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Verification of benefits and/or approval of services after preauthorization are not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, copayments, coinsurance and deductibles, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in the member's policy certificate and/or benefits booklet and/or summary plan description as well as any pre-existing conditions waiting period, if any.
Home Infusion Therapy Guidelines
The information in this section is provided as a supplement to the Blue Cross and Blue Shield of Illinois (BCBSIL) agreement with the independently contracted Home Infusion Therapy (HIT) providers participating in the various health benefit products offered by BCBSIL. This section is to familiarize providers 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 on a CMS-1500 claim form. Electronic billing of claims is required. In addition, all HIT providers must meet all credentialing requirements which include current accreditation by one of the nationally recognized accreditation organizations (Joint Commission, ACHC, CHAP, etc.) in order to contract with BCBSIL.

Drugs considered as self-injectable may be considered eligible for benefits under the BCBSIL member’s drug prescription card in most cases, and may not be delivered or billed by the HIT provider to BCBSIL.

Specialty Pharmacy injectable/infusible medications may be required to treat complex medical conditions such as growth hormone deficiency, hepatitis C, immune deficiency, hemophilia, multiple sclerosis and rheumatoid arthritis. BCBSIL has contracted with independent specialty pharmacies for many of these medications. The list of these medications and the independently contracted specialty pharmacies’ contact information may be found on the Specialty Pharmacy Program page in the Pharmacy Program section of our website at bcbsil.com/provider.

Many intravenous/injectable therapies are subject to specific medical necessity criteria in order to be eligible for benefits. All providers are encouraged to review relevant BCBSIL Medical Policies, which are located in the Standards and Requirements section of our Provider website, prior to rendering services. For BCBSIL non-HMO members, it is highly recommended to complete a Predetermination Request Form, located in the Education and Reference Center/Forms section of our Provider website. The Predetermination Request Form may be submitted along with the appropriate medical necessity documentation, as required.

Services normally considered eligible
Intravenous (IV) solutions and/or injectable medications may be considered eligible for benefits, in most instances, if all of the following criteria are met:

1. Prescription drug is U.S. Food and Drug Administration (FDA) approved or meets benefit 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 as part of a written treatment plan for a covered medical condition;
4. Home care is provided by a specialized home infusion company; and
5. Infusion in the home must be safe and medically appropriate.

Description
Home infusion and injectable therapy involves the administration of any of the following items:

- Nutrients
- Medications
- Solutions

These items may be administered intravenously, intramuscularly, enterally, subcutaneously or epidurally, as medically appropriate and ordered by the member’s physician.

Infusion therapy originates with a prescription from a physician who is overseeing the care of the member and is designed to achieve physician defined beneficial outcomes.
Specific infusion therapies may include, but are not limited to, the following:

- Anti-infectives
- Blood transfusions
- Chemotherapy
- Immunosuppressive therapy
- Hydration therapy
- Immunotherapy
- Inotropic therapy
- Pain management
- Parenteral and enteral nutrition (refer to BCBSIL Medical Policy (MED201.011) Nutritional Support)

Pre-certification Requirements
Many benefit plans require notification and approval prior to the provision of any home infusion services. Providers should inquire whether benefit prior authorization/pre-certification is necessary when checking the member’s eligibility and benefits. In order to help members maximize their benefits, most benefit plans require members to utilize in-network providers.

Please refer to the Benefit Prior Authorization section of this manual for information and procedures on prior authorization/pre-certification.

Verification of benefits and/or approval of services after preauthorization are not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, copayments, coinsurance and deductibles, supporting medical documentation and other terms, conditions, limitations and exclusions set forth in the member’s policy certificate and/or benefits booklet and/or summary plan description as well as any pre-existing conditions waiting period, if any.

Important Note for all HMO Illinois®, Blue Advantage HMO℠, Blue Precision HMO℠, BlueCare Direct℠ and Blue FocusCare℠ Members: All services must have Medical Group/Independent Practice Association approval. The PCP must authorize all referrals to home infusion therapy providers within the independently contracted HMO network.

Billing Guidelines
All claims for home infusion therapy must be submitted on a CMS-1500 Claim form or electronically with the appropriate National Drug Code (NDC) with total units of measurement dispensed as well as the Healthcare Common Procedure Coding System (HCPCS) drug code with appropriate units (per the description of the HCPCS code) per the dosage ordered and administered.

