Guidelines

This document is provided as a supplement to the Blue Cross Blue Shield of Illinois (BCBSIL) Contract Agreement with Home Infusion Therapy (HIT) Providers to familiarize you with BCBSIL policies concerning HIT, particularly billing of services. All HIT Providers are required to abide by these BCBSIL policies and are accountable to deliver services and bill accordingly. Electronic billing of claims is required. In addition, all HIT Providers must be accredited by one of the nationally recognized accreditation organizations (JCAHO, ACHC or CHAP) in order to contract with BCBSIL.

Drugs considered as self injectable are covered under the BCBSI member's drug prescription card, in most cases, and may not be delivered or billed by the HIT provider.

Many intravenous/injectable therapies will have specific medical necessity criteria in order to be eligible for coverage. All providers are encouraged to review relevant BCBSIL medical policies (found on the BCBSIL Web site at www.bcbsil.com) prior to rendering services. Submitting a request for pre-determination of benefit along with the appropriate medical necessity documentation may also be appropriate.

Coverage

Intravenous (IV) solutions and/or injectable medications may be considered medically necessary if all of the following are met:

1. Prescription drug is FDA approved or meets coverage criteria for off-label use;
2. The provision of services in the home is not primarily for the convenience of the member, the member's caregivers or the provider;
3. Therapy is managed by a physician; or nursing visits are provided in the home under the direction of a physician; **AND**
4. Treatment can be safely administered in the home.

Description

Home infusion and injectable therapy involves the administration of:

1. Nutrients
2. Medications
3. Solutions

These items may be administered intravenously, intramuscularly, enterally, subcutaneously or epidurally.

Infusion therapy originates with a prescription from a physician who is overseeing the care of the patient and is designed to achieve physician defined beneficial outcomes.

Home Infusion Therapy (cont.)

Description (cont.)

Specific therapies provided may include, but are not limited to:

1. Anti-infectives
2. Blood transfusions
3. Chemotherapy
4. Growth hormone
5. Hydration therapy
6. Immunotherapy
7. Inotropic therapy
8. Pain management
9. Parenteral and enteral nutrition (refer to medical policy: Alternative Modes of Nutrition in the Outpatient and Home Setting)
10. Tocolytic therapy

Billing

All claims must be submitted with the appropriate drug code and units (per the description of the HCPCS code and drug dosage ordered and administered).

Drugs without a valid HCPCS code should be billed using the HCPCS code J3490 with the appropriate NDC number and units ordered and administered.

Physician orders must include:

- Date of order
- Patient name and address
- Suppliers name, address and telephone #
- Diagnosis warranting infusion therapy treatment
- Name of drug, dosage, administration route, frequency of administration, duration of treatment
- Physician name, address and telephone #
- Physician signature and date

Infusion therapy supplies should be billed utilizing the appropriate per diem HCPCS codes (S codes) for the specific drug or drug category. All per diem codes are inclusive of the following:

- Administrative services
- Professional pharmacy services
- Care coordination
- Delivery
- All necessary supplies and equipment
- IV solutions and diluent

Home Infusion Therapy (cont.)

Billing (cont.)

The per diem HCPCS code must be billed on the same claim as the corresponding drug for the same dates of service. Modifiers SH (second concurrently administered infusion therapy) and SJ (third or more concurrently administered infusion therapy) must be indicated with the HCPCS code, as appropriate. Reimbursement for the second or subsequent concurrent infusion of same therapy class will be at 50% of normal per diem for that code.

Nursing visits may only be billed by a licensed home health agency with a BCBSIL Coordinated Home Care agreement (on a UB-04 claim form).

All providers are encouraged to review relevant BCBSIL medical policies (found on the BCBSIL Web site at www.bcbsil.com) prior to rendering services. It may be appropriate in some cases to complete a Predetermination Form to assure benefit and medical necessity criteria. This form may be submitted along with the appropriate medical necessity documentation.

BCBSIL reserves the right to update these guidelines as necessary.

Home Infusion Therapy (cont.)

When the patient is under a Plan of Treatment and the Blue Cross Coordinated Home Care (CHC) benefit, home infusion and supplies are billed with the skilled nursing visits on a UB-04 utilizing your National Provider Identifier (NPI) number.

When the patient is not under the Blue Cross CHC benefit, home infusion drugs and supplies are billed on the CMS-1500 (08/05) utilizing your NPI number.

