CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4112	**Date: August 10, 2018**
	Change Request 10836

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 1, 2018. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

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

I. SUMMARY OF CHANGES: 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). This payment covers the cost of items and services furnished in coordination with administration of certain transitional home infusion drugs administered through an item of DME.

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 7, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	20/108/Billing for Home Infusion Therapy Services

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4112	Date: August 10, 2018	Change Request: 10836

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

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 7, 2019

I. GENERAL INFORMATION

A. 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). This payment covers the cost of items and services furnished in coordination with administration of certain transitional home infusion drugs administered through an item of DME.

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

B. Policy: As described in the Bipartisan Budget Act of 2018 (Pub. L 115-123), a separate payment for home infusion therapy services will be made under the temporary transitional payment to eligible home infusion suppliers. Effective January 1, 2019, 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:

- **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

- **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

- **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 Home Infusion Therapy benefit, a Common Working File (CWF) edit will be implemented for the submitted G-code claims. If a J-code is not found 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 no J-code claim is found in claims history, the G-code claim will be denied. 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 unprocessable.

Providers should report visit length in 15-minute increments (15 minutes=1unit). See the attachments to this CR for the Table of rounding of units, Payment Categories for Transitional Payment for Home Infusion Therapy Professional Services, and Payment Categories for Transitional Payment for Home Infusion Drugs.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10836.1	Contractors shall allow a separate payment for home infusion therapy services which will be made under the temporary transitional payment to eligible home infusion suppliers effective for claims with dates of service January 1, 2019, and valid through December 31, 2020.				X					
10836.2	Contractors shall accept and manually load the new G-codes below for the professional services				X				X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	rendered on an infusion drug administration calendar day for each payment category in attachment A with the effective/end dates specified in BR 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 • **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 • **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									
10836.2.1	Contractors shall use Type of Service (TOS) Code 1 for all 3 G codes.				X				X	
10836.2.2	Contractors shall use CWF Category Code 60 for all 3 G codes.				X				X	
10836.2.3	Contractors shall make modifications, if necessary, to load the descriptions for the new temporary transitional home infusion therapy "G" codes to correctly reflect on any Medicare Summary Notice messaging.				X			X		
10836.3	Contractors shall pay only 1 of the G codes listed above per line item date of service when one of				X			X	X	

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the drugs from the applicable category (see attachment A) is billed with the same line item date of service or a date of service within 30 days prior to the G code visit by the same supplier. **Note:** • The fees associated with the G codes on the DMEPOS fee file will be "a per day rate;" therefore, the units on the line should not be multiplied by the rate. • The drug remains separately payable from the G code line item.									
10836.3.1	Contractors shall return claims as un-processable w/ multiple G codes on the same line item date of service				X					
10836.3.2	Contractors shall reject 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.								X	
10836.3.3	Contractors shall deny the CWF rejected claim if a new G code is received for the same date of service as a previous claim was paid for the same line item date of service. **Note:** The supplier should submit an adjustment to the original claim to receive the higher payment.				X			X		
10836.3.3.1	Contractors shall use the following CARC/RARC codes when denying claims: 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				X			X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	adjudicated. Claim Adjustment Group Code - CO (Contractual Obligation)									
10836.4	Contractors shall reject the claim if one of the drug J codes from the allowable codes on the attachment A is not found on the same claim with the same line item date of service or within 30 days prior to the visit (G code) date of service from the same supplier.								X	
10836.4.1	The Contractor shall recycle the G-code claim up to 3 times for a total of 15 business days until a claim from the same supplier containing an allowable drug from attachment A is received with the same line item date of service or within 30 days prior to the line item date of service of the G code.							X		
10836.4.2	The contractor shall deny the CWF rejected G code line when the claim has recycled 3 times without finding the associated drug code claim.				X			X		
10836.5	Contractors shall use the following CARC/RARC codes when denying claims: 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. RARC N657 - This should be billed with the appropriate code for these services. Claim Adjustment Group Code - CO (Contractual Obligation)				X			X		
10836.6	CMS shall provide a "dummy" fee schedule file for testing no later than October 8, 2018.									CMS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10836.6.1	Contractors shall load the dummy fee schedule file for performing testing on this CR.				X			X		
10836.7	The contractors shall send the following denial MSN message: 41.14: This service/item was billed incorrectly. 41.14- Este servicio o artículo fue facturado incorrectamente.				X					
10836.8	The Contractors shall perform testing of this Change Request due to the STC only being able to perform limited testing due to the dates of service and the STC test environment.				X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10836.9	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.				X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	See Attachment A - Transitional Payment for Home Infusion Therapy

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Diana Motsiopoulos, diana.motsiopoulos@cms.hhs.gov (Billing Requirements) , Ashli Clark, M.S., Ashli.Clark@cms.hhs.gov (Policy Contact)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Attachment A: Transitional Payment for Home Infusion Therapy

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

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 provides a complete list of J-codes associated with the infusion drugs that fall within each category.

Table 3: ***Temporary Transitional Payment Categories for Home Infusion Therapy Services, by Infusion Drug (J-Code)***

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
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
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

Medicare Claims Processing Manual

Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

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(Rev. 4112, 08-10-18)

Medicare Claims Processing Manual Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

180 - Billing for Home Infusion Therapy Services
(Rev. 4112, Issued: 08-10-18, Effective: 01-01-19, Implementation: 01-07-19)

Effective January 1, 2019 and until the implementation of the full home infusion therapy benefit, Medicare makes separate temporary transitional payments for Home Infusion Therapy (HIT) services to eligible home infusion suppliers (i.e., a licensed pharmacy that provides external infusion pumps and external infusion pump supplies). This payment amount covers the cost of professional services, including nursing services, training and education (not otherwise paid for as durable medical equipment), remote monitoring, and monitoring services for the provision of home infusion therapy furnished by a qualified home infusion with administration of certain transitional home infusion drugs administered through an item of DME.

Temporary transitional payments are made for HIT services based on the home infusion drug provided. Home infusion drugs are assigned to three payment categories, determined by the Healthcare Common Procedure Coding System (HCPCS) J-code. Each DME MAC maintains a list of drugs that are administered through an item of DME and HIT payment is made for days on which home infusion therapy services are furnished by skilled professionals in the individual's home on the day of infusion drug administration.

Temporary Transitional Payment Categories for Home Infusion Therapy Services, by Infusion Drug (J-Code)

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*
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*
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*

The payment category for subsequent transitional home infusion drug additions to the Local Coverage Determinations (LCDs) and compounded infusion drugs not otherwise classified, as identified by HCPCS codes J7799 and J7999, will be determined by the DME MAC.
A single unit of payment will be made for HIT services provided in the individual's home during an infusion drug administration calendar day.
Suppliers will report the following HCPCS G-codes associated with the payment categories for the professional services furnished in the individual's home and on an infusion drug administration calendar day:

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

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.

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

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*

Claims that include G-codes for HIT services are not required to, but may also include the HCPCS J-code for the infusion drug, the E-code for the external infusion pump, and A-codes for supplies other than the drug.

A submitted claim for HIT services is subject to a Common Working File (CWF) edit in the event that a transitional drug J-code is not found on the same claim as the billed professional HIT services, or in claims history in the previous 30 days. If a J-code is not found 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 no J-code claim is found in claims history, the G-code claim will be denied.

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. Visits are denied if the appropriate drug for the visit is not billed. 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 unprocessable.