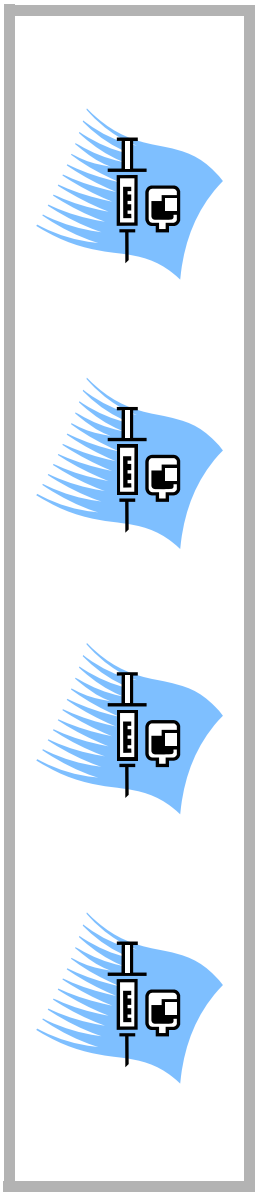

Home Infusion Therapy Services

Medicaid and Other Medical Assistance Programs

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

September 2014

This publication supersedes all previous Home Infusion Therapy Service handbooks. Published by the Montana Department of Public Health & Human Services, June 2004.

Updated May 2008, April 2012, and September 2014.

CPT codes, descriptions, and other data only are copyright American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.

My NPI:

Table of Contents

Key Contacts and Key Websites **ii.1**

Key Websites **ii.2**

Introduction **1.1**
- Manual Organization 1.1
- Manual Maintenance 1.1
- Rule References 1.1
- Claims Review (MCA 53-6-111, ARM 37.85.406) 1.2
- Getting Questions Answered 1.2
- Other Department Programs 1.2

Covered Services **2.1**
- General Coverage Principles 2.1
  - Services within Scope of Practice (ARM 37.85.401) 2.1
  - Licensing (ARM 37.86.1502 and ARM 37.85.402) 2.1
  - Services for Children (ARM 37.86.2201–2221) 2.1
- Non-Covered Services (ARM 37.85.207) 2.2
  - Verifying Coverage 2.2
- Items Included in the Medicaid Rate 2.2
- Coverage of Specific Services 2.4

Prior Authorization **3.1**
- Prior Authorization Requirements 3.1
- Prior Authorization for Retroactively Eligible Members 3.2

Coordination of Benefits **4.1**
- When Members Have Other Coverage 4.1
- When a Member Has Medicare 4.1
  - Medicare Part B Crossover Claims 4.1

Billing Procedures **5.1**
- Claim Forms 5.1
- Member Cost Sharing (ARM 37.85.204) 5.1
- Coding Tips 5.2
- Using the Medicaid Fee Schedule 5.2
- Using Modifiers 5.2
- Per Diem Rate and Units 5.3
- Billing Tips for Specific Providers 5.3
  - Home Health Agency 5.3
  - Home Infusion Therapy Agency 5.3
  - Pharmacy Providers 5.4

Montana Department of Public Health and Human Services

How Payment Is Calculated 6.1
Overview 6.1
How Cost Sharing is Calculated on Medicaid Claims 6.1
How Payment Is Calculated on TPL Claims 6.1
How Payment Is Calculated on Medicare Crossover Claims 6.1
Other Factors That May Affect Payment 6.2

Appendix A A.1

Definitions and Acronyms B.1

Index C.1

Montana Department of Public Health and Human Services

Key Contacts and Key Websites

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In-state" will not work outside Montana. For additional contacts and websites, see the Contact Us link on the Provider Information website.

Licensure Bureau

406-444-2676 Phone
406-444-1742 Fax

Quality Assurance Division
DPHHS
2401 Colonial Drive, 2nd Floor
P.O. Box 202953
Helena, MT 59620-2953

Prior Authorization

For prior authorization requests or for authorization for therapy requests not included in the Medicaid fee schedule:

800-395-7961
406-443-6002 Helena

Mail backup documentation to:
Mountain-Pacific Quality Health
3404 Cooney Drive
Helena, MT 59602

Fax backup documentation to:
800-294-1350
406-513-1928 Helena

Key Websites

Web Address	Information Available
Health Resources Division http://dphhs.mt.gov/hrd	The Health Resources Division (HRD) administers Medicaid Physician, Acute and Hospital/Clinic healthcare services for low-income and disabled Montanans and oversees the benefits of the Healthy Montana Kids plan. HRD provides administration, policy development, and reimbursement for primary and acute portions of the Medicaid program.
Medicaid Mental Health and Mental Health Services Plan (MHSP) http://dphhs.mt.gov/amdd/Mentalhealthservices	Mental health services information for Medicaid and MHSP.

Introduction

Thank you for your willingness to serve members of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rules are available on the Provider Information website. Paper copies of rules are available through the Secretary of State's office.

