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Temporary Transitional Payment for Home Infusion Therapy Services for CYs 2019 and 2020

MLN Matters Number: MM10836
Related Change Request (CR) Number: 10836
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Related CR Transmittal Number: R4112CP
Implementation Date: January 7, 2019

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended for eligible Home Infusion Therapy (HIT) providers and suppliers who bill Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for HIT services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 10836 alerts providers and suppliers that effective January 1, 2019 and until the implementation of the full HIT benefit, Medicare makes separate temporary transitional payments for HIT services to eligible home infusion suppliers (such as, a licensed pharmacy that provides external infusion pumps and external infusion pump supplies).

This payment amount covers the cost of items and services furnished in coordination with administration of certain transitional home infusion drugs administered through an item of DME. Please make sure that your billing staffs are aware of these changes.

BACKGROUND

Section 50401 of the Bipartisan Budget Act of 2018 (Pub. L 115-123) amended Section 1834(u) of the Social Security Act (the Act) by adding paragraph (7), which requires a temporary, transitional payment be made to eligible home infusion suppliers for home infusion therapy services furnished on or after January 1, 2019 until the implementation of the full home infusion therapy benefit, as required by section 5012(d) of the 21st Century Cures Act (Pub. L. 144-255).

As outlined in section 1834(u) (7)(C) of the Act, transitional home infusion drugs are assigned to three payment categories, as determined by the HCPCS J-code.

1. Payment category 1 includes certain antifungals and antivirals, uninterrupted long-term infusions, pain management, inotropic, and chelation drugs.
2. Payment category 2 includes subcutaneous immunotherapy.

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3. Payment category 3 includes certain chemotherapy drugs.

In accordance with 1834(u) (7)(D) of the Act, a single payment amount for each of the three categories will be established for professional services furnished for each infusion drug administration calendar day. Each payment category will be paid at amounts in accordance with the physician fee schedule for each infusion drug administration calendar day in the individual's home for drugs assigned to such category without geographic adjustment.

A separate payment for HIT services will be made under the temporary transitional payment to eligible home infusion suppliers. Effective January 1, 2019, the Centers for Medicare & Medicaid Services (CMS) will establish a G-code for the professional services rendered on an infusion drug administration calendar day for each payment category.

Each payment category will be paid at amounts consistent with the physician fee schedule for codes and units of such codes. The three new G-codes are:

1. **G0068**: 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.
    - Short Descriptor: Adm of infusion drug in home

2. **G0069**: Professional services for the administration of subcutaneous immunotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes.
    - Short Descriptor: Adm of immune drug in home

3. **G0070**: Professional services for the administration of chemotherapy for each infusion drug administration calendar day in the individual's home, each 15 minutes.
    - Short Descriptor: Adm of chemo drug in home

NOTE: The G-code payment rates are being added to the DMEPOS fee schedule.

In the event that multiple drugs, which are not all assigned to the same payment category, are administered on the same infusion drug administration calendar day, a single payment would be made that is equal to the highest payment category. These G-codes could be billed separately from or on the same claim as the DME, supplies, and infusion drug; and would be processed through the DME MACs.

To identify and process claims for the items and services furnished under the HIT benefit, a Common Working File (CWF) edit will be implemented for the submitted G-code claims. If Medicare does not find a J-code on the same claim as the billed professional services, the claims processing system will recycle the G-code claim for the professional services associated with the administration of the home infusion drug, until a claim containing the J-code for the infusion drug is received in the CWF.

The professional visit claim will recycle three times (with a 30-day look back period) for a total of 15 business days. After 15 business days, if CWF finds no J-code claim in claims history,

Medicare will deny the G-code claim. Suppliers must ensure that the appropriate drug associated with the visit is billed with the visit or no more than 30 days prior to the visit. In the event that multiple visits occur on the same date of service, suppliers must only bill for one visit and should report the highest paying visit with the applicable drug. Claims reporting multiple visits on the same line item date of service will be returned as un-processable.

