Priority Health	BILLING POLICY No. 042
HOME INFUSION	
Date of origin: Oct. 7, 2024	**Review dates: 2/2025**

APPLIES TO
All plans

DEFINITION
This policy identifies billing and payment requirements associated with home infusion services. Home infusion therapy is the intravenous administration of medication to patients in their own home or an authorized home infusion facility.

MEDICAL POLICY

- Infusion Services and Equipment (#91414)

See our Provider Manual for site of service restrictions applied for infusion services.

POLICY SPECIFIC INFORMATION
CPT codes 99601 and 99602 are used to report high-tech RN services. These are provided by an RN with special education and training in home administration of drugs via infusion, home administration of specialty drugs, and/or home nursing management of disease state and care management programs. Typical services include evaluation and assessment, education and training for the patient or caregiver, inspection and consultation of aseptic home environment, and catheter insertion.

The per diem “S” codes are used to code the provision of home therapy administration. The per diem includes pharmacy professional and cognitive services, including drug mixture, patient assessment, clinical monitoring and care coordination; infusion-related equipment and supplies; and comprehensive 24 hour per day, seven days per week delivery and pick-up services.

Modifiers
Two situationally used modifiers allow specification of second, third or more therapies provided on the same dates of service:

- **SH**: Second concurrently administered therapy.
- **SJ**: Third or more concurrently administered therapy

RESOURCES

- National Home Infusion Association

DISCLAIMER
Priority Health’s billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member’s benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member’s benefit plan or authorization isn’t being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 13, 2025	Added "Disclaimer" section