Providers are responsible for knowing and following current laws and regulations.

In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to the home infusion therapy program:

- Code of Federal Regulations (CFR)
  - 42 CFR 440.70
- Social Security Act (USC)
  - 42 USC 1396r – 8(G)
- Montana Codes Annotated (MCA)
  - MCA 50-5-101 – 50-5-213, 17-6-103
- Administrative Rules of Montana (ARM)
  - ARM 37.86.1501 – 37.86.1506 Home Infusion Therapy
  - ARM 37.106.2401 – 2433 Home Infusion Therapy Agency

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims that it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. The Department performs periodic retrospective reviews, which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Manual Organization

This manual provides information specifically for providers of **home infusion therapy services**. Additional essential information for providers is in the separate *General Information for Providers* manual. Each provider is asked to review both manuals.

A table of contents and an index allow you to quickly find answers to most questions. For a list of key contacts and key websites, see the previous chapter and the Contact Us link on the Provider Information website. The margins contain important notes with extra space for writing notes. We have also included a space on the back side of the front cover to record your National Provider Identifier (NPI) for quick reference when calling Provider Relations.

Manual Maintenance

In order to remain accurate, manuals must be kept current. Changes to manuals are provided through provider notices and replacement pages, which are posted on the Provider Information website. When replacing a page in a paper manual, file the old pages and provider notices in the back of the manual for use with claims that originated under the old policy.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a prior authorization contractor or Provider Relations). For a list of key contacts and key websites, see the previous chapter and the Contact Us link on the Provider Information website. Medicaid manuals, provider notices, replacement pages, fee schedules, forms, and more are available on the Provider Information website.

Other Department Programs

The Medicaid home infusion services in this manual are not benefits of the Mental Health Services Plan (MHSP), so the information in this manual does not apply to the MSHP program. For more information on the MHSP program, see the mental health manual available on the Provider Information website.

The Medicaid home infusion services in this manual are not covered benefits of Healthy Montana Kids (HMK)/CHIP. Additional information regarding HMK/CHIP benefits is available by contacting Blue Cross and Blue Shield of Montana at 1-877-543-7669, or by visiting the HMK website.

Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services provided by home infusion therapy providers. Like all healthcare services received by Medicaid members, services rendered by these providers must also meet the general requirements listed in the *General Information for Providers* manual, Provider Requirements chapter. Home infusion therapy services are covered for members with Basic Medicaid coverage. (See the Medicaid Covered Services chapter of the *General Information for Providers* manual.)

Home infusion therapy is a comprehensive treatment program of pharmaceutical products and clinical support services provided to members who are living in their home, a nursing facility, or any setting other than a hospital. A physician's authorization (prescription) for home infusion therapy allows Medicaid members to avoid or leave the hospital care setting and receive medical care at home. Under the guidance of the member's physician, the licensed home infusion therapy provider develops and implements a treatment program to meet the particular requirements of the member.

Services within Scope of Practice (ARM 37.85.401)

Services are covered only when they are within the scope of the provider's license.

Licensing (ARM 37.86.1502 and ARM 37.85.402)

Home infusion therapy providers must be licensed under Montana's healthcare service licensing laws. To obtain licensing requirements and procedures, contact the DPHHS Health Care Facility Licensure Bureau. (See Key Contacts.) A provider must be enrolled with Montana Medicaid as a home infusion therapy provider. Providers who are also providing pharmacy services must enroll with Montana Medicaid as a pharmacy provider.

Services for Children (ARM 37.86.2201–2221)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a comprehensive approach to healthcare for Medicaid members ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid-eligible children may receive any medically necessary covered service, including all home infusion therapy services described in this manual. All applicable Passport to Health and prior authorization requirements apply.

Non-Covered Services (ARM 37.85.207)

Medicaid does not cover the following services:

The Department determines which therapies are allowed as home infusion therapy services in consultation with the Department's Drug Use Review Board.

- Medications which can be appropriately administered orally, through intramuscular or subcutaneous injection, or through inhalation;
- Drug products that are not FDA-approved or whose use in the non-hospital setting present an unreasonable health risk to the member; or
- Services provided to Medicaid members who are absent from the state, with the following exceptions:
  - Medical emergency.
  - Required medical services are not available in Montana. Prior authorization may be required. See the Passport to Health Program chapter in the *General Information for Providers* manual.
  - If the Department has determined that the general practice for members in a particular area of Montana is to use providers in another state.
  - When out-of-state medical services and all related expenses are less costly than in-state services.
  - When Montana makes adoption assistance or foster care maintenance payments for a member who is a child residing in another state.

Verifying Coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in this chapter and in the Provider Requirements chapter of the *General Information for Providers* manual. Use the fee schedule in conjunction with the detailed coding descriptions listed in the CPT and HCPCS Level II diagnosis coding books. Use the fee schedule and coding books that pertain to the date of service.

Fee schedules are available on the Provider Information website.

Items Included in the Medicaid Rate

The following products and services are included in Medicaid's per diem rate for home infusion therapy services. These items may not be billed separately to Medicaid. Each per diem represents a 24-hour period.

- All business, overhead, and operational expenses.
- Home infusion therapy agency staff service.
  - Case management activities including coordination of treatment with other healthcare providers.
  - Coordination of benefits, care, and services.
  - Development of member assessment and member education materials.
  - Development and monitoring of nursing care plans.

- Coordination of education, training, and competency of field nursing staff (or sub-contracted agencies).
- Comprehensive 24/7 delivery and pick-up services. Includes 24/7 availability of a dedicated infusion team consisting of pharmacists, nurses, and all other medical professionals responsible for clinical response, problem solving, troubleshooting, question answering, and other professional duties.
- Any other services provided by the agency staff related to the member's home infusion.
- Infusion therapy equipment and supplies including, but not limited to, the following:
  - Infusion therapy administration devices (e.g., durable, reusable infusion pumps and elastomeric, disposable infusion pumps).
  - Needles, gauze, sterile tubing, catheters, dressing kits, and other supplies necessary for the safe and effective administration of infusion therapy.
  - Infusion access devices both short peripheral vascular devices and subcutaneous access devices, excluding peripherally inserted central catheter (PICC) lines, midlines, and other centrally placed lines.
  - Other applicable supply expenses.
  - Pharmacist professional services.
  - Development and implementation of pharmaceutical care plans.
  - Coordination of care with physicians, nurses, members, member's family, other providers, and other caregivers.
  - Patient/caregiver education.
  - Sterile procedures, including preparation and compounding of infusion medications, clean room upkeep, vertical and horizontal laminar flow hood certification and all other biomedical procedures necessary for a safe environment.
  - Initial and ongoing member assessment and clinical monitoring to include but not limited to:
    - Medication and dosage changes based upon clinical findings.
    - Pharmacokinetic dosing.
    - Monitoring of potential drug interactions.
    - Medication profile setup.
    - Recommend appropriate laboratory monitoring.
    - Review and interpretation of laboratory values and therapy progression and reporting clinical information to the member's physician and other healthcare providers.
  - 24/7 call status.

Montana Department of Public Health and Human Services

Coverage of Specific Services

The Montana Medicaid Home Infusion Therapy program covers all of the drugs used in covered therapies as described in this section. All covered drugs shall be used within the FDA-approval or standard of practice. Any drug outside of these areas may require literature support and Drug Use Review (DUR) Board review. For requests not found here, contact the Prior Authorization Unit. (See Key Contacts.)

Professional physician and nursing services provided in the physician's office are to be billed to Medicaid by those providers, not the home infusion therapy provider. Nursing services provided by licensed nurses employed by the home infusion therapy agency will be reimbursed to the agency as specified in the home infusion therapy fee schedule. Home nursing services for infusion/specialty drug administration are not billable when the home infusion therapy program is provided in a skilled nursing facility.

The following table lists home infusion therapy covered services, criteria, and whether the service requires prior authorization. (See the Prior Authorization chapter in this manual.) All covered drugs, solutions, or durable medical equipment (DME) which are not included in the per diem are billed separately by the pharmacy or DME provider unless otherwise stated.

Home Infusion Therapy Covered Services

Service	Criteria	PA
Alpha 1 proteinase inhibitor	Treatment of congenital alpha-1 antitrypsin deficiency. Infusion pump is always required.	Y
Anticoagulant therapy	Continuous anticoagulant infusion therapy (e.g., heparin). Low molecular weight heparin is not covered as an infusion therapy.	Y
Antiemetic therapy	Intermittent or continuous IV infusion of antiemetic therapy that prevents or alleviates intractable nausea and vomiting.	Y
Anti-infective therapy	Intravenous administration of antibacterial, antiviral or antifungal medications appropriately constituted and admixed with an IV solution. Treatment normally requires an infusion pump, especially if more than one anti-infective is being infused or if prescribed for a pediatric member.	Y
Antispasmodic therapy	Infusion of antispasmodic agents, which prevents or alleviates muscle spasms. Typically this requires an infusion pump.	Y
Anti-tumor necrosis factor	Infusion of anti-tumor necrosis factor-alpha for an FDA-approved use. Typically this therapy requires an infusion pump.	Y
Catheter care	Occasionally a member will require care of a catheter other than simple flushing supplies, which the member shall complete independently. Covered catheter care shall include catheter declotting and catheter repair supply kit. Simple maintenance flushing of a catheter shall not be routinely covered under a per diem procedure; extenuating circumstances may be negotiated with the Prior Authorization Unit.	N

Home Infusion Therapy Covered Services (Continued)

Service	Criteria	PA
Chelation (desferal therapy)	Therapy that is used parenterally to reduce the iron stored in the body in members with hemochromatosis, acute iron poisoning, or abnormal storage of iron due to multiple blood transfusions.	Y