Here are some guidelines for appropriate submission of valid NDCs and related information:

- Submit the NDC along with the applicable HCPCS or CPT procedure code(s)
- The NDC must be in the proper format (11 numeric characters, no spaces or special characters)
- The NDC must be active for the date of service
- The appropriate qualifier, unit of measure, number of units and price per unit also must be included, as indicated below

Electronic Claims Guidelines

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Field Description</th>
<th>ANSI (Loop 2410) – Ref Desc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product ID Qualifier</td>
<td>Enter N4 in this field.</td>
<td>LIN02</td>
</tr>
<tr>
<td>National Drug CD</td>
<td>Enter the 11-digit NDC (without hyphens) assigned to the drug administered.</td>
<td>LIN03</td>
</tr>
<tr>
<td>Drug Unit Price</td>
<td>Enter the price per unit of the product, service, commodity, etc.</td>
<td>CTP03</td>
</tr>
<tr>
<td>NDC Units</td>
<td>Enter the quantity (number of units) for the prescription drug.</td>
<td>CTP04</td>
</tr>
<tr>
<td>NDC Unit / MEAS</td>
<td>Enter the unit of measure of the prescription drug given. (Values: F2 – international unit; GR – gram; ML – milliliter; UN – unit)</td>
<td>CTP05-1</td>
</tr>
</tbody>
</table>
Paper Claims Guidelines

In the shaded portion of the line-item field 24A-24G on the CMS-1500, enter the qualifier N4 (left-justified), immediately followed by the NDC. Next, enter the appropriate qualifier for the correct dispensing unit (F2 – international unit; GR – gram; ML – milliliter; UN – unit), followed by the quantity and the price per unit, as indicated in the example below. (The HCPCS/CPT code corresponding to the NDC is entered in field 24D)

Example:

```
N4 2315 5019631  ML 2 12.82
   09 01 18 09 07 18 11 12405 1 25.64 N 4
   0917654521
```

New drugs without a valid HCPCS code should be billed using the HCPCS code J3490 or J3590, as applicable, with the appropriate NDC number and units ordered and administered.

Physician orders must include, at a minimum, the following elements:

- Date of order
- Member name and address
- Diagnosis warranting infusion therapy treatment
- Name of drug, dosage, administration route, frequency of administration and duration of treatment
- Physician name, address and telephone number
- 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 diluents

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 percent of normal per diem for that code.

Nursing visits provided in tandem with HIT services, may only be billed, electronically or on a UB-04 claim form, by a licensed home health agency, separate and apart from the HIT services which must be billed on a CMS-1500 or electronically.

In order to help members maximize their benefit, nursing services should be performed by a provider that has a coordinated home care (CHC) agreement with BCBSIL. Please review the BCBSIL Coordinated Home Care section of the Provider Manual for additional CHC billing guidelines.

This material is for educational purposes only and is not intended to be a definitive source for what codes should be used for submitting claims for any particular disease, treatment or service. Health care providers are instructed to submit claims using the most appropriate code based upon the medical record documentation and coding guidelines and reference materials.
Home Infusion Therapy Billing Examples

The following billing examples are provided as a reference only. BCBSIL requires electronic submission of all claims.

*Note:* BCBSIL reserves the right to update these guidelines as necessary. Providers should review the guidelines posted in the BCBSIL Standards and Requirements section on the BCBSIL Provider website periodically to ensure compliance.
### Billing Example 1

#### HEALTH INSURANCE CLAIM FORM

1. Medicare
2. Medicaid
3. TRI-CARE
4. CHAMPVA
5. GROUP™
6. FeIDA
7. OTHER
8. PFCA

**Beneficiary Information**
- Last Name: Doe
- First Name: John
- Middle Initial: J
- Date of Birth: 01/01/1954
- Social Security Number: 123-456-7890

**Provider Information**
- Name: Dennis Lobber
- Tax ID: 1234567890

**Diagnosis**
- Diagnosis Code: S9365
- Procedure Code: J1815
- Procedure Code: B4185

**Home Infusion**
- Address: 123 Main Street, Anytown, IL 60000
- Phone: (312) 555-2667

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**PLEASE PRINT OR TYPE**

BCBSIL Provider Manual — October 2018

NNUC Instruction Manual available at: www.nucc.org
Billing Example 2

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>Insured's SS Number</td>
<td>XOF234567890</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>02 02 1952</td>
</tr>
<tr>
<td>Other Insurers' Policy or Group Number</td>
<td>BCBSIL</td>
</tr>
<tr>
<td>Diagnosis or Nature of Illness or Injury</td>
<td>1234 567890</td>
</tr>
<tr>
<td>Physician's Name</td>
<td>Dennis Lobber</td>
</tr>
<tr>
<td>Hospital's Address</td>
<td>456 Main St. Anytown, IL 60000</td>
</tr>
<tr>
<td>Physician's Office Code</td>
<td>312324567</td>
</tr>
<tr>
<td>Service Facility Location Information</td>
<td>Home Infusion 123 Main Street Anytown, IL 60000</td>
</tr>
</tbody>
</table>