**PHARMACY INVOICE AND RECORD OF HOME IV THERAPY (HIT) AND**
**DURABLE MEDICAL EQUIPMENTS/DISPOSABLE MEDICAL SUPPLIES (DME/DMS) DISPENSED**

Maryland Pharmacy Program
Tel#: 410-767-1455 or 1-800-492-5231 Option 3
**(Mail form to OOE, PO Box 2158, Baltimore, MD 21203)**


1. Recipient: _____DOB:_____MA#_____
   Recipient enrollment: □ MCO; □ Medicare Part D; □ Fee-for-Service MA- Body Weight:_____kg
2. List secondary insurance: _____Amount paid by other insurance:$ _____
3. Patient Location: __Residence; __Hospital;__Nursing Home; __ Clinic __Other-Specify:_____
4. Service provider # _____NABP# _____Pharmacy Name:_____Phone #_____
5. Rx: Drug order:_____Attach a copy. Number of drugs used concurrently by infusion:# _____
6. Drug Wastage: _____; Reason: _____
   (Drug wastage allowed only on single dose vials and not multiple dose vials)
7. **Drug Portion** :

□ **Premix/Commercial systems-** All providers: For the one-component premix system, do not bill any diluent- Bill active drug under one Rx#. Diluents may be billed only for the two-component IV systems, ie. AddVantage™ and MiniBagPlus™ systems.

□ **One-component premix system**: Submit with Compound Code "0 or 1". Claim adjudicates on-line.
**Rx# _____DOS:____/_____/_____Drug/strength:**_____
**Dosage**:_____ NDC# :_____**Qty**: _____(ml) -**Days**:____

□ **Two-component premix system:** Submit each component under separate Rx#, using compound code "0 or 1".
**DOS:_____/_____/_____ Drug/Strength**:_____**Dosage**_____
**Active Drug Rx#**_____**Drug**:_____**NDC#**_____**Qty**_____**(**ml)**Days:____**
**Diluent Rx#**: _____**Drug**:_____**NDC#**_____**Qty**_____**(**ml)**Days:_____**

□ **Compounded IV Admixture (non-premix):** Homecare providers:

□ Single active ingredient-Do not bill diluent: List & bill NDC& quantity per batch of active drug, Compound Code 0 or 1, one Rx#, in order to generate a paid claim with a pharmacy fee. Bill supplies HCPC codes under DME.

□ Multi-active ingredients (i.e. TPN & Hydration therapy)- Bill all ingredients including diluents on-line as one Rx#, using Compound Code 2 under the multi-ingredient segment- Claim adjudicates with payment for all ingredients and a pharmacy fee. List all ingredient NDCs below-Use a separate sheet if more space is needed.

**Note**: For nursing home and fee-for-service PAC recipients, refer to billing instructions- Use Compound Code 2 and "99" in the Submission Clarification Field to deny for manual pricing. Submit copy of order(s) with this invoice.

**Rx#:_____Date of Service**: ___/___/_____**# of Doses per Container**:_____ **# containers**: ___D**ays:**____

| Drug Name/strength | NDC | Pkg Size-ea./ml | Qty/container | Qty per batch | Drug Cost | Reimbursement |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

Calculated reimbursement of drug cost per container (manual claims): $_____
Calculated reimbursement of drug cost per batch ( X_____ # of containers) = $_____

8. **Supply Portion** – Check appropriate box for the type of containers billable under either Pharmacy or DME Services.

□ **Bag,** includes IV supplies, IV tubings, diluents, and professional fees:

□ **Premix bag, commercial system, one-component (**ie. Levaquin in D5W**) or two-component system**
(i.e.AddVantage™,Mini-Bag Plus™)- Bill active drug ingredient and diluent bag under the drug portion.

□ A4221 Catheter care supplies- 2 units/week # units: ___Period fr: _____to_____ or/and

□ A4223 Gravity bag, incl.diluents, tubings & supplies & fees, #units:___ DOS:_____ fr_____to_____
The Program allows reimbursement of IV tubings&misc. supplies for administering the drug via this code.