Infusion therapy can be defined as the therapeutic introduction of a fluid into the vein in order to nourish or medicate the body. When it is more feasible for the patient to receive this therapy in the comfort of their home surroundings, it becomes Home Infusion Therapy.

Home Infusion Therapy may include, but is not limited to:

I.V. Antibiotic Therapy: Numerous diseases and wound infections can be treated at home with intravenous antibiotic therapy including urinary tract infections, osteomyelitis, cystic fibrosis and soft tissue infections.

I.V. Chemotherapy: Some intravenous drugs used in cancer treatment can be administered in a home care infusion program. Such treatments at home can save the ambulatory cancer patient money, time and energy from frequent visits to the doctor's office.

I.V. Pain Management: Hospice patients or patients experiencing chronic pain from debilitating illnesses or the effects of trauma can control or minimize their pain with in-home infusions of analgesic medications.

Hyperalimentation (TPN): Patients who are unable to receive their daily nutrients orally or have malabsorption difficulties can receive their total daily nutritional requirements through intravenous feedings.

Hydration Therapy: Patients with severe diarrhea or vomiting who become dehydrated can be hydrated at home through intravenous fluids.

General Coverage Criteria

The types of services that are covered by employee contracts vary considerably. Therefore, providers should always check eligibility and benefits for patients before rendering services by calling the Provider Telecommunications Center (PTC) at (800) 972-8088 or by accessing NDAS Online.

Home Infusion Therapy (cont.)

When it is determined that home infusion therapy is a benefit of the patient's employer contract, the following must be met:

- The home infusion therapy must be medically necessary
- There must be physician's orders for all treatments including, but not limited to, diagnosis, infusion to be administered, frequency and anticipated time patient will need home infusion therapy.
- Services must be rendered by a skilled professional nurse trained in home infusion therapy and/or taught to the patient/caregiver for self-administration, as appropriate.

Precertification Requirements

Many employer groups require notification and approval prior to rendering any home infusion services. Providers should inquire whether precertification is necessary when checking the patient's eligibility and benefits.

Most employer group contracts require members to utilize in-network providers for maximum benefit. Home Infusion Therapy companies wishing to participate contractually as a PPO/HMO provider must be accredited by a nationally recognized accrediting organization and be state licensed as a retail pharmacy and/or Home Health Agency.

HMO Illinois, BlueAdvantage HMO and BlueAdvantage Entrepreneur HMO Precertification

All services must have Medical Group/IPA approval. The Primary Care Physician must authorize all referrals to infusion therapy providers within the HMO contracted network.

Home Infusion Therapy Billing Example

Home infusion agents and supplies are billed with the skilled nursing visits on a UB-04 utilizing your 4 or 5 digit Blue Cross number when the patient is under a Plan of Treatment and the Blue Cross Coordinated Home Care Benefit (CHC).

The 1st billing example on the following page demonstrates the method used to bill home care nursing visits and the I.V. medication and supplies utilized in administering the drug during the nursing visits.

The 2nd and 3rd billing examples demonstrate the method used when the home infusion provider is acting as the supplier of the infusion agents and supplies only (i.e., not under the CHC benefit.)

Home Infusion Therapy (cont.)

Billing Example 1

1	2	3a PAT. CNTL #	4 TYPE OF BILL
Home Infusion Agency 123 Main Street Anytown, IL 60000 312-123-4567	Home Infusion Agency P.O. Box 123 My Town, IL 60000	09917765 b. MED. REC. # 07765	311

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
	010308	011608	

8 PATIENT NAME	9 PATIENT ADDRESS
a Doe, Jane	b 456 Main Street Anytown IL 60000

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18–28 CONDITION CODES	29 ACDT STATE	30
01011948	F	010308			1		30			

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
11	010308													

38

39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a					
b					
c					
d					

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	250	Vancomycin	J3370		48	489 00		
2	264	IV Perdiem	S9501		14	1120 00		
3	551	SN Visits	99341	010308	1	250 00		
4	551	SN Visits	99349	010408	1	150 00		
5	551	SN Visits	99349	010608	1	150 00		
6	551	SN Visits	99349	010908	1	150 00		
7	551	SN Visits	99349	011108	1	150 00		
8	551	SN Visits	99349	011608	1	150 00		
9								
10	001	Total				2609 00		
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23		PAGE 1 OF 1	CREATION DATE	020108	TOTALS	2609 00		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI 9876054321
A	Blue Cross 121						57
B							OTHER
C							PRV ID