Chemotherapy	• Antineoplastic/cytotoxic agents. Any agent that destroys or prevents the development, growth or proliferation of malignant cells. This group of compounds is most often used in cancer chemotherapy.
	• Other drugs used for the treatment of a cancer diagnosis must meet one of the following criteria in order to be presented for review by the DUR Board:
	  • The drug must be FDA-approved for the diagnosis.
	  • The drug must be standard of practice for treatment of the diagnosis.
	• Parenteral administration of antineoplastic medications appropriately reconstituted and possibly admixed with an IV solution and requiring cytotoxic precautions in preparation, administration, and disposal of supplies.
	• Often requires an infusion pump or specialized delivery system.
	• Continuous administration is defined as that which occurs without interruption over a period of 24 hours or more. Intermittent administration is for chemotherapy administered for a period of less than 24 hours.
		Y

Corticosteroid therapy	Anti-inflammatory treatment with various steroid hormones used to control acute or chronic symptoms such as those of multiple sclerosis.	N
Epoprostenol therapy	Intravenous administration of epoprostenol therapy for the treatment of pulmonary hypertension. Always requires an infusion pump.	N
Hydration	• Parenteral administration of combinations of dextrose or its derivative and/or saline solution, or lactated ringer's solution and possibly electrolytes to correct or prevent dehydration. • Treatment may require an infusion pump.	N
Immunomodulating agents	Treatment involving the modification of the functioning of the immune system by the action of a substance that increases or reduces the ability to produce antibodies.	Y
Inotropic agents	• Intravenous administration of sympathomimetic/inotropic (e.g., dobutamine) medications to improve cardiac performance. • Therapy requires the use of an infusion pump due to the potential for adverse cardiac effects.	Y
Pain management	• Intravenous or subcutaneous administration of narcotic analgesics admixed in IV solutions with individualized dosage units and delivery systems per member-specific needs. • Always requires an infusion pump. • The fee applies regardless of the method of delivery or the number of cassettes used per week.	Y
Tocolytic therapy (preterm labor prevention)	Subcutaneous or intravenous administration of tocolytic drugs for prevention and control of preterm uterine contractions.	N

Montana Department of Public Health and Human Services

Montana Department of Public Health and Human Services

Home Infusion Therapy Covered Services (Continued)

Service	Criteria	PA

Total parenteral nutrition (TPN)	• Providing complete nutritional requirements intravenously by carefully controlling the composition of fluid given with respect to total calories derived from protein hydrolysate and dextrose, as well as fats, electrolytes, minerals, and vitamins.
	• Any IV solution including amino acids and one or more non-protein sources of calories plus electrolytes, minerals, vitamins, insulin, or other medications for a member who is unable to take or absorb food orally. Always requires an infusion pump.
	• The basic parenteral nutrition solution containing standard TPN elements as defined below are included in the per diem rate:
	  • Non-specialty amino acids
	  • Concentrated dextrose solutions
	  • Sterile water
	  • Electrolytes (e.g., CaCl2, KCL, KPO4, MgSo4, NaAc, NaCl, NaPO4)
	  • Standard multi-trace element solutions
	  • Standard multivitamin solutions
	  • Insulin
	• **Not included in the TPN per diem** are the following items to be coded separately:
	  • Specialty amino acids for renal failure; hepatic failure; high-stress conditions; with concentrations of 15% or more when medically necessary for fluid restricted members
	  • Lipids
	  • Added trace elements not from a standard multi-trace solution
	  • Added vitamins not from a standard multivitamin solution
	  • Products serving non-nutritional purposes (e.g., other drugs, heparin, H2 antagonists)
		Y

Other infusion therapies	Anticipating that new infusion therapies will be developed or that a current therapy has been overlooked, the Department will consider authorization of other therapies on an individual basis. These special requests may require literature documentation, peer review, and review by the DUR Board. In addition, the request will require cost information for setting a per diem rate. Contact the Prior Authorization Unit. (See Key Contacts.)	Y

Prior Authorization

Prior Authorization Requirements

Many services require prior authorization **before** they may be provided. These requirements have been established after consultation with the Department's DUR Board. Criteria listed for each therapy are derived from reviews completed by the University of Montana's School of Pharmacy and approved by the DUR Board. Prior Authorization requests are reviewed for medical necessity. When seeking prior authorization, keep in mind the following:

