Home Infusion Therapy Benefit

The 21st Century Cures Act established a new home infusion therapy services benefit under Medicare Part B to be effective January 1, 2021. This benefit covers the professional services (including nursing services) furnished in accordance with the plan of care, patient training and education (not otherwise covered under the durable medical equipment, or DME, benefit), remote monitoring, and other monitoring services for the provision of home infusion drugs furnished by a qualified home infusion therapy supplier.

The Bipartisan Budget Act of 2018 established a home infusion therapy services "temporary transitional payment" system for certain items and services furnished in coordination with the rendering of transitional home infusion drugs beginning January 1, 2019, and ending December 31, 2020, that is, for the 2-year period leading up to the January 1, 2021, implementation date as required by the 21st Century Cures Act.

In the CY 2020 Home Health (HH) PPS Final Rule, CMS finalized several items related to the implementation of the permanent Medicare Part B benefit for coverage of home infusion therapy services beginning January 1, 2021.

- A home infusion drug is a parenteral or biological administered intravenously (IV) or subcutaneously, and must require infusion through an external infusion pump. If the drug/biological can be infused through a disposable pump or by a gravity drip, it does not meet this criterion.
- The drug cannot be on the self-administered drug exclusion list. Drugs are on the self-administered drug exclusion list if more than 50% of Medicare beneficiaries are able to self-administer the drug (as described in the Medicare Benefit Policy Manual, Chapter 15, §50.2).
- *Infusion drug administration calendar day* is defined as the day on which home infusion therapy services are furnished by skilled professionals in the patient's home on the day of drug administration.
    - **The single, bundled payment for home infusion therapy services is only made when a skilled professional is in the home on the day of the drug administration.**
- Drugs identified for coverage of home infusion therapy services are paid under the Part B DME benefit, therefore, services related to furnishing the drug, remote or otherwise, are paid under the DME benefit. This includes services by the DME supplier, such as preparation and dispensing of the drugs, and education and training on how to effectively and safely use the DME equipment.
- **Services covered under this "new" home infusion therapy benefit are distinct from those paid under the DME benefit** and may include the following:
    - Training and education on care and maintenance of vascular access devices (e.g., hygiene education, what to do in the event of a dislodgement or occlusion, education on signs and symptoms of infection, flushing/locking the catheter, dressing changes/site care)

- Patient assessment and evaluation (e.g., review of patient history and assessment of current physical and mental status – including vital signs, assessment of adverse effects, evaluation of family/caregiver support, obtaining blood for lab work)
- Medication and disease management education (e.g., instruction on self-monitoring, lifestyle and nutritional modifications, drug mechanism of action, side effects/interactions/adverse reactions, home infusion therapy goals and progress, education on administration of pre-meds)
- Remote patient monitoring services
- Other monitoring services (e.g., communication with patient regarding changes in condition and treatment plan, patient response to therapy, assessing compliance)

HOME INFUSION THERAPY BENEFIT VS. HOME HEALTH BENEFIT

A beneficiary is not required to be homebound to be eligible for the home infusion therapy benefit, and there may be instances where a beneficiary under a HH plan of care (POC), that is, a homebound patient, also requires home infusion therapy services. In this case, the beneficiary can utilize both benefits concurrently. And, the home health agency (HHA) and the home infusion therapy supplier may be the same entity in cases where the HHA is approved as a home infusion therapy supplier.

If a patient receiving home infusion therapy is also under a HH POC and received a visit that is unrelated to home infusion therapy, payment would be covered by the HH PPS and billed on the HH claim. When the HHA is the qualified home infusion therapy supplier and conducts a home visit exclusively for purposes of furnishing items and services related to the administration of the home infusion drug, the HHA would submit a home infusion therapy services claim under the home infusion therapy benefit. If a home visit includes provision of both HH and home infusion therapy services (i.e., separate services), the HHA would submit claims under the HH PPS and the home infusion therapy benefits. However, in this case, the HHA must separate the time spent providing the HH and home infusion therapy services.

As of January 1, 2021, home infusion therapy will no longer be provided to homebound patients under the home health benefit. Home infusion therapy services will be covered under the home infusion benefit for both homebound and non-homebound patients.

HOME INFUSION PAYMENT CATEGORIES

CMS also finalized its proposal to maintain the three home infusion payment categories, with the associated J-codes (which describe the drugs covered under the benefit), currently being utilized under the temporary transitional payments for home infusion therapy services during 2019 and 2020.

