

## Home Infusion Therapy

### Policy

Harvard Pilgrim reimburses contracted home infusion therapy agencies for home infusion therapy services, subject to prior authorization. Home infusion therapy services are provided when a member is medically homebound or when home is determined to be the most appropriate setting, as determined by a Harvard Pilgrim nurse care manager or a participating Harvard Pilgrim clinician.

### Policy Definition

*Home Infusion Therapy* is defined as high technology services, including, but not limited to, line care, chemotherapy, pain management infusion, antibiotic, antiviral or antifungal therapy.

### Prerequisite(s)

Applicable Harvard Pilgrim referral, notification and authorization policies and procedures apply. Refer to [\*Referral, Notification and Authorization\*](#) for more information.

### HMO/POS/PPO

Prior authorization may be required for home infusion therapy services including nursing care, drugs, and biologicals. Refer to [\*Home Health Care Authorization\*](#) for specific requirements.

### Open Access HMO and POS

For [\*Open Access HMO and Open Access POS\*](#) products, no referral is required to see a contracted specialist.

### Harvard Pilgrim Reimburses<sup>1</sup>

#### HMO/POS/PPO

Harvard Pilgrim reimburses home infusion therapy services on a per diem basis only when an actual drug infusion is administered that day, which is inclusive of:

- Administrative services
- Professional pharmacy services
- Care coordination
- All necessary supplies and equipment for the effective administration of infusion, specialty drug and nutrition therapies. Including but not limited to:
  - DME (pumps, poles and accessories) for drug and nutrition administration, equipment maintenance and repair (excluding patient owned equipment)
  - Short peripheral vascular access devices, needles, gauze, non-implanted sterile tubing, catheters, dressing kits, and flushing solutions, including heparin and saline
  - Delivery and removal of supplies and equipment

Harvard Pilgrim reimburses the following services separately from the per diem rate:

- Nursing visits related to infusion services
- Enteral formula when administered via gravity, pump or bolus only (does *not* apply to nutritional formulas taken orally)
- Covered DME not related to infusion therapy (billed separately from infusion services) when provided by a contracted DME provider
- Drugs and biologicals, based on Harvard Pilgrim's drug fee schedule
  - Reimbursement for listed and unlisted drugs will not exceed Harvard Pilgrim's drug fee schedule allowables
  - Harvard Pilgrim's drug fee schedule is periodically updated based on Average Sale Price (ASP), Average Wholesale Price (AWP), *Harvard Pilgrim Specialty Pharmacy Program*, or Medicare.

For home infusion therapy services provided in conjunction with home hospice services, refer to *Hospice Care* for reimbursement information.

## Member Cost-Sharing

Services are subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible).

## Provider Billing Guidelines and Documentation

### Coding<sup>2</sup>

Code	Description	Comment
E0781	Ambulatory infusion pump, single or multi channels, electric or battery op, worn by pt	Reimbursed for office initiated chemotherapy treatment only. Not reimbursed separately for home infusion services.
S9379	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	Documentation required with claim. Should only be billed for a service or procedure that does not have a valid specific therapy code available and should only be billed if the actual medication is infused separately from any other service being provided on the same date of service.

### Other Information

- Bill home infusion therapy services using industry standard HCPCS coding.
- DME that is not related to infusion therapy must be billed separately from infusion services and must be provided by a contracted DME provider.
- Bill for drugs, formula, and other biologicals with the HCPCS code that most accurately describes the dosage administered to the member that day.
- For multiple dates of service report a separate line for each date of service with the applicable procedure code(s) and the number of units.
- Effective for dates of service on or after February 1, 2025, Point32Health will require the following modifiers when billing multiple home infusion therapies.
  - SH identifies the second concurrently administered infusion therapy.
  - SJ identifies the third or more concurrently administered infusion therapy.