MACS will use the following CARC/RARC codes when denying claim because no J-code is found in history after the incoming claim is recycled three times:

- Claim Adjustment Reason Code (CARC) 16 - Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) N657 - This should be billed with the appropriate code for these services.
- Claim Adjustment Group Code - CO (Contractual Obligation)

MACs will reject/deny an incoming claim line for a G code when a claim in history has paid for a G code visit on the same line item date of service. In denying such claims, MACs will use the following messages:

- CARC 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- RARC N111 - No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
- Claim Adjustment Group Code - CO (Contractual Obligation)

Providers should report visit length in 15-minute increments (15 minutes=1unit). Providers/suppliers need to review the following tables:

- The table of rounding of units (Table 1)
- Payment categories for transitional payment for home infusion therapy professional services (Table 2)
- Payment categories for transitional payment for home infusion drugs (Table 3)

Table 1 shows the time increments providers should report visit length in 15-minute increments (15 minutes=1unit). See the table below for the rounding of units.

Table 1: Time increments/Rounding of Time Units

Unit	Time
1	<23 minutes
2	= 23 minutes to <38 minutes
3	= 38 minutes to <53 minutes
4	= 53 minutes to <68 minutes
5	= 68 minutes to <83 minutes
6	= 83 minutes to <98 minutes
7	= 98 minutes to <113 minutes
8	= 113 minutes to <128 minutes
9	= 128 minutes to <143 minutes
10	= 143 minutes to <158 minutes

Table 2 shows the use of the three G-codes established for the home infusion therapy temporary transitional payment, and reflects the therapy type and complexity of the drug administration.

Table 2: Payment categories for transitional payment for home infusion therapy professional services

	Category 1	Category 2	Category 3
Description	Anti-infective, pain management, chelation, pulmonary hypertension, and inotropic infusion drugs	Subcutaneous immunotherapy	Chemotherapy
G-Code	G0068	G0069	G0070

Table 3: Complete list of J-codes associated with the infusion drugs that fall within each category

Category 1

J-Code	Description
J0133	Injection, acyclovir, 5 mg
J0285	Injection, amphotericin b, 50 mg
J0287	Injection, amphotericin b lipid complex, 10 mg
J0288	Injection, amphotericin b cholesteryl sulfate complex, 10 mg

J-Code	Description
J0289	Injection, amphotericin b liposome, 10 mg
J0895	Injection, deferoxamine mesylate, 500 mg
J1170	Injection, hydromorphone, up to 4 mg
J1250	Injection, dobutamine hydrochloride, per 250 mg
J1265	Injection, dopamine hcl, 40 mg
J1325	Injection, epoprostenol, 0.5 mg
J1455	Injection, foscarnet sodium, per 1000 mg
J1457	Injection, gallium nitrate, 1 mg
J1570	Injection, ganciclovir sodium, 500 mg
J2175	Injection, meperidine hydrochloride, per 100 mg
J2260	Injection, milrinone lactate, 5 mg
J2270	Injection, morphine sulfate, up to 10 mg
J2274	Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg
J2278	Injection, ziconotide, 1 microgram
J3010	Injection, fentanyl citrate, 0.1 mg
J3285	Injection, treprostinil, 1 mg

Category 2

J-Code	Description
J1555 JB	Injection, immune globulin (cuvitru), 100 mg
J1559 JB	Injection, immune globulin (hizentra), 100 mg
J1561 JB	Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg

J-Code	Description
J1562 JB	Injection, immune globulin (vivaglobin), 100 mg
J1569 JB	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg
J1575 JB	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin

Category 3

J-Code	Description
J9000	Injection, doxorubicin hydrochloride, 10 mg
J9039	Injection, blinatumomab, 1 microgram
J9040	Injection, bleomycin sulfate, 15 units
J9065	Injection, cladribine, per 1 mg
J9100	Injection, cytarabine, 100 mg
J9190	Injection, fluorouracil, 500 mg
J9200	Injection, floxuridine, 500 mg
J9360	Injection, vinblastine sulfate, 1 mg
J9370	Injection, vincristine sulfate, 1 mg

ADDITIONAL INFORMATION

The official instruction, CR10836, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4112CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
November 2, 2018	Initial article released.