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Doe, Jane	18	XOC123456789	XYZ Company	P02600
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A			
B			
C			

66 DX: 041.10 | 250.42

69 ADMIT DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI | 73

74 PRINCIPAL PROCEDURE CODE / DATE | a. OTHER PROCEDURE CODE / DATE | b. OTHER PROCEDURE CODE / DATE | 75

c. OTHER PROCEDURE CODE / DATE | d. OTHER PROCEDURE CODE / DATE | e. OTHER PROCEDURE CODE / DATE

	NPI	QUAL	LAST	FIRST
76 ATTENDING	9876054321		Smith	Michael
77 OPERATING				
78 OTHER				
79 OTHER				

80 REMARKS

81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Home Infusion Therapy (cont.)

Billing Example 2

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
	R1234567	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Doe, John	01 01 1947 M[X] F[ ]	Doe, Jane
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
456 Main St.	Self [ ] Spouse [X] Child [ ] Other [ ]	456 Main St.
CITY: Anytown STATE: IL	8. PATIENT STATUS: Single [ ] Married [X] Other [ ]	CITY: Anytown STATE: IL
ZIP CODE: 60000 TELEPHONE (Include Area Code): (312) 1234567	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: 60000 TELEPHONE (Include Area Code): (312) 1234567
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
		FEP
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX
		02 02 1946 M[ ] F[X]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M[ ] F[ ]	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
		Good Company
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? [ ] YES [X] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
		BCBSIL
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
02 01 2008		
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
Dennis Lobben	17b. NPI 1234567890	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
1. 579.3 INTEST POSTOP NONA 3. ____		23. PRIOR AUTHORIZATION NUMBER
2. 285.9 ANEMIA NOS 4. ____		

	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	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02 01 2008	02 07 2008	12		S9365		5793	2165 16	7		NPI	0987654321
2	02 01 2008	02 07 2008	12		J1815		5793	120 43	10		NPI	0987654321
3	02 01 2008	02 07 2008	12		B4185		5793	1120 00	7		NPI	0987654321
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For gov. claims, see back)	28. TOTAL CHARGE
361234567 [ ] [X]		[X] YES [ ] NO	$ 3405 59
29. AMOUNT PAID	30. BALANCE DUE		
$	$		

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (312) 5552667
SIGNED Mary Biller DATE 02/10/2008	Home Infusion 123 Main St Anytown IL 60000	Home Infusion PO Box 123 Mytown IL 60000
	a. 0987654321 b.	a. 0987654321 b.

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APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Home Infusion Therapy (cont.)

Billing Example 3

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [ ] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [X] (ID)		1a. INSURED'S I.D. NUMBER (For Program in Item 1): XOF234567890
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Doe, Jane	3. PATIENT'S BIRTH DATE MM DD YY: 01 01 1954 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial): Doe, John
5. PATIENT'S ADDRESS (No., Street): 456 Main St.	6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]	7. INSURED'S ADDRESS (No., Street): 456 Main St.
CITY: Anytown STATE: IL	8. PATIENT STATUS: Single [ ] Married [X] Other [ ]	CITY: Anytown STATE: IL
ZIP CODE: 60000 TELEPHONE (Include Area Code): (312) 1234567	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]	ZIP CODE: 60000 TELEPHONE (Include Area Code): (312) 1234567
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER: P00001
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]	a. INSURED'S DATE OF BIRTH MM DD YY: 02 02 1952 SEX M [X] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME: Good Company
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES [ ] NO [X]	c. INSURANCE PLAN NAME OR PROGRAM NAME: BCBSIL
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY 12 31 2007 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dennis Lobben	17a. [ ] 17b. NPI 1234567890	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. 730.27 2. 3. 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	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	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 2008	01 07 2008	12		J3370		1	525 00	28		NPI	0987654321
2	01 01 2008	01 07 2008	12		S9503		1	700 00	7		NPI	0987654321
3											NPI	
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER: 361234567 SSN [ ] EIN [X]	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES [X] NO [ ]	28. TOTAL CHARGE $ 1225 00	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED Mary Biller DATE 01/10/2008	32. SERVICE FACILITY LOCATION INFORMATION: Home Infusion, 123 Main St, Anytown IL 60000 a. 0987654321 b.		33. BILLING PROVIDER INFO & PH # (312)5552667: Home Infusion, PO Box 123, Mytown IL 60000 a. 0987654321 b.		

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CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION