CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10883	**Date: August 9, 2021**
	Change Request 12324

SUBJECT: Clarifying Instructions for Billing and Processing Claims with Multiple Units to Indicate the Length of Time Per Home Infusion Therapy Service Visit

I. SUMMARY OF CHANGES: The purpose of this change request is to provide clarifying guidance and claims processing systems changes necessary to properly implement Section 5012(d) of the 21st Century Cures Act, specifically systems requirements when processing claims with multiple units indicating length of time per home infusion therapy service visit. These payments began January 1, 2021.

EFFECTIVE DATE: January 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	32/411/6/CWF and MCS Editing Requirements

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background:

Section 5012(d) of the 21st Century Cures Act (Pub. L 144-255) amended sections

1861(s)(2) and 1861(iii) of the Social Security Act (the Act), requiring the Secretary to establish a new Medicare home infusion therapy services benefit. The Medicare home infusion therapy services 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 benefit), remote monitoring, and monitoring services for the provision of home infusion therapy services and home infusion drugs furnished by a qualified home infusion therapy supplier.

Section 1861(iii)(3)(C) of the Act defines "home infusion drug" as a parenteral drug or biological administered intravenously, or subcutaneously for an administration period of 15 minutes or more, in the home of an individual through a pump that is an item of durable medical equipment (as defined in section 1861(n) of the Act). Such term does not include insulin pump systems or self-administered drugs or biologicals on a self administered drug exclusion list.

Section 1834(u)(1)(A)(ii) of the Act states that a unit of single payment under this payment system is for each infusion drug administration calendar day in the individual's home, and requires the Secretary, as appropriate, to establish single payment amounts for different types of infusion therapy, taking into account variation in utilization of nursing services by therapy type.

Section 1834(u)(1)(A)(iii) of the Act also provides a limitation to the single payment amount, requiring that it shall not exceed the amount determined under the Physician Fee Schedule (under section 1848 of the Act) for infusion therapy services furnished in a calendar day if furnished in a physician office setting.

Section 1834(u)(1)(C) of the Act allows the Secretary discretion to adjust the single payment amount to reflect outlier situations and other factors as the Secretary determines appropriate, in a budget neutral manner.

B. Policy:

As described in the 21st Century Cures Act, a separate payment for home infusion therapy services will be made under the permanent home infusion therapy benefit to qualified home infusion suppliers, effective January 1, 2021.

Home infusion drugs are assigned to three payment categories, as determined by the HCPCS J-code. CMS uses Healthcare Common Procedure Coding System G-codes for the professional service visit furnished on an infusion drug administration calendar day for each payment category. CMS has established a single payment amount for each of the three categories for professional service visits furnished for each infusion drug administration calendar day.

See Attachment A in Change Request (CR) 11880 for detailed descriptions of the Home Infusion Therapy service G-codes, the Time Increments table for reporting multiple units per G-code, the Payment Categories for Home Infusion Therapy Professional Services, and the Payment Categories for Home Infusion Drugs.

Section 1834(u)(1)(A)(ii) of the Act states that a single payment under this payment system is for each infusion drug administration calendar day in the individual's home. 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 and payment category. In the event that multiple drugs, which are not all assigned to the same payment category, are administered on the same infusion drug administration calendar day, a single payment would be made that is equal to the highest payment category. Claims reporting multiple visits (different G-codes) on the same line item date of service will be returned as unprocessable.

When billing for each visit (single G-code), suppliers should report multiple units to identify the visit length in 15-minute time increments (15 minutes = 1 unit). The multiple units per G-code reflect the number of 15-minute increments associated with the home infusion therapy service visit.

Due to an issue with interpretation of CR 11880 requirements, hard-coded the Multi-Carrier System (MCS) 027K audit was denying the entire detail when any visit greater than 1 unit was billed. This CR is being issued to clarify the systems requirements for processing a claim submitted with multiple units of a single visit (G-code).

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12324.1	MCS shall price Home Infusion Therapy service units as '1' on the claim line even if multiple units of a single G-code are reported.						X			
12324.2	MCS shall update audit 027K to allow for multiple units billed on the same claim detail, for example, a single code with multiple units billed on the same claim detail.						X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	CR11880 TDL210397

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cheryl Gilbreath, 410-786-5919 or cheryl.gilbreath@cms.hhs.gov , Yvette Cousar, 410-786-2160 or yvette.cousar@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

411.6 – CWF and MCS Editing Requirements

(Rev. 10883, Issued:08-09-21, Effective:01-01-21, Implementation: 01-03-22)

MCS shall create a new edit to identify when there is more than one of the following six HCPCS 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' with Date of Service on or after 1/1/2021 for the same Date of Service on the same Part B Professional claim.

MCS shall price HIT service unit as '1' on the claim line even if multiple units are reported.

MCS shall update audit 027K to allow for multiple units billed on the same claim detail, for example a single code with multiple units billed on the same claim detail.

CWF shall create a new reject for a Part B Professional claim with one of the following six HCPCS codes 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' with Date of Service on or after 1/1/2021 and there is no DME claim in history with one of the identified J-codes within 30 days prior to the incoming Date of Service.

NOTE: This edit shall have override capability at the claim detail line

CWF and contractors shall recycle 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' claim up to three times for a total of 15 days until a claim containing an allowable drug J-code from above is received with the same line item date of service or within 30 days prior to the line item date of service of the G-code.

CWF shall create a new reject for a Part B Professional claim with one of the following six 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' codes with a Date of Service on or after 1/1/2021 when there is a Part B claim in history with one of the identified six 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' codes for the same Date of Service.

NOTE: This edit shall have override capability at the claim detail line

CWF shall create a new reject for a Part B Professional claim with one of the new 'G0088', 'G0089', or 'G0090' codes and in history is an allowed DME or Part B Professional claim with any of the six 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' codes and the Dates of Service is within 60 days prior to the incoming claim's Dates of Service. The incoming claim has Dates of Service on or after 1/1/2021.

CWF should still subject an incoming Part B Professional claim to the edit if it is within 60 days of posted DME claim, and if the claim in history is DME and has one of the three existing 'G0068', 'G0069' 'G0070' codes and has Dates of Service prior to 1/1/2021.

CWF shall create a new Informational Unsolicited Response (IUR) when a Part B Professional claim or a DME claim with one of the six 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' codes is received and in history is a Part B Professional claim with one of the three new 'G0088', 'G0089', or 'G0090' codes with Dates of Service within 60 days after the incoming claim's Dates of Service.

CWF shall ensure that all new edits and the IUR appear on the ORPN Report.

CWF shall create a new reject claim when a Part B Professional claim with one of the following six HCPCS 'G0068', 'G0069' 'G0070', 'G0088', 'G0089', or 'G0090' and DME claim in history with one of the following not otherwise classified J-codes (J7799 or J7999) within 30 days prior to the incoming Date of Service.

CWF will allow the override of the new reject in the detail line.