- Prior authorization does not guarantee payment.
- Always refer to the current Medicaid fee schedule to verify if prior authorization is required for specific services. The table on the following page, Prior Authorization Criteria for Specific Services, lists services that require prior authorization and the corresponding criteria.
- Remember to bill for only the number of units that were prior authorized.
- To request prior authorization, providers must submit the information requested on the Mountain-Pacific Quality Health Request for Drug Prior Authorization form to the Prior Authorization Unit. This form is available on the Forms page of the Provider Information website.
- Physicians, home infusion therapy providers, or pharmacy providers may submit prior authorization requests by mail, telephone, or fax to the Prior Authorization Unit.
- Requests are reviewed and decisions made immediately in most cases. Decisions on requests with special circumstances that require further peer review are made within 24 hours. Requests received after the Prior Authorization Unit's regular working hours of 8 a.m. to 5 p.m. Monday through Friday or on weekends or holidays are considered received at the start of the next working day.
- If the weekend/holiday request is for an emergency situation, providers may supply therapies shown on the Medicaid fee schedule and payment will be authorized up to a maximum of 3 days. Medicaid may routinely audit these emergency authorizations for validity and appropriateness. Therapies in the "other infusion therapies" category will not be authorized on an emergency basis. Provider who are billing point-of-sale should refer to the *Prescription Drug Program* manual when billing for emergency therapies.
- The Prior Authorization Unit notifies the provider when prior authorization has been granted or denied. Upon approval, providers will receive a prior authorization number that must be recorded on the claim.

Prior Authorization for Retroactively Eligible Members

When submitting claims for retroactively eligible members in which the date of service is more than 12 months earlier than the date the claim is submitted, attach a copy of the Provider Notice of Eligibility (Form 160-M). To obtain Form 160-M the provider needs to contact the member's local Office of Public Assistance and request the form. For a list of local Offices of Public Assistance, see the DPHHS website, http://dphhs.mt.gov/hcsd/OfficeofPublicAssistance.

Montana Department of Public Health and Human Services

Prior Authorization Criteria for Specific Services

Service	Criteria
Alpha 1 proteinase inhibitor (Prolastin)	Alpha 1 antitrypsin deficiency must be documented via laboratory information.
Anticoagulant therapy	• Member must not be a candidate for low molecular weight heparin therapy, either due to therapy failure, member status, or diagnosis. • A plan for oral therapy must be submitted, if appropriate.
Antiemetic therapy	Member must have failed all other forms of antiemetic therapy including oral, rectal, and intermittent subcutaneous injection.
Anti-infective therapy (antibiotics/antifungals/antivirals)	• IV antibiotic therapy for two weeks or less will be authorized upon request. • IV antibiotic therapy for more than two weeks will be considered on an individual basis depending on diagnosis and member condition. • IV antibiotic therapy using IV fluoroquinolones or metronidazole has not been found to have any therapeutic advantage over oral therapies and also requires prior authorization.
Antispasmodic therapy	Member must have failed oral forms of antispasmodic therapy.
Anti-tumor necrosis factor (Remicaid)	The indication must be FDA-approved or have good published studies supporting the indication for use.
Chemotherapy	• The indication must be FDA-approved or have good published studies supporting the indication for use. • The drugs must not be considered vesicants, which cause severe local necrosis (tissue damage) and should not be given in the home; extravasation (leaking out of the vein into local tissue) needs to be recognized and treated immediately. Too dangerous a side-effect for the home administration.
Chelation (desferal therapy)	Documentation of hemochromatosis, acute iron poisoning, or abnormal storage of iron due to multiple blood transfusions.

Prior Authorization Criteria for Specific Services

Service	Criteria

Immunomodulating agents	• Prior authorization is required for the use of any intravenous immunoglobulin (IVIG) products.
	• Must be a diagnosis of one of the following:
	  • Primary immunodeficiency disorders with a history of recurrent infections
	  • Idiopathic thrombocytopenic purpura (ITP):
	  • Children with newly diagnosed ITP who are not a risk for serious hemorrhage
	  • Chronic ITP
	  • Adult-onset ITP in those members who do not respond to initial corticosteroid therapy
	  • Allogeneic bone marrow transplantation
	  • Symptomatic pediatric HIV infection and CD4 lymphocyte count greater than 200
	  • Chronic lymphocytic leukemia with a history of at least one serious bacterial infection
	  • Guillain-Barre syndrome
	  • Kawasaki syndrome

Inotropic agents (dobutamine therapy)	Must be a diagnosis of chronic refractory CHF which meets these criteria: • Member shows no clinical improvement (FC-III or FC-IV) despite treatment with maximum or near-maximum tolerated doses of standard oral therapy for CHF (unless allergic or intolerant). • Member is clinically stable on the dosage to be administered at home prior to discharge from the hospital. • Member demonstrates either an improvement in FC from IV to III or an improvement in symptoms (less dyspnea, improved diuresis, improved renal function, and/or reduction in weight) and hemodynamic parameters (at least 20 percent increase in cardiac output, decreased pulmonary artery pressure, and/or a decrease in pulmonary capillary wedge pressure, measured invasively within six months prior to the initiation of therapy). • Member demonstrates a clinical dependence on the inotrope as evidenced by deterioration in clinical status when the drug is tapered or discontinued.
Pain management	• All other forms of pain therapy must have failed, including but not limited to oral, sublingual, rectal, or topical. • The member must not be a candidate for or member of hospice services.