□ E0776- IV pole-□disposable □durable: □Rental DOS: fr_____to_____or □Purchase: DOS:_____

□ **Gravity Bag, for truly compounded IV admixture**, **run by gravity, and not used with external pump**:

□ A4221 Catheter care supplies- 2 units/wk # units :__ _ DOS:_____ fr_____to_____

□ A4223 Gravity bag, incl.diluents, IV tubings & supplies for compounding and administering the drug & fees- applies to bags not used with external pump (i.e. anti-infectives or any therapy infused intermittently over less than 8 hour periods- #units:____ DOS: _____fr:_____to_____

□ Gravity bags for nursing home/fee-for-service PAC recipients at $8.67 ea. x #____ bags = $_____

□ E0776- IV pole- □disposable; □durable: □Rental DOS: fr_____to_____or □Purchase: DOS:_____

**PHARMACY INVOICE AND RECORD OF HOME IV THERAPY (HIT) AND DURABLE MEDICAL EQUIPMENTS/DISPOSABLE MEDICAL SUPPLIES (DME/DMS) DISPENSED**



□ **Bag, IV, for use with external pump,** stationary or ambulatory, portable (ie. Cadd Pump™ or Prism™), for infusion of listed Medicare-approved drugs requiring controlled flow rate over at least an 8-hour period.
- □ A4221 Catheter care supplies- 2 units/wk; # units :____ DOS:_____ fr_____to_____
- □ A4222 Bag & tubing & diluents & batteries & supplies & professional fees, **per bag (and not per day)**- Bill this code for drug requiring controlled rate of infusion with an external pump over at least 8 hr periods. #units:_____DOS: _____/_____/____fr_____to_____Specify drug:_____
- □ Gravity bags for use with external pump- applies to manual claims- @ $8.67 ea X ____# bags = $_____
- □ E0776 IV pole- □disposable; □durable: □ Rental- or □Purchase DOS: from_____to_____
- □ E0781 Ambulatory external pump □ Rental □ Purchase- DOS:_____ fr_____to_____
- □ E0791 Stationary pump- □ Rental □ Purchase- DOS:_____fr_____to_____

□ **Elastomeric or Home Pump-** Includes compounding and administering supplies, diluents and professional fees.
- □ A4221 Supplies for catheter care-2 units/wk; # units :____ DOS:_____fr_____to_____
- □ A4305 Elastomeric pump, tubings & diluents & supplies & fees, flow rate>=50ml/hr- **per home pump- not** per day- # units :_____ DOS_____ fr_____to_____
- □ A4306 Elastomeric pump, tubings & diluents & supplies & fees, flow rate< =5ml/hr- **per home pump- not** per day- # units :_____ DOS:_____fr_____to_____
- □ Elastomeric pump, any flow rate- Manual claims- @ $16.99 ea. X _____#pumps = $_____

□ **Cassette** - Includes compounding and administering supplies, diluents and professional fees.
- □ A4221 Catheter care supplies-2 units/wk; # units :_____ DOS:_____ fr_____to_____
- □ A4222 Cassette & tubing & batteries & supplies & diluents & fees, **per cassette**- i.e. 1 cassette of morphine lasting 7 days should be billed with quantity of 1 and not 7. #units:___ DOS: _____ fr_____to____
- □ Cassette dispensed to nursing home recipients @$26.35/cassette X # ____cassettes = $_____
- □ E0781 Ambulatory pump □ Rental; □ Purchase; DOS:_____ fr_____to_____

□ **Mechanical Syringe for use w. infusion pump&Prefilled Syringe**-Includes diluents/compounding supplies/fees.
- □ A4221 Catheter care supplies-2 unis/wk; # units :___DOS:_____ fr_____to_____
- □ A4213 Syringe, each, sterile, 20 cc or >, with diluents & supplies & fees # units:_____ DOS: _____ fr_____to_____
- □ Mechanical syringe- incl.diluents&supplies (fees added separately) @ $4.29 ea X___#syringes = $_____ Add a dispensing fee of $ 7.25 per day of therapy x # _____days -See below
- □ Prefilled syringe- incl.diluents&supplies (fees added separately) @ $ 0.40 ea. X____# syringe = $_____ Add a dispensing fee, per batch, of $3.69 for brands and $4.69 for generics = $_____
- □ E0779 Ambulatory pump, mechanical, > 8hr infusion # units:_____DOS: _____fr_____to_____
- □ E0780 Ambulatory pump, mechanical, < 8hr infusion #units _____ DOS: _____ fr_____to_____
- □ E0776 IV pole- □disposable; □durable: □Rental; □ Purchase; DOS: from_____to_____

