Reimbursement Considerations for Home Infusions and Injections

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Introduction

For payers and pharmaceutical manufacturers, the home has increasingly become a desirable site of care (SOC) for infusion and injection services as an option to increase access for patients and lower the costs of infusion services. This option is convenient for patients, especially those with transportation challenges and/or with serious health conditions that make visits to medical settings like a physician office or hospital outpatient department risky. The COVID-19 pandemic further contributed to more wide-spread adoption of home infusion[1] as some patients were unable to receive services in traditional settings. However, challenges in coverage and appropriate payment to obtain home infusion care still exist. In this white paper, we explore the reimbursement issues impacting access to home infusion services under traditional Medicare and provide general information for Medicare Advantage, Medicaid, and commercial plans.

Reimbursement concepts

Before discussing reimbursement considerations in the home, let's review some basic reimbursement concepts that apply to all SOC. Payer reimbursement varies for injectable drugs and biologics when they are administered in the home. There are several parameters to consider.

- **Coverage:** First, there must be a benefit that covers the components of home infusion, including the drug, the skilled nursing services required to administer the drug and/or monitor the patient, and, if needed, durable medical equipment (DME) such as the external infusion pump (EIP) to deliver the drug. In some cases, the different components of home infusion care may be covered under different health benefits (eg, major medical, pharmacy, DME, or home health [HH]) each with specific criteria that must be met. This has the potential to increase the complexity of determining coverage parameters for these services.

- **Coding:** Home injection/infusion providers must understand the appropriate use of unique codes and code modifiers used to report component services and supplies furnished via home infusion. Payers vary with respect to codes accepted by the various entities involved in the provision of a drug and/or performing a specific service in the home.

- **Billing:** Billing for home infusion supplies and services varies by type of provider and by payer. Payers may require or allow different provider types to bill for component home infusion services and/or supplies. This can result in multiple claim forms from one or multiple entities for one home infusion treatment. It is important to understand specific payer criteria for claims to adjudicate properly.

- **Payment:** Reimbursement methodologies for home infusion supplies and services also vary by provider and payer. Payers use a wide range of reimbursement methodologies for drugs, EIP, other supplies, and skilled nursing required to administer the drugs in the home.

Commercial and managed care payers, including managed Medicare and managed Medicaid plans, routinely cover a wide range of home infusion therapy, including high-cost chemotherapy or monoclonal antibodies, along with home infusion nursing services, as the home is seen as a cost-effective alternate SOC. In contrast, the traditional Medicare offering is more fragmented and still lags behind other payers in providing beneficiaries with access to home infusion services despite recent adjustments to its coverage of home infusion services. Let's examine the different SOC and provider types that Medicare uses to provide home infusion services to patients.

Traditional Medicare—coverage, coding, billing, and payment

Home Health (HH)

Medicare Coverage Overview[2]

For many years, Medicare Part A has had a limited home infusion benefit. Under the HH benefit, Medicare may cover the home infusion service if certain criteria are met. However, the HH benefit does not cover most drugs or the EIP. The drugs and EIP may be covered under other Medicare benefits.

Medicare Coverage Requirements for HH Infusion Services

Traditional Medicare has covered the administration of infused/injected drugs by nurses at home under the HH benefit under limited circumstances. Coverage for home infusion services is limited to cases where a patient meets the Centers for Medicare & Medicaid Services (CMS) criteria for being "homebound" and other criteria like having an established home care plan. The HH requirements for home infusion services are listed in Appendix A (below).

Medicare Coverage for Drug and EIP

HH does not have a drug benefit. However, if a patient is eligible for home infusion services under the HH benefits, the drugs may be accessed under the Medicare Part D prescription drug benefit[3] when patients are enrolled in a Part D plan that covers the drug. Also, the EIP may be covered under the Part B DME benefit if the pump meets the coverage requirements of DME.

If a patient is not eligible for home infusion services under the HH benefits (ie, does not meet the CMS criteria for being "homebound"), then the drug and its infusion and related EIP will not be covered under the HH benefit.

Coding Overview

Coding home infusion services under the HH benefit varies by the type of provider that bills for the specific service or supply.