### Unlisted Drugs

Bill unlisted J codes as follows:

#### • Electronic claim submitters

837P — Report the unlisted J code in the SV101-2, loop 2400 and the NDC Number with N4 qualifier in the LIN segment, loop 2410. When reporting NDC the CTP segment is required — both CTP04 (NDC count) and CTP05 (unit of measure)

837I — Report the unlisted J code in the SV202-2, loop 2400 and the NDC Number with N4 qualifier in the LIN segment, loop 2410. When reporting NDC in LIN segment the CTP segment is required — both CTP04 (NDC count) and CTP05 (unit of measure)

#### • Paper claim submitters

CMS-1500 form: Report the unlisted J code in 24D and units in 24G. To report NDC: In shade area of the line-item field (24A-24G), enter the N4 qualifier immediately followed by 11-digit NDC number — left justified, enter 1 space then qualifier for dispensing unit of measure followed by quantity.

UB-04 form: Report the unlisted J code in Form Locator 44 and units in Form Locator 46. To report NDC: In Form Locator 43 enter the N4 qualifier immediately followed by 11-digit NDC number without hyphens —

left justified. NDC will be followed immediately by the qualifier for dispensing unit of measure followed by quantity.

## Related Policies

### Payment Policies

- Durable Medical Equipment (DME)
- Drugs and Biologicals
- Home Health Care
- Hospice Care
- Interim Billing
- Unlisted and Unspecified Procedure Codes
- Audit Policy

### Medical Necessity Guidelines

- Formulas and Enteral Nutrition
- Home Health Care Authorization
- Lyme Disease: Antibiotic Coverage

### Authorization/Notification Policies

- Prior Authorization Policy

### Billing & Reimbursement

- Claims Submission Guidelines

### Forms

- Pedi/Adult Formula Review Request Form

## PUBLICATION HISTORY

01/01/02	original documentation
04/01/03	annual review; separately reimbursed drug costs based on AWP or Harvard Pilgrim Specialty Pharmacy Program
10/01/03	annual review; clarified reimbursement services; updated coding
04/30/04	annual coding review
01/31/05	annual review; biological terminology added to drug references
10/31/05	annual review; added coding
01/31/06	annual coding review
01/31/07	annual review; clarified per diem definition, and billing for drugs
04/30/08	annual review; added reimbursement information for Lyme disease treatment
01/31/09	annual review; clarified items included in per diem rate
11/15/09	annual review; minor edits for clarity
11/15/10	annual review; minor edits for clarity
02/15/11	added clarification to enteral formula
12/15/11	annual review; minor edits for clarity
01/01/12	removed First Seniority Freedom information from header
01/15/12	added clarification to treatment of Lyme disease
12/15/12	annual review; "medical necessity" added to treatment of Lyme disease; clarified billing for S9379; added Unlisted and Unspecified Procedure Codes payment policy to Related Policies
07/15/13	added E0781 reimbursement clarification
12/15/13	annual review; administrative edits
06/15/14	added <i>Connecticut Open Access HMO</i> referral information to Prerequisites
12/15/14	annual review; E0781 removed effective 07/01/2013
12/15/15	annual review; no changes
09/15/16	updated treatment of Lyme disease
12/15/16	annual review; updated descriptions of services
02/15/17	added S9346 and S9357
12/15/17	annual review; administrative edits

## PAYMENT POLICIES

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01/02/18	updated billing for unlisted J codes; added report multiple dates of service on a separate line; updated Open Access Product referral information under Prerequisites
12/03/18	annual review; administrative edits; added Formulas and Enteral Nutrition Medical Review Criteria to Related Policies
12/02/19	annual review; no changes
11/04/20	updated Related Policies
12/01/20	annual review; updated Provider Billing Guidelines and Documentation; removed reference to Version 5010
12/01/21	annual review; no changes
12/01/22	annual review; removed reference to lyme disease and added medical policy
12/01/23	annual review; no changes
11/29/24	annual review; added modifier SH and SJ; added related policies

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<sup>1</sup>This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

<sup>2</sup>The table may not include all provider claim codes related to home infusion therapy.