□ **TPN bag**
- □ A4221 Catheter care supplies- 2 units/wk- # units:_____DOS:_____fr_____to_____
- □ B9004 Parenteral nutrition pump, portable-# Unit: __ □ Rental-□ Purchase- DOS_____fr_____to_____
- □ B9006 Parenteral nutrition pump, stationary-# Unit:__ □ Rental-□ Purchase- DOS_____fr_____to_____
- □ B4222 Parenteral nutrition supply kit, homemix (TPN), supplies & diluents & professional fees, per day- # units:_____DOS_____fr:_____to_____-Submit TPN formula.
- □ B4224 Parenteral nutrition administration kit, supplies & tubings & fees, per day # units:_____DOS_____fr:_____to_____
- □ TPN bag supply for nursing home recipients @ $17.10/bag w. electrolytes X #___bags = $_____
- □ E0776 IV pole- □disposable; □durable: □ Rental: □ Purchase- DOS fr_____to_____

□ **Other HCPCS codes**: □ HCPCS_____ □ HCPCS_____ □ HCPCS_____

**Dispensing Fees:** NH/fee-for service PAC only: $7.25/day or per container whichever is less X ___days:$_____

**Total Reimbursement for Manually priced IV Compound Claim:** Rx#_____U/C:$_____ $_____

Specify Rx numbers for listed claims above Rx#_____U/C:$_____ $_____

Rx#:_____ U/C:$_____ $_____

I certify that I have reviewed above charges. They are accurate and complete and reflect the units that were actually dispensed.

Pharmacist's signature (or Billing Manager):_____Title: _____

Full Name: _____Phone #: (_____)-_____-_____ Date: _____/_____/_____

Title: _____ Fax #: (_____)-_____- _____

# INSTRUCTIONS FOR COMPLETION OF THE
## PHARMACY INVOICE AND RECORD
## OF HOME IV THERAPY (HIT) AND DME/DMS SUPPLIES DISPENSED

### RECORDS REQUIREMENTS AND CLAIM SUBMISSION TIME LIMITATIONS

Effective August 1, 2006, the "Pharmacy Invoice and Record of HIT and DMS/DME Supplies Dispensed" must be completed, signed and forwarded to the Program along with an IV order for post-payment review whenever an HIT service is rendered. Verbal orders from the prescriber are acceptable as long as these are taken by a pharmacist who transcribe them into written orders, sign and date them with his/her full name. IV orders should always be written for a specific length of therapy which can be changed (extended or shortened). The order may also be discontinued any time based on the individual patient's clinical condition and response to IV therapy.

The Pharmacy Invoice and Record of HIT and DME/DMS Supplies Dispensed is required for all premix or commercial IV admixtures and compounded IV preparations in order to facilitate the review of all supply HCPCS codes billed under DMS/DME Services and to verify drug quantities billed under Pharmacy Services. Due to the frequent errors in the units billed by providers for the drug portion of the IV admixture, which affects the amount of rebate the State receives from the drug manufacturers, it is mandatory that the form be sent to the Program and kept on file for 6 years as official record of drugs and supplies dispensed by the pharmacy for possible audit by the Program. The form may be downloaded from the following website: www.www.dhmh.state.md.us/mma/mpap.

The time limitation for on-line claim submission is 9 months. The time limitation for submission of the Pharmacy Invoice and Record of HIT and DMS/DME Supplies Dispensed is 60 days from the date of service. The Program reserves the rights to deny or reverse any payments made for any IV claims that do not have a valid invoice or record kept on file. Other causes for claim reversal are gross errors in the quantity of drug or supplies billed or inappropriate prescribing for therapies that are not medically necessary. Providers will be notified of such payment reversals and will be given opportunity for appeal. Providers may appeal the Program's decision by sending the proper supporting documents clarifying the drug NDC and HCPCS codes units billed. Each appeal will be reviewed on a case-per-case basis. Appeals must be made within 60 days of provider notification by the Program of such claim reversals.