Each category payment amount will be in accordance with the six CPT infusion codes described under the Physician Fee Schedule and equal to five hours of infusion services in a physician's office. The payment amounts for each of the three payment categories will be increased for the first visit by the difference in payment for a new patient over an existing patient using the physician evaluation and management (E/M) Fee Schedule rates. This will be done in a budget-neutral manner, resulting in a small decrease to the payment amounts for subsequent visits. A gap of at least 60 days is required for another "first visit" to be billed (i.e., the patient must have been discharged from home infusion therapy for at least 60 days).

Home infusion therapy services payment is contingent upon a home infusion drug J-code being billed. Suppliers must ensure the appropriate drug associated with the visit was billed with the visit *no more than 30 days prior* to the visit. Payment will be made for each infusion drug administration calendar day.

TABLE 30: Infusion Drug J-Codes Associated with Home Infusion Therapy Service Payment Categories for CY 2021

J-Code	Drug
Category 1	
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
J3010	Injection, fentanyl citrate, 0.1 mg
J3285	Injection, treprostinil, 1 mg
Category 2	
J1555 JB*	Injection, immune globulin (cuvitru), 100 mg
J1561 JB*	Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (for example, liquid), 500 mg
J1562 JB*	Injection, immune globulin (vivaglobin), 100 mg
J1569 JB*	Injection, immune globulin (gammagard liquid), non-lyophilized, (for example, liquid), 500 mg
J1575 JB*	Injection, immune globulin/hyaluronidase (hyqvia), 100 mg immune globulin
Category 3	
J9000	Injection, doxorubicin hydrochloride, 10 mg
J9030	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
J9360	Injection, vinblastine sulfate, 1 mg
J9370	Injection, vincristine sulfate, 1 mg

*The JB modifier indicates that the route of administration is subcutaneous.

TABLE 31: Payment Categories for Home Infusion Therapy Services Payment for CY 2021

CPT Code	Description	Units
Category 1		
96365	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (excludes chemotherapy & other highly complex drug or highly complex biologic agent administration) – up to one hour	1
96366	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (excludes chemotherapy & other highly complex drug or highly complex biologic agent administration) – each additional hour	4
Category 2		
96369	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (excludes chemotherapy & other highly complex drug or highly complex biologic agent administration) – up to one hour	1
96370	Therapeutic, Prophylactic, and Diagnostic Injections and Infusions (excludes chemotherapy & other highly complex drug or highly complex biologic agent administration) – each additional hour	4
Category 3		
96413	Injection and Intravenous Infusion Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration – up to one hour	1
96415	Injection and Intravenous Infusion Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration – each additional hour	4

TABLE 32: 5-hour Payment Amounts Reflecting Payment Rates for First and Subsequent Visits

CPT Code	Description	2020 Proposed PFS Amounts	5-hour Payment – First Visit	5-hour Payment – Subsequent Visits
96365	Ther/proph/diag IV inf 1 hr	$71.45	$255.25	$153.54
96366	Ther/proph/diag IV inf add hr	$22.02		
96369	Sub Q Ther inf up to 1 hr	$161.32	$357.44	$215.00
96370	Sub Q Ther inf add hour	$15.52		
96413	Chemo IV inf 1 hr	$141.47	$422.70	$254.26
96415	Chemo IV inf add hr	$30.68		

Home infusion therapy services rates will be adjusted by the *geographic adjustment factor (GAF)*, which represents the combined impact of the three geographic practice cost index (GPCI) components of the Physician Fee Schedule, work, practice expense, and malpractice.

Note: Providers will submit a single HCPCS G-code associated with the payment categories for the professional services furnished in the individual's home and on an infusion drug administration calendar day, *not* the aforementioned CPT codes. The CPT codes in Table 32 were used by CMS to determine the payment amounts for the home infusion therapy services. The claim will include a G-code, in line item detail, for each infusion drug administration calendar day, and the claim should include the length of time, in 15-minute increments, for which the professional services were furnished.

These G-codes are outlined in Transmittal R4112 (and referenced in the Final Rule):

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)

Qualified home infusion therapy suppliers, whether a DME supplier, HHA, or other entity, will submit all home infusion therapy service claims on the 837p/CMS-1500 professional and supplier claims form to the A/B Medicare Administrative Contractors (MACs). DME suppliers, concurrently enrolled as qualified home infusion therapy suppliers, would need to submit one claim for the DME, supplies, and drug on the 837p/CMS-1500 professional and supplier claims form to the DME MAC and a separate 837p/CMS-1500 for the home infusion therapy professional services to the A/B MAC. CMS states they are considering creating a "home infusion therapy supplier" type on the 855B enrollment form, but in the meantime, providers can enroll using the "other" option on the 855.

For more information, access **Transmittal 4112**.

Access the **Final Rule**.