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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, 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) Contract Agreement with Home Infusion Therapy (HIT) providers 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 be accredited by one of the nationally recognized accreditation organizations (Joint Commission, ACHC or CHAP) 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.

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 these medications. The list of these medications and contracted specialty pharmacies’ contact information may be found at http://www.bcbsil.com/provider/pharmacy/specialty_pharmacy.html.

Many intravenous/injectable therapies will have 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 the BCBSIL Provider website, prior to rendering services. It may be appropriate for BCBSIL non-HMO members to complete a Predetermination Request Form, which is located in the Education and Reference section. The Predetermination Request Form may be submitted along with the appropriate medical necessity documentation, as required.

Services normally considered eligible for benefits
Intravenous (IV) solutions and/or injectable medications may be considered eligible for benefits under the criteria for medical necessity if all of the following 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 treatment plan for a covered medical condition;
4. Home care is provided by a home health care agency or 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:

- Nutrients
- Medications
- Solutions

These items may be administered intravenously, intramuscularly, enterally, subcutaneously or epidurally.

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 therapies provided may include, but are not limited to:

- Anti-infectives
- Blood transfusions
- Chemotherapy
• Growth hormones
• Hydration therapy
• Immunotherapy
• Inotropic therapy
• Pain management
• Parenteral and enteral nutrition (refer to BCBSIL Medical Policy Alternative Modes of Nutrition in the Outpatient and Home Setting)
• Tocolytic therapy

Pre-certification Requirements
Many benefit plans require notification and approval prior to rendering any home infusion services. Providers should inquire whether benefit pre-certification is necessary when checking the member’s eligibility and benefits.

Most benefit plans require members to utilize in-network providers to obtain maximum benefits. Home Infusion Therapy companies wishing to participate contractually as a PPO/HMO provider must be accredited by a nationally recognized accrediting organization and be state-licensed as a retail pharmacy and/or Home Health Agency.

Please refer to the Contacts and Resources section of this manual for information and procedures on 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, 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.

Note for HMO Members: All services must have MG/IPA* approval. The PCP must authorize all referrals to home infusion therapy providers within the independently contracted HMO network.

*B Medical Group/Independent Practice Association

Billing Guidelines
All claims must be submitted with the appropriate National Drug Code (NDC) with total units of measurement dispensed as well as the 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:

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:
- 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 may only be billed, electronically or on a UB-04 claim form, by a licensed home health agency with a BCBSIL Coordinated Home Care agreement.

When the member is under a plan of treatment and the Blue Cross Coordinated Home Care benefit, non-Specialty Pharmacy injectable/infusible medications and supplies may be billed electronically on a UB-04 claim form with the skilled nursing visits utilizing your National Provider Identifier (NPI) number.

Specialty Pharmacy medications, including but not limited to immunoglobulin may not be billed on a UB-04 claim form under the Blue Cross Coordinated Home Care benefit. See BCBSIL contracted Specialty Pharmacies with a listing of specialty drugs at http://bcbsil.com/provider/pharmacy/specialty_pharmacy.html.

When the member is not under the Blue Cross Coordinated Home Care benefit, home infusion medications and supplies must be billed on the CMS-1500 form or electronically utilizing the provider NPI number.
All providers are encouraged to review relevant BCBSIL Medical Policies, located in the Standards and Requirements section of the BCBSIL Provider website, prior to rendering services. It may be appropriate in some cases to complete a Predetermination Request Form, which is located in the Education and Reference Center/Forms section, and which may be submitted along with the appropriate medical necessity documentation, as required.

Home Infusion Therapy Billing Example
Non-Specialty pharmacy home infusion agents and supplies are billed electronically or on a UB-04 claims form with the skilled nursing visits when the member is under a plan of treatment and the BCBSIL Coordinated Home Care benefit.

The first billing example on the following page demonstrates the method used to bill home care nursing visits and the non-speciality pharmacy IV medication and supplies utilized in administering the drug during the nursing visits.

The second and third billing examples demonstrate the method used when the home infusion provider is acting as the supplier of the infusion agents and supplies only (i.e., not under the Coordinated Home Care benefit.)

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Start Date</th>
<th>End Date</th>
<th>Amount</th>
</tr>
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<tbody>
<tr>
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<td>Vancomycin</td>
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<td></td>
<td>48</td>
</tr>
<tr>
<td>264</td>
<td>IV Periact</td>
<td></td>
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<td>14</td>
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<td>SN Visits</td>
<td>01/03/14</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>551</td>
<td>SN Visits</td>
<td>01/04/14</td>
<td></td>
<td>1</td>
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<td></td>
<td>1</td>
</tr>
<tr>
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<td>SN Visits</td>
<td>01/09/14</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>551</td>
<td>SN Visits</td>
<td>01/11/14</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Total: $2,609.00