**Form to be mailed to: OOE- P.O. Box 2158, Baltimore, MD 21203 along with a copy of the signed IV order.**

**INSTRUCTIONS FOR COMPLETION OF THE**
**PHARMACY INVOICE AND RECORD OF**
**HOME IV THERAPY (HIT) AND DME/DMS SUPPLIES DISPENSED**


**Completion of the Form**: This form must be sent along with a copy of the prescriber's IV order to the Program within 60 days of the date of service. The Pharmacy Program reserves the right to reverse any paid drug or supply claim if these documents are not forwarded to the Program for post-payment review. This applies to all premix or commercial IV systems and all IV admixtures that are compounded under laminar flow hood. All requested information on the form must be completed. Specific points to note:

## NURSING HOME AND FEE-FOR-SERVICE PRIMARY ADULT CARE (PAC) INFUSION THERAPY PROVIDERS

Unlike the IV claims for homecare fee-for-service Medical Assistance recipients, all IV therapy compound claims for nursing home and fee-for-service Primary Adult Care recipients must deny for manual pricing when submitted on-line. Providers are to bill all ingredients of the compound under one Rx#, using compound code 2 and "99" in the submission Clarification Code Field. The compound code 2 allows the System to accept all ingredients under one Rx number based on the multi-ingredients functionality. The code 99 tells the System to deny the compound claim for manual pricing. With the exception of the diluents in hydration therapies, nursing home and fee-for-service PAC providers may not bill for any diluents in other types of therapies. For ex. the water for injection used for reconstituting a powder anti-infective injectable drug and the Dextrose 5% in Water used in diluting the drug should not be billed as diluents since the reimbursement for these are already included in the flat rate reimbursement for the specific types of container.

The reimbursement for the IV compound manual claim reflects the cost of the drug, compounding supply and materials & diluents, compounding fee and administrative charges such as coordination of care and drug monitoring ($7.25 per day of therapy). All supplies including IV tubings or administration sets and other supplies used in connection with the administration of the IV admixture and the maintenance of catheter care for recipients in the nursing home setting are covered under the nursing home facility per diem rate. Thus, nursing home IV providers may not bill DME/DMS Services for any supplies related to compounding and administration of intravenous infusion therapy. There is no supply benefits payable under DME/DMS for these patient populations. Nursing home IV providers should refer to the On-line Billing Instructions for Compounded Home IV Therapy Claims for detail instructions on billing IV compounds in order to have the System deny for manual pricing.

### Premix Systems

Nursing home infusion therapy providers are encouraged to dispense the premix or commercial IV products whenever possible to avoid incurring increased costs associated with compounding. The majority of IV anti-infective agents now come premixed. Depending on whether a one-component or a two-component IV premix system is used, providers may submit one or two claims for the commercial product. Whenever a two-component commercial IV premix systems is used, providers may bill a separate prescription for each component of the IV premix. Providers may submit the active drug ingredient NDC under one Rx#, and the diluent NDC under another Rx#. They must bill per batch or per delivery, at reasonable billing intervals. The Pharmacy Invoice and Record of HIT and DMS/DME Supplies Dispensed must be completed and forwarded to the Program within 60 days of the date of service for a post-payment review. For premix systems dispensed that are returned to stock unused, or reusable and in sealed packaging (i.e. IV metronidazole premix), providers must credit the Program for the unused portion of the batch sent. The Program has removed the Interchangeable Drug Cost (IDC) from the following mini-bag diluents in order to generate a fair reimbursement to providers: All 0.9% Sodium Chloride for Injection and Dextrose 5% in Water in 50ml, 100ml, 250ml package sizes.

The dispensing fees per batch or per delivery for the premix systems for nursing home claims are $ 4.69 for generics or preferred drugs and $ 3.69 for brands or non-preferred drugs.

### IV Compounds

In situations where the nursing HIT provider must compound the IV admixture, providers should bill all ingredients under the multi-ingredient segment using compound code 2 and code 99 in the Submission Clarification Field to allow claim denial for manual pricing and payment release. The Pharmacy Invoice and Record of Home IV Therapy and DME/DMS Dispensed must be completed and forwarded to the Program along with a copy of the IV order within 60 days of the date of service. This must be done for all IV compound claims including claims for the IV premix.