Montana Department of Public Health and Human Services

Montana Department of Public Health and Human Services

Prior Authorization Criteria for Specific Services

Service	Criteria

Total parenteral nutrition (TPN)	• Recertification is required at 3 months, 9 months, and 24 months after the initiation of therapy. After 2 years, authorization will be determined on a case-by-case basis. If, at any time, there is a break in service to the member of two consecutive months, the entire review process will begin again.
	• Members must meet the following criteria:
	  • A member must be unable to meet nutrient requirements via the GI tract safely and adequately. Adequate nutrition cannot be completely possible by dietary adjustment, oral supplements, or tube enteral nutrition.
	  • The member's GI tract must be severely diseased, preventing absorption of adequate nutrients to maintain weight and strength consistent with the member's overall status. TPN must be necessary to sustain the member's life. Examples of conditions and/or functional impairments that may qualify for coverage include, but are not limited to:
	  • Massive small bowel resection
	  • Crohn's disease
	  • Sprue disease
	  • Short bowel syndrome
	  • Radiation enteritis
	  • Malabsorption documented by a physician
	  • GI tract mechanical obstruction
	  • A total caloric intake of 20–35 kcal/kg (of ideal body weight)/day constitutes nutritional dependence.
	  • Peripheral parenteral nutrition may be used in selected members to provide partial or total nutrition support for up to 2 weeks in members who cannot ingest or absorb adequate oral or enteral tube-delivered nutrients, or when central-vein parenteral nutrition is not feasible.
	  • The member should not have pulmonary edema, congestive heart failure (New York Heart Association Functional Class 3 or 4), or any other medical condition that would increase the risk of home administration.
	  • Central-vein parenteral nutrition support, including support via a PICC line, is provided when parenteral feeding is indicated for longer than 2 weeks, peripheral venous access is limited, or nutrient needs are large or fluid restriction is required.

Other therapies	Anticipating that new infusion therapies will be developed or that a current therapy has been overlooked, the Department will consider authorization of other therapies on an individual basis. These special requests may require literature documentation, peer review, as well as review by the DUR Board. In addition, the request will require cost information for setting a per diem rate. Contact the Prior Authorization Unit. See Key Contacts.

Coordination of Benefits

When Members Have Other Coverage

Medicaid members often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers should bill other carriers before billing Medicaid, but there are some exceptions. (See Exceptions to Billing Third Party First in the *General Information for Providers* manual.) **Please note that Medicare is processed differently than other sources of coverage.** For additional information on what to do when a member has TPL, see the section titled When a Member Has TPL (ARM 37.85.407) in the *General Information for Providers* manual.

When a Member Has Medicare

Medicare claims are processed and paid differently than other non-Medicaid claims. The other sources of coverage are called third party liability (TPL), but Medicare is not.

Medicare Part B Crossover Claims

Home infusion therapy services may be covered under Medicare Part B. The Department has an agreement with the Medicare Part B carriers for Montana (Noridian) and the Durable Medical Equipment Regional Carrier (DMERC) under which the carriers provide the Department with a magnetic tape of CMS-1500 claims for members who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically and must have their Medicare provider number on file with Medicaid.

When members have both Medicare and Medicaid covered claims, and have made arrangements with Medicare and Medicaid, Part B services need not be submitted to Medicaid. When a crossover claim is submitted only to Medicare, Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit. (See the Billing Procedures chapter in this manual.)

Submit Medicare Part B crossover claims to Medicaid only when necessary.

All Part B crossover claims submitted to Medicaid before the 45-day Medicare response time will be returned to the provider.

Providers should submit Medicare crossover claims to Medicaid only when:

- The referral to Medicaid statement is missing. In this case, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- The referral to Medicaid statement is present, but you do not hear from Medicaid within 45 days of receiving the Medicare EOMB. Submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- Medicare denies the claim, you may submit the claim to Medicaid with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

When submitting electronic claims with paper attachments, see the Billing Electronically with Paper Attachments section of the Submitting a Claim chapter in this manual.

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the NPI and Medicaid member ID number. It is the provider's responsibility to follow-up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit. (See the Billing Procedures chapter in this manual.)

Montana Department of Public Health and Human Services

Billing Procedures

Claim Forms

Services provided by the healthcare professionals covered in this manual must be billed either electronically or on a CMS-1500 claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Member Cost Sharing (ARM 37.85.204)

Cost sharing fees are a set dollar amount per visit based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. Cost sharing for home infusion therapy services is $5.00 per visit **or span**. When providing therapy over a span of several days, cost sharing is assessed once for the time span for each different therapy provided. For example, if a member is receiving pain management (S9326) and anti-infective therapy (S9500) once a day for 15 days, a $10.00 cost sharing fee will be charged. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for the following services is shown below.

