim Type

HIT services are billed on the CMS-1500 claim form.

B. Diagnosis Codes that Support Medical Necessity

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Billing for Drug Therapies

1. Procedure Codes for Drug Therapies

HIT drug therapies are covered under a per diem charge. The per diem covers the therapy administration, supplies, and the nursing component (teaching, monitoring) of the therapy. HIT drug therapy must be billed using two HCPCS codes for each day of service to comply with national coding standards in accordance with HIPAA requirements. The applicable therapy code plus the nursing component code T1030 must be used for each day of therapy. An additional nursing charge is allowed with the administration of Amphotericin B. The code T1002 with the modifier SD is used if nursing services are required for **more than** 2 hours. The additional nursing charge is not allowed with any other infusion therapy.

The codes used to bill HIT drug therapies are listed in the chart below.

Code	Description
S9494	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drug and nursing visits coded separately), per diem. This code can only be used for antibiotic therapy. Antiviral and antifungal infusions are non-covered under the HIT Medicaid program.
S9329	Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drug and nursing visits coded separately), per diem.
S9325	Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (drug and nursing visits coded separately), per diem.
T1030	Nursing care, in the home, by registered nurse, per diem. This code must be billed with each therapy code billed. The reimbursement rate for the nursing component is prorated as a daily charge to cover the cost of nursing for the entire course of treatment.

Code	Description
S9379	<p>Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drug and nursing visits coded separately), per diem.</p> <p>This code can only be used for the drug therapy termination allowance. The service is covered when the therapy is discontinued or changed prior to the end of the prescribed treatment period. Medicaid will reimburse the termination allowance charge to cover each day for the lesser of the remainder of the treatment period or the cycle of delivery. Each day is billed as one unit with a maximum of seven days (7 units) for this code.</p>
T1002 SD	<p>RN Services, up to 15 minutes</p> <p>The modifier SD denotes that the service was provided by a registered nurse with specialized, highly technical home infusion training. The modifier must be used when billing this code.</p> <p>This code can be used for only RN monitoring (over 2 hours) for Amphotericin B infusion therapy.</p>

2. Additional Billing Information

Always bill the primary therapy code (S9494, S9329, or S9325) first.

Bill nursing services (T1030) after the related primary therapy code. Nursing services will not be paid unless the related primary therapy code has been paid for the same date of service.

The therapy and the nursing component are billed for each day in the prescribed course of treatment (1 unit equals one day).

When billing the termination allowance (S9379), bill the allowance after the related primary therapy code. The termination allowance will not be paid unless one of the therapy codes has been paid for a corresponding date of service.

When billing additional RN monitoring for the administration of Amphotericin B, three codes must be billed: S9494, antibiotic therapy, T1030 for the first two hours of nursing services covered with all therapies, and T1002 with the modifier SD in 15 min increments (1 unit equals 15 minutes).

Refer to **Attachment B**, Billing for HIT Services, for examples of billing for drug therapy services.

3. Billing Multiple Drug Therapies

Multiple drug therapies administered concurrently are billed using the applicable drug infusion code with a modifier. The provider enters a primary therapy code plus the code for the nursing component (T1030) for each date of service. Each additional therapy is billed with the applicable code and modifier to indicate secondary and tertiary therapy. The therapies can be billed in any order.

The modifiers used to indicate second and third drug therapies are listed in the chart below.

Modifier	Description
SH	Indicates the second concurrently administered infusion therapy.
SJ	Indicates the third concurrently administered infusion therapy.

Refer to **Attachment B, Billing for HIT Services**, for examples of billing for multiple drug therapies.

D. **Billing for Enteral Nutrition Therapy and Total Parenteral Nutrition Therapy**

Nutrition therapy covers the equipment, supplies, and formulae/solutions ordered by the physician and provided according to standards of practice. The reimbursement for all components includes delivery to a recipient's residence. Each component is discussed below.

Formulae and solutions listed on the Home Infusion Therapy Fee Schedule are reimbursed either by the day or by the unit of service listed on the fee schedule.

Some medical supplies listed on the Medicaid Home Infusion Therapy Fee Schedule are provided as part of a kit.

Medical equipment, such as pumps used for EN and TPN and the IV pole, is reimbursed as a daily rental, a monthly rental, or a new or used purchase.

The item is **rented** if the physician documents that the anticipated need is six months or less.

The item may be **rented** or **purchased** if the physician documents that the anticipated need exceeds six months.

Rental of most equipment is covered as a **capped rental** item. The reimbursement is considered capped rental when the sum total of the rental payments equals the Medicaid allowable purchase price.

The appropriate modifier must be used when billing for medical equipment (HCPCS procedure codes B9002, B9004, B9006, E0781, and E0776).

NU	New purchase
UE	Used purchase
RR	Rental

Note: E0781 can only be billed with the RR modifier.

E. **Reimbursement Rate**

Providers must bill usual and customary charges.

Refer to **Attachment C, Completing the CMS-1500 for HIT Services**, for instructions to complete the CMS-1500 claim form with information specific to HIT billing.

Refer to Clinical Coverage Policy # 3H-2 on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/mpindex.htm> for information on billing for tocolytic therapy.

General instructions for completing the CMS-1500 form can be found in Section 5 of the **Basic Medicaid Billing Guide** on the DMA Web site at <http://www.ncdhhs.gov/dma/medbillcaguide.htm>.

Attachment B: Billing for HIT Services

Examples of Billing for HIT Drug Therapy. The nurse component HCPCS code must be billed with the therapy code for correct reimbursement of the per diem.