Coding for the Infusion Service Under the HH Benefit

Home health agencies may report skilled nursing services with Healthcare Common Procedure Coding System (HCPCS) G-codes and Q-codes when the services are included in the HH 30-day episodic rate. Home infusion per day and per hour services are reported with HCPCS or Current Procedural Terminology (CPT®) codes. The HCPCS and CPT Codes for Skilled Nursing/Home Infusion Services Under HH are listed in Appendix B (below).

Billing and Claims Submission

HH providers may report the home infusion skilled nursing services from Appendix B on the Institutional CMS 1450/UB-04 claim form to the Part A Medicare Administrative Carrier (MAC). These claims are paid under the Home Health Prospective Payment System.

Medicare Payment Methodology Overview

Medicare pays HH providers under the Medicare HH PPS for each 30-day episode of care that includes the administration of drugs in the home. Medicare adjusts payment for periods of care that do not meet the 30-day threshold. Medicare also adjusts the payment for patient characteristics, geography, wage index high- and low-use thresholds, and reporting quality metrics.[4] The national payment rates are published annually in the HH PPS Final Rule.

Durable Medical Equipment (DME)

Medicare Coverage Overview

The DME benefit under Medicare Part B has also been available for many years to cover the EIP and related supplies, including drugs. Medicare covers the drug and EIP under the DME benefit if they are provided by a supplier in the competitive bidding program[5], are listed in the DME MAC Local Coverage Determination (LCD) for EIP or otherwise meet either of the following sets of criteria (1) or (2) in Table 1[6]:

Table 1. General DME Coverage Criteria for Home Infusion of Drug and EIP

Criteria Set 1	Criteria set 2
Parenteral administration of the drug in the home is reasonable and necessary	Parenteral administration of the drug in the home is reasonable and necessary
An infusion pump is necessary to safely administer the drug	An infusion pump is necessary to safely administer the drug
The drug is administered by a prolonged infusion of at least 8 hours because of proven improved clinical efficacy	The drug is administered by intermittent infusion (each episode of infusion lasting less than 8 hours) which does not require the beneficiary to return to the practitioner's office prior to the beginning of each infusion
The therapeutic regimen is proven or generally accepted to have significant advantages over intermittent bolus administration regimens or infusions lasting less than 8 hours	Systemic toxicity or adverse effects of the drug are unavoidable without infusing it at a strictly controlled rate as indicated in the Physicians Desk Reference or the US Pharmacopeia Drug Information

The drug is covered under the DME benefit as a supply when it is administered through the covered EIP.

The DME benefit does not cover professional services, such as the infusion service.

Coding Overview

Coding for EIPs, supplies, and covered drugs will require HCPCS codes from different subsets:

- Infusion service (G-codes)
- Pump (E-, K-codes)
- Drug (J-codes)
- Supplies (A-, E-, K-codes)

The Part B DME MAC's Local Coverage Determination (LCD) for External Infusion Pump (EIP) includes the HCPCS codes for the covered EIPs, supplies, and drugs that may be reported by the DME supplier.

Items covered in the LCD have additional policy-specific requirements that must be met to justify Medicare reimbursement. It is important to carefully review the limited coverage parameters listed in the LCD for EIP for each item listed in the policy.

Billing and Claims Submission Overview

DME suppliers may bill Medicare for EIPs, supplies, and drugs. DME suppliers submit claims to the DME MAC using the Professional CMS-1500 claim form.

Medicare Payment Methodology Overview

The EIP and related supplies are reimbursed under the Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) fee schedule. The drug is also reimbursed under the DMEPOS fee schedule and payment is based on average sales price (ASP) + 6% as listed in the Medicare Part B Drug Average Sales Price Drug Pricing File. An overview of the Medicare payment methodologies and fee schedules used by type of service is shown in Table 2:

Table 2. Medicare Payment Methodologies Under DME

Service/Supply	Payment Methodology
EIP	DMEPOS Fee Schedule
Drug	ASP File – Rates based on ASP+ 6%

Home Infusion Therapy (HIT)

Medicare Coverage Overview

As discussed, there are limitations on home infusion services under both the HH and DME benefit. To address some of these limitations, the CMS created a new benefit under Part B. The HIT benefit covers the infusion service, while the pump and drugs continue to be covered under the DME benefit.