The following members are exempt from cost sharing:

- Members under 21 years of age.
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed).
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid members who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.
- IHS members who have ever been seen in an IHS facility.

A provider cannot deny services to a Medicaid member because the member cannot pay cost sharing fees at the time services are rendered. However, the member's inability to pay cost sharing fees when services are rendered does not lessen the member's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid members, that same policy may be used for Medicaid members. A provider may sever the relationship with a member who has unpaid cost sharing obligation, as long as a consistent policy is followed with Medicaid and non-Medicaid members. Once the relationship is severed, with prior notice to the member either verbally or in writing, the provider may refuse to serve the member.

Coding Tips

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use the correct CPT, HCPCS Level II, and ICD diagnosis coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use the correct "units" measurement on the claim. See Per Diem Rates and Units in this chapter.

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the CPT and HCPCS Level II coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers and prior authorization indicators. Fee schedules are available on the Provider Information website.

Using Modifiers

- Review the guidelines for using modifiers in the CPT, HCPCS Level II, or other helpful resource.
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes three pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- Modifiers SH and SJ must be used when billing for multiple concurrent therapies. The per diem rate of multiple concurrent therapies are discounted 20% off the per diem rate for the second concurrently administered therapy and 25% for the third or more concurrently administered therapy. The discounts may be applied to the lower cost therapy.
- Use modifier **SH** for the second concurrently administered therapy.
- Use **SJ** for the third or more concurrently administered therapy.
- Use SS to indicate when home infusion services are provided in the infusion suite of the IV therapy provider.

Per Diem Rate and Units

The term "per diem" represents each day that a member is provided access to a prescribed therapy, beginning the day therapy is initiated and ending with the day the therapy is permanently discontinued. Each day represents a 24-hour period. The expected course and duration of therapy is determined by the plan of care as prescribed by the ordering physician with pharmacist evaluation.

The number of units billed represents a 24-hour period. When a prescription is written in a number of doses, per diem units are calculated by dividing the total prescribed doses by the daily dosing schedule rounded **up to the nearest day**.

When dosing is given less frequently than every 24 hours (e.g., 48 or 72 hours), the per diem unit count starts with dose 1 and ends with the last dose counting only days in which the therapy was provided.

Billing Tips for Specific Providers

Home Health Agency

Nursing services provided by a Medicaid-enrolled home health agency must be billed by that agency and not by the home infusion therapy provider. Nursing services are billed in accordance with home health program procedures. (See the Home Health Services manual.)

Home Infusion Therapy Agency

Nursing services provided by licensed nurses employed by the home infusion therapy agency will be reimbursed to the agency as specified in the home infusion therapy fee schedule. Home nursing services for infusion/specialty drug administration are not billable when the home infusion therapy program is provided in a skilled nursing facility.

Agencies must use the following codes for billing Medicaid for home infusion therapy services provided by a registered nurse employed by the agency. Passport provider approval is required for these services. See the Passport to Health Program chapter in the *General Information for Providers* manual.

Home Infusion Therapy Nursing Codes	
99601	Home infusion, specialty drug administration, per visit up to 2 hours
99602	Home infusion, specialty drug administration, each additional hour

Providers are responsible for maintaining documentation to support all nursing services billed. The Quality Assurance Division periodical verifies billed nursing services.

Montana Department of Public Health and Human Services

Pharmacy Providers

All pharmaceuticals associated with the delivery of an infusion therapy are billed through the pharmacy program using the individual product National Drug Code (NDC). Pharmacy providers that are also Medicaid-enrolled home infusion therapy services providers should refer to the *Prescription Drug Program* manual for billing instructions.

Montana Department of Public Health and Human Services

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims. These examples are for the July 1, 2013 fee schedule and may not apply at other times.

How Cost Sharing is Calculated on Medicaid Claims

Member cost sharing for home infusion therapy services is $5.00 per visit. (See the Billing Procedures chapter, Member Cost Sharing). The member's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount. (See the Remittance Advices and Adjustments chapter in the *General Information for Providers* manual.) For example, a home infusion therapy provider visits a member and provides one unit of TPN therapy (S9365) every day for 15 days. This services is billed as 15 units during a 15-day span, and one $5.00 cost sharing fee is deducted.

Many Medicaid payment methods are based on Medicare, but there are differences. In these cases, the Medicaid method prevails.

How Payment Is Calculated on TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability (TPL). In these cases, the other insurance is the primary payer (as described in the Coordination of Benefits chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, a member receives 30 units of antiemetic therapy (S9351) and 30 days of pain management therapy (S9327) during a 30-day period. The third party insurance is billed first and pays $5,000.00. The Medicaid allowed amount for these services totals $6,900.00. The amount the insurance paid ($5,000.00) is subtracted from the Medicaid allowed amount ($6,900.00), leaving a balance of $1,900.00, which Medicaid will pay if all prior authorization criteria is satisfied.

How Payment Is Calculated on Medicare Crossover Claims

When a member has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the Coordination of Benefits chapter of this manual. Medicaid then makes a payment as the secondary payer. For home infusion services covered in this manual, Medicaid's payment is calculated so that the total payment is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called *lower of* pricing.

Montana Department of Public Health and Human Services

Other Factors That May Affect Payment

When Medicaid payment differs from the fee schedule, consider the following:

- The Department pays the lower of the established Medicaid fee or the provider's charge
- Modifiers SH and SJ reduce payment on multiple concurrent therapies.
- The member may have an incurment amount that must be met before Medicaid will pay for services. (See the Coverage for the Medically Needy section in the Member Eligibility and Responsibilities chapter of the *General Information for Providers* manual.)
- Date of service; fees for services may change over time.
- Cost sharing, Medicare, and/or TPL payments, which are shown on the remittance advice.

Appendix A

These forms are available on the Forms page of the Provider Information website.

- Request for Medicaid Home Infusion Therapy Authorization
- Individual Adjustment Request
- Paperwork Attachment Cover Sheet

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms specific to this provider type. For additional definitions and acronyms, click the Definitions and Acronyms link in the menu on the left of the Provider Information website.

Bolus
A small volume of drug, which is administered directly into the vein, usually over a time period of 3–5 minutes.

Continuous
A controlled method of prolonged drug administration that includes the ability to control the delivery rate. This system permits the drug to be available to the body at a constant level.

Infusion
A parenteral solution administered intravenously or subcutaneously over an extended period of time. Typically requires an infusion pump, but may be accomplished by gravity feed.

Infusion Device/Infusion Pump
Electronic or mechanical device designed to provide continuous, intermittent, circadian, cyclical and/or bolus delivery of medications or nutrients via parenteral. Infusion pumps are generally considered to be closed systems, which helps to prevent inadvertent contact with sterile solutions. Infusion devices may be disposable or reusable. All are covered within the per diem.

Intravenous (IV)
Injection of a solution directly into the vein, usually the cephalic or median basilica vein of the arm.

National Drug Code (NDC)
An 11-digit number the manufacturer assigns to a pharmaceutical product and attaches to the product container at the time of packaging that identifies the product's manufacturer, dose form and strength, and package size.

Parenteral
Denoting any medication route other than the alimentary canal, such as intravenous, subcutaneous, intramuscular, or mucosal.

Subcutaneous
Infusion of solutions into the subcutaneous tissue beneath the skin.

Index

A

Acronyms and definitions B.1

B

Billing tips 5.3
Bolus B.1

C

Carrier B.1
Claim forms 5.1
Clean claim B.1
Member cost sharing 5.1
Member/Members
  has Medicare 4.1
  with other insurance 4.1
Code/Coding 5.2
  books 2.2
  conventions 5.2
  for therapy agency 5.3
  suggestions 5.2
Continuous B.1
Cost sharing 5.1
  do not show when billing 5.1
  how calculated 6.1
  members who are exempt 5.1
  services that do not require 5.1
Coverage
  other insurance 4.1
  specific services 2.4
Crossover
  when to submit claims to Medicaid 4.2

D

Definitions and acronyms B.1
drugs, FDA approved 2.4

E

EPSDT 2.1

Montana Department of Public Health and Human Services

Montana Department of Public Health and Human Services

F

Fee schedules, how to use 5.2

G

General coverage principles 2.1

H

Health Resources Division ii.2
Home health agency, billing 5.3
Home infusion therapy agency, billing 5.3

I

Infusion B.1
Infusion device/pump B.1
Insurance, when members have other 4.1
Internal control number (ICN) B.1
Intravenous (IV) B.1
Items Included in the Medicaid Rate 2.2

K

Key websites ii.2

L

Licensing 2.1

M

Medicaid mental health ii.2
Medical coding conventions 5.2
Medical necessity 3.1
Medicare B.1
    member has 4.1
    Part B 4.1
MHSP ii.2
Modifiers 5.2
    informational 5.2
    pricing 5.2

N

National Drug Code (NDC) B.1
Non-Covered Services 2.2

O

Other insurance 4.1

P

Prior authorization criteria for specific services 3.2
Parenteral B.1
Payment
how calculated on Medicare crossover claims 6.1
how calculated on TPL claims 6.1
other factors that may affect 6.2
Per diem
rate and units 5.3
per diem rate, items included in 2.2
Pharmacy providers, billing 5.4
Prior authorization 3.1
special circumstances 3.1
Prior authorization for retroactively eligible members 3.2
Provider notices 1.1

Q

Questions answered 1.2

R

Remittance advice B.1
Replacement pages 1.1

S

Services
for children 2.1
when providers cannot deny 5.1
Services within scope of practice 2.1
Subcutaneous B.1
Suggestions for coding 5.2

U

Units 5.3

W

Websites ii.2

Montana Department of Public Health and Human Services