When billing for...	Use these codes...
Antibiotic Therapy	S9494 —Home infusion therapy, antibiotic <i>and</i> T1030 —Nursing care, in the home, by registered nurse, per diem
Chemotherapy	S9329 —Home infusion therapy, chemotherapy infusion <i>and</i> T1030 —Nursing care, in the home, by registered nurse, per diem
Pain Management Therapy	S9325 —Home infusion therapy, pain management infusion <i>and</i> T1030 —Nursing care, in the home, by registered nurse, per diem
Amphotericin B Therapy <i>Exceeding 2 hours of nursing</i>	S9494 —Home infusion therapy, antibiotic <i>and</i> T1030 —Nursing care, in the home, by registered nurse, per diem <i>and</i> T1002 — RN Monitoring of Amphotericin B: Enter the number of 15-minute units of monitoring in excess of two hours on the date of service. SD Modifier —Must be used with T1002.

Examples of Billing for Combination Therapies. Concurrent therapies can be billed in any order.

Concurrent Therapies	How to Bill
Two Concurrent Antibiotic Therapies	S9494 —Home infusion therapy, antibiotic <i>and</i> S9494 with modifier SH —Antibiotic therapy as the second billed therapy <i>and</i> T1030 —Nursing care, in the home, by registered nurse, per diem
Antibiotic and Chemotherapy	S9494 —Home infusion therapy, antibiotic <i>and</i> S9329 with modifier SH —Chemotherapy as the second billed therapy <i>and</i> T1030 —Nursing care, in the home, by registered nurse, per diem
Antibiotic and Pain Management	S9494 —Home infusion therapy, antibiotic <i>and</i> S9325 with modifier SH —Pain management infusion as the second billed therapy <i>and</i> T1030 —Nursing care, in the home, by registered nurse, per diem
Chemotherapy and Pain Management	S9329 —Home infusion therapy, chemotherapy <i>and</i> S9325 with modifier SH —Pain management infusion as the second billed therapy <i>and</i> T1030 —Nursing care, in the home, by registered nurse, per diem

Concurrent Therapies	How to Bill
Antibiotic, Chemotherapy, and Pain Management	S9494 —Home infusion therapy, antibiotic <i>and</i> S9329 with modifier SH —Chemotherapy as the second billed therapy <i>and</i> S9325 with modifier SJ —Pain management infusion as the third billed therapy <i>and</i> T1030 —Nursing care, in the home, by registered nurse, per diem

Attachment C: Completing the CMS-1500 for HIT Services

The following information specified below shall be used to complete the blocks that are specific to HIT billing. The program-specific information starts with block 24. Instructions for completing the CMS-1500 can be found in Section 5 of the *Basic Medicaid Billing Guide*. This document is posted on the DMA Web site <http://www.ncdhhs.gov/dma/medbillcaguide.htm>.

24A. DATE(S) OF SERVICE, From/To:

Drug Therapy Codes: Enter the date for the month that the course of treatment begins in the **From** block. Enter the last day of the course of treatment for the month in the **To** block.

When billing for a **second** therapy, the dates of service must be the same as the primary therapy. When billing for a **third** therapy, the dates of service must be the same as the primary and second therapy.

Nursing Services: Enter the same dates of service as listed for the related drug therapy.

RN Monitoring for Amphotericin B: Use a separate line for each day the monitoring is done. Enter the date of the monitoring in the **From** block. Enter the same date in the **To** block.

Termination Allowance for an Interrupted Course of Treatment: Enter the date of the last day of treatment in the **From** block. Enter the same date in the **To** block.

24B. PLACE OF SERVICE:

Enter **12** to show that the items/services were provided at the recipient's home.

24C. TYPE OF SERVICE:

Enter **15**.

24D. PROCEDURES, SERVICES OR SUPPLIES:

Enter the appropriate HCPCS code.

For a second or third concurrent therapy, enter the appropriate modifier (second SH or third SJ) under MODIFIER.

For medical equipment HCPCS codes B9002, B9004, B9006, E0781, and E0776 enter one of the following under MODIFIER:

NU for new purchase

UE for used purchase

RR for rental

Note: E0781 can only be billed with the RR modifier.

24E. DIAGNOSIS CODE:

Leave blank.

Note: The diagnosis code must be entered in block 21. Enter the ICD-9-CM code for the principal diagnosis that corresponds to the service rendered. "V" codes are not acceptable.

24F. CHARGES:

Enter the total charge for the items on the detail line.

24G. DAYS OR UNITS:

Enter the number of units billed on the detail line as indicated below.

Drug Therapy Codes: Enter the number of consecutive days shown in 24A.

Nursing Services: Enter the number of consecutive days shown in 24A.

RN Monitoring of Amphotericin B: Enter the number of 15-minute units of monitoring in excess of two hours on the date of service. Calculate the number of units as follows:

Step 1: Total the amount of time that the RN is with the patient to monitor the administration of the drug on the date of service. (Do not include travel time or indirect time not spent with the recipient).

Step 2: Subtract the two hours included in the per diem.

Step 3: Divide the remaining number of minutes by 15 to get the number of whole units.

Step 4: Add an additional unit if the remainder is 8 minutes or more.

Example: The RN is with the recipient for 3 hours, 47 minutes on 11/15/04 to monitor the administration of Amphotericin B. The first two hours are included in the per diem rate and may not be billed. Divide the remaining one hour, forty-seven minutes (a total of 107 minutes) by 15. 107 minutes divided by 15 equals 7 units with a remainder of 2. Because the remainder is less than 8, do not add an additional unit. Bill for 7 units for 11/15/04 under HCPCS code T1002SD.

Termination Allowance: Enter the number of days that the allowance applies, not to exceed seven days.

24H. EPSDT/FAMILY PLANNING:

Leave blank.

24I. EMG:

Leave blank.

24J. COB:

Optional.

24K. RESERVED FOR LOCAL USE:

Optional.