Medicare Coverage for Infusion Service

Home infusion under the HIT benefit is distinct from that under the HH benefit. Under the Medicare HIT benefit there is no criteria for homebound status; however, the beneficiary must be under a physician-established plan of care and meet other criteria such as the infusion service must be performed by a qualified HIT supplier. The HIT requirements for home infusion services are listed in Appendix C (below).

In addition to the administration service, drug, and pump, the Medicare HIT benefit also covers patient training and education (not otherwise covered under the DME benefit), remote monitoring, monitoring services for the provision of HIT services rendered by a qualified HIT supplier.

Finally, Section 5012(c)(3) of the 21st Century Cures Act amended Section 1861(m) of the Act to exclude home infusion therapy from the HH beginning on January 1, 2021.[7] Therefore, a home infusion service that is under a HH plan of care and is covered under the HIT benefit is excluded from coverage under the HH benefit.

Coding Overview

Coding for home infusion services will require only HCPCS codes from different subsets for the infusion service, pump, and drug.

Medicare Coding for Infusion Services

The Part B DME MAC's LCD for EIP includes the HCPCS codes for the covered infusion pumps and products that must be reported for the infusion service under HIT to be covered. The Medicare Learning Network (MLN) Matters MM11880 Billing for Home Infusion Therapy Services identifies the drugs that qualify for coverage with each HIT service.[8] The HH agency reports the infusion/injection service to Medicare with HCPCS G-codes to the Part B MAC (non-DME). The codes for home infusion services under HIT are listed in Appendix D (below).

Coding for EIP and Drugs

Qualified HIT providers should report the codes for EIPs and drugs that are included in the individual LCD for EIP to the DME MAC. Drugs that are infused or injected in the home are typically reported with HCPCS codes. Medicare does not typically require reporting of a National Drug Code (NDC) for drugs with unique HCPCS codes. However, payers such as Medicaid do require an NDC in addition to the unique HCPCS code for the drug.

Billing and Claims Submission Overview

Various entities that are accredited by a Medicare-approved accreditation organization may bill Medicare for HIT home infusion nursing services. HIT providers bill on one type of claim form to two different MACs depending on the services provided. An overview of the services billed to the different contractors is shown in Table 3.

Table 3: Claim Forms Used to Bill Home Infusion Services

Benefit	Claim Form	Appropriate Use	Payer/Contractor
HIT and DME	Professional CMS-1500 (electronic equivalent 837P) for physicians	DME (pump) listed on DME LCD for EIP	DME MAC
		HIT drugs listed on DME LCD for EIP	DME MAC
		HIT home infusion services	A/B MAC

Claims for HIT infusion services are reported on the CMS-1500 and are processed by the A/B MACs. Part B MAC coverage for HIT infusion services depends on the J-code for the drug being billed on the CMS-1500 to the DME MAC. If the drug is not billed to the DME MAC within 30 days of the date of the home infusion nursing service, then Part B MAC coverage and payment for the HIT skilled nursing service will be denied.[5] Claims for the pump and other supplies are also billed to the DME MAC.

Medicare Payment Methodology Overview

An overview of the Medicare payment methodologies and fee schedules used by type of service is shown in Table 4:

Table 4. Medicare Payment Methodologies Under HIT

Service/Supply	Payment Methodology
HIT skilled nursing infusion service	Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule
HIT infusion pump	DMEPOS Fee Schedule
HIT infusion drug	ASP File – Rate based on ASP+ 6%

Medicare Payment for HIT Infusion Service

The CMS pays HIT suppliers for professional services furnished for each infusion drug administration calendar day. The payment per unit for each infusion drug cannot exceed the amount that would be paid for infusion therapy services if furnished in a physician's office, and the payment amount cannot reflect more than 5 hours of infusion for a particular therapy per calendar day.[9] Payment rates for HIT infusion services are assigned per drug category as listed in Appendix D. Medicare pays higher rates for new or initial patient visits compared to subsequent patient visits.

Medicare will only pay for one of the G-codes listed per line-item date of service. Only one payment for the highest payment category is made and the payment will be equal to only one single unit per visit, regardless of the number of units billed.[5]

Medicare Payment for Drug and EIP

The EIP is reimbursed under the DMEPOS fee schedule. The infusion drug is also reimbursed under the DMEPOS fee schedule and is based on ASP + 6%.

Medicare Part D (Pharmacy)

Medicare Coverage Overview

When home infusion is covered under the HH benefit, the Part D pharmacy benefit may cover drugs infused at home if the patient's Part D plan covers the drug. Part D does not cover the EIP or the administration service.

Coding Overview

The drug's 11-digit NDC is typically used by pharmacies to report a drug used for home infusion. Some payers may also require the HCPCS code for the drug on claims.

Billing and Claims Submission Overview

Pharmacies typically use the Universal Claim Form to report the drugs used for home infusion to payers.

Medicare Payment Methodology Overview

Payment methodologies for drugs vary by payer and plan, as commercial payers are the administrators of the Part D plans. Payment rates are typically either contractual or listed in fee schedules which may be based on a percentage of ASP, wholesale acquisition cost (WAC), or average wholesale price (AWP).

Pulling It All Together

Home infusion services may be covered under multiple Medicare benefits when certain criteria are met. It is important to understand which benefits cover the various aspects of home infusion as there are different coverage criteria, codes, claims, payment methodologies, and patient costs. A summary of coverage for home infusion services under the various Medicare benefits is shown in Table 5 below:

Table 5. Medicare Fee-for-Service (FFS) Coverage for Home Infusion Services

Benefit	Drug	EIP	Infusion Service
HH	N	N	Y
Pharmacy	Y	N	N
DME	Y	Y	N
HIT	N	N	Y

Medicare Advantage (Part C), Medicaid, and Commercial Plans

Coverage

Medicare Advantage, Medicaid, and commercial plans generally recognize home infusion as a cost-effective SOC and cover drugs and home infusion services. Generally, both the home infusion service, pump, and drug are covered more broadly than under traditional Medicare.

At a minimum, Medicare Advantage (Part C) plans must cover the services that are covered under Part A and Part B, and many plans also have a pharmacy benefit (Medicare Advantage Prescription Drug Plan [MA-PDP]). These plans typically cover home infusion and the infusion products under the medical and pharmacy benefits. The coverage criteria vary by plan benefit design.

Medicaid and commercial payers also cover home infusion and infusion drugs under the medical and pharmacy benefits. Medicaid plans may cover home skilled nursing for infusion, the pump, and supplies under a HH benefit. The Medicaid and commercial payer insurance benefit design also drives whether a drug is accessed under the pharmacy benefit or medical benefit. Home infusion coverage for drugs and nursing services looks very similar across these plans.

Coding

Medicare Advantage (Part C), Medicaid and commercial payers vary with respect to the codes recognized for reporting home infusion skilled nursing and the infusion drugs. They may recognize different codes such as CPT codes for these services. Additional codes used to report home infusion services are listed in Appendix E (below).

Billing

Home infusion services providers can bill on one of three types of claim forms depending on the benefit (HH, medical, or pharmacy), provider type, and the services provided. The claim form used, and the benefit billed, depends on the payer plan design.

Payment

Home infusion services and drugs are paid based on fee schedules or contracted rates. Some common payment methodologies for home infusion services, drug, and supplies are listed in Table 6.

Table 6. Non-Medicare Payment Rate Methodologies for Home Infusion Services

	Medicare Advantage	Medicaid	Commercial
Infusion Service	• Skilled nursing services provided by a Home Health Agency (HHA) for drug administration are covered by the MA plan and are reimbursed on a per-visit or a 60-day episode contract rate	• Per diem or episodic payment rate • Other • Rates vary by state	• Separate contract payment or bundled with the nursing per diem • Rates vary by plan
Infusion EIP/ Supplies	• Separate contract payment or bundled with the nursing per diem • Rates vary by plan	• Separate payment or bundled with the nursing per diem • Rates vary by state	• Separate contract payment or bundled with the nursing per diem • Rates vary by plan
Infused Drug	• Drugs accessed under an MA-PDP or pharmacy (retail, specialty pharmacy) are reimbursed under a contract rate	• Separate payment as a percentage of Wholesale Acquisition Cost • Rates vary by state	• Percentage of ASP, WAC, or AWP • Rates vary by plan

Summary

Patients, payers, and providers see the home as a viable alternative to more costly SOC. As a result, reimbursement for home infusion services has expanded in recent years to better address the needs of patients who would benefit from HIT. The introduction of the Medicare FFS HIT benefit begins to fill in the previous gap for coverage and payment of infusion services when DME-covered IV pumps and drugs are administered at home. However, it is not a complete solution for all home infusion therapy. This industry is continuing to grow as more therapies are approved, and patients have positive outcomes at home. Understanding reimbursement for home infusion services will be imperative as there are many factors that affect coverage and access.

