Priority Health	BILLING POLICY No. 041
INFUSION SERVICES SUPPLIES	
Effective date: July 15, 2025 **Date of origin: Oct. 7, 2024**	**Review dates: 2/2025, 5/2025, 8/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

This policy identifies billing and payment requirements associated with Infusion services supplies.

MEDICAL POLICY

- Infusion Services and Equipment (#91414) – reference for coverage details

Additional information on site of service restrictions applied for infusion services can be found in our Provider Manual.

POLICY SPECIFIC INFORMATION

- Supply HCPCS codes A4224 and A4225 used with an external infusion pump other than HCPCS code E0784 will be denied as incorrect coding.
- Compounded drugs NOC (J7999) billed with an external infusion pump will be denied.
- Claims for compounded drugs that don't use code Q9977 or J7999 will be denied as incorrect coding.
- Replacement batteries (K0601, K0602, K0603, K0604, K0605) aren't separately payable when billed with a rented infusion pump.
- Claims for codes A4221, A4222 and K0552 must only be used with a non-insulin external infusion pump (E0779, E0780, E0781, E0791 or K0455).
- A4224 describes all necessary supplies used with an external infusion pump (E0784) for the administration of continuous subcutaneous insulin and includes, but isn't limited to, all cannulas, needles, dressings and infusion supplies. Separate billing for any item will be denied as unbundling. Claims for codes A4224 and A4225 must only be used with insulin infusion pumps (E0784).
- Codes A4230 and A4231 aren't valid for claim submission. They're included in code A4224.
- 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
- Thebelow HCPCS codes are used with different types of external infusion pumps. The HCPCS codes listed in the "Associated codes" column should be used with the corresponding "Pump HCPCS code." Claims for supply codes listed in the "Non-associated codes" column will be denied as incorrect coding if they're used with an external infusion pump listed in the "Pump HCPCS code" column of the same line.

Pump HCPCS code	Associated codes	Non-associated codes
E0779	A4221, A4222, K0522*	A4224, A4225

E0780	A4221, A4222	A4224, A4225, K0552
E0781	A4221, A4222	A4224, A4225, K0552
E0748	A4224, A4225, A4238**, A4239**	A4221, A4222, K0552
E0791	A4221, A4222	A4224, A4225, K0552
K0455	A4221, A4222, K0552*	A4224, A4225

**For E0779 and K0455 pumps, either A4222 or K0552 may be billed, but not both.*
***For E0784 pumps, either A4238 or A4239 may be billed if used in conjunction with an integrated adjunctive or non-adjunctive CGM, respectively.*

Professional services:
Professional services include 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 supplier with administration of certain transitional home infusion drugs administered through an item of DME.

Modifiers (HCPCS)

- **EY**: No physician or other licensed health care provider order for this item or service
- **GA**: Waiver of liability statement issued as required by payer policy, individual case
- **GY**: Item or service statutorily excluded or does not meet the definition of any Medicare benefit
- **GZ**: Item or service expected to be denied as not reasonable and necessary
- **JB**: Administered Subcutaneously
- **JK**: One month supply or less of drug or biological
- **JL**: Three month supply of drug or biological
- **JW**: Drug amount discarded/not administered to any patient
- **JZ**: Zero drug amount discarded/not administered to any patient
- **KX**: Requirements specified in the medical policy have been met

Frequency

Code	Frequency allowed
A4230, A4231	31 per month
A4232	60 per month
E0784	1 Per 5 Years; 10 Per 5 Years with Modifier RR
S5498, S5501, S5502	1 Per day
S9338	8 per month
S9351, S9374, S9375, S9376, S9377	210 Per Year
S9490, S9497, S9500, S9501, S9502, S9503, S9504	60 Per 4 Months
S9537	1 Per Day

Documentation requirements

We align with the Centers for Medicare & Medicaid Services (CMS) standard documentation requirements for supplies and DME. Reference CMS Article A55426 – Standard Documentation Requirements for All Claims Submitted to DME MACs for documentation requirements.

RESOURCES

- National Home Infusion Association
- LCD – External Infusion Pumps (L33794) (CMS)

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
May 13, 2025	• Added "Frequency" section • Updated "Applies to" section
Aug. 14, 2025	Added "Professional services" section