Appendices

A. HH Requirements for Home Infusion Services[10]

1. A physician certification that the patient is "homebound" as documented in the medical record
2. Services are received under a home plan of care established and reviewed by a physician
3. The patient does not need more than part-time or intermittent skilled nursing care
4. A face-to-face encounter with a physician or qualified non-physician practitioner must occur no more than 90 days prior to the HH start of care date or within 30 days after the start of care
5. Care must be furnished by or under arrangements made by a Medicare-participating HHA

Patients may meet Medicare's homebound status if they have a medical condition that makes it difficult to leave home or leaving home is contraindicated. Absences from home are allowed for infrequent, short duration visits to receive medical care, religious services, or for other unique or infrequent visits.

B. HCPCS and CPT Codes for Skilled Nursing/Home Infusion Services Under HH

Code Type	Code	Description
HCPCS[11]	G0299	Direct skilled nursing services of a registered nurse (RN) in the HH or hospice setting, each 15 minutes
	G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the HH or hospice setting, each 15 minutes
	G0162	Skilled services by an RN for management and evaluation of the plan of care; each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential nonskilled care achieves its purpose in the HH or hospice setting)
	G0493	Skilled services of an RN for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the HH or hospice setting)
	G0494	Skilled services of an LPN for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the HH or hospice setting),
	G0495	Skilled services of an RN, in the training and/or education of a patient or family member, in the HH or hospice setting, each 15 minutes
	G0496	Skilled services of an LPN, in the training and/or education of a patient or family member, in the HH or hospice setting, each 15 minutes
	Q5001	Hospice or HH Care Provided in Patient's Home/Residence
	Q5002	Hospice Or HH Care Provided in Assisted Living Facility
	Q5009	Hospice Or HH Care Provided in Place Not Otherwise Specified (NOS)
CPT[12]	99601	Home infusion/specialty drug administration, per visit (up to 2 hours)
	99602	Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)

C. HIT Requirements for Home Infusion Services[13]

1. Patient requires home infusion of a Part B-covered drug, excluding insulin pump systems, self-administered drugs, or drugs on a self-administered drug exclusion list
2. Beneficiary must be under a physician-established plan of care
3. Drugs must be administered intravenously or subcutaneously for 15 minutes or more
4. Infusion must occur through a covered piece of DME, such as an EIP or continuous intravenous infusion (CIVI) pump
5. Infusion services must be performed in the home of a patient by a qualified HIT supplier

D. Medicare Rates for Home Infusion Services Under HIT[14]

HCPCS Code and Description	Medicare CY 2023 National Rate
Category 1 Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, and/or inotropic infusion drug(s) for each infusion drug administration calendar day in the individual's home, each 15 minutes **G0088 Initial visit** **G0068 Subsequent visit**	 $214.95 $176.73
Category 2 Professional services for the administration of subcutaneous immunotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes **G0089 Initial visit** **G0069 Subsequent visit**	 $290.42 $238.80
Category 3 Professional services for the administration of chemotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes **G0090 Initial visit** **G0070 Subsequent visit**	 $361.30 $297.08

E. Additional Codes Used to Report Home Infusion Services

Code Type	Code	Description
HCPCS8	**S9325 – S9379**	Home infusion therapy, per diem [These codes may be recognized by Medicaid and other payers except Medicare]
CPT9	**96365 – 96368***	Intravenous infusion, for therapy, prophylaxis, or diagnosis
	96369 – 96371*	Subcutaneous infusion for therapy or prophylaxis
	96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion
	96413 – 96417*	Chemotherapy administration, intravenous infusion technique
	96521	Refilling and maintenance of portable pump

***Some codes in the 96XXX series are time-based and have specific appropriate use criteria that must be documented in the medical record.**

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