**IV Compounds** (Cont'd)
The Program will continue to pay the supply portion of the truly compounded IV admixture for nursing home recipients under the current flat rate for each type of container. The supply rate reimburses providers for the empty container, the diluents, and all materials and supplies used for compounding the IV therapy. It does not reimburse providers for any other DMS/DME supplies used for administering the IV infusion therapy such as the administration sets (IV tubings) since these supplies are included as reimbursement under the nursing home facility per diem rate.

With the exception of total parenteral nutrition, hydration therapies and diluents used as part of a two-component premix system, nursing home providers need not bill the Program for the diluents used in reconstituting and diluting the drugs when compounding an IV admixture. The diluent used for compounding TPNs (water for injection) and the electrolytes dispensed are reimbursed under the supply flat rate of $17.10 per bag. Thus, providers need not bill for the electrolytes on-line, nor list them on the Pharmacy Invoice. They should only bill for the TPN main 3 active ingredients, the amino acids, the dextrose, and lipids (for 3:1 TPN formulas). The lipids may be billed separately if the order called for a 2:1 formula. For other non-TPN IV therapies, the reimbursement for the diluents is already included in the supply rate (i.e. $8.67 for the gravity bag, $16.99 for the home pump,$26.35 for the cassette, $4.29 for the mechanical syringe, and $0.40 for prefilled syringes).

The prefilling of syringes is not considered compounding. Thus, claims for syringes that are prefilled under laminar hood will be reimbursed with the same dispensing fees as the premix products as described above. The dispensing fee for true IV compounds is $7.25 per day of therapy. Such fees cover for services that are not limited to the dispensing, clinical monitoring, care coordination, and other support costs. Nursing visits are billed separately.

## HOMECARE INFUSION THERAPY PROVIDERS

Infusion therapy providers servicing the homecare sector must bill the HIT claim under two services, Pharmacy Service and DMS/DME Services.

### Premix Systems

Drug Portion**:** The NDCs of IV premix systems are billed under either one Rx number for the one-component system or two Rx numbers for the two-component IV system using the compound code 0 or 1 for non-compound. Each claim will adjudicate with a dispensing fee of $ 3.69 for generics or preferred drugs per batch and $ 2.69 for brands or non-preferred drugs per batch.

Supply Portion: Providers may bill the appropriate supply HCPCS codes under DMS/DME Services as listed on the "Pharmacy Invoice and Record of HIT and DMS/DME Supplies Dispensed". Providers may not bill the HCPCS code for the gravity bags since these are already reimbursed under the NDC(s) of the premix product. Providers may bill for other pertinent HCPCS codes such as maintenance of catheter care supplies, IV pole. The billing of A3223 for the reimbursement of the IV tubings is appropriate if these items are dispensed for the administration of the IV therapy.

Invoice Requirement: Providers are to send a copy of the "Pharmacy Invoice and Record of HIT and DMS/DME Supplies Dispensed" along with a copy of the IV order to the Pharmacy Program even when the premix systems are dispensed. For commercial or premix IV products dispensed that are returned to stock unused, or reusable and in sealed packaging, providers must credit the Program for the unused portion of the batch.

### Compounded IV Admixtures

Implementation of the new Point-of-Sale multi-ingredient functionality has now allowed providers to bill multi-ingredient formula such as total parenteral nutrition (TPN) and hydration therapy on-line with payment of all ingredients of the IV compound released under one prescription number and one pharmacy dispensing fee. Instead of denying at the point-of-sale as it has been in the past, the IV compound drug claim can now adjudicate right on-line when submitted with the proper codes. Providers are to refer to the On-Line Billing Instructions for Compounded Home IV Therapy Claims for the proper use of these codes for the different types of IV therapies in order to generate a paid claim.

Drug Portion

When submitted under one Rx number, and Compound Code 2, the TPN ingredients will be automatically priced by the system. The cost of each ingredient submitted will be calculated and included in the total reimbursement of the IV compound that includes a pharmacy dispensing fee for the whole IV admixture. Providers should not bill each ingredient that makes up the compound as a separate claim with the compound code 0 or 1. This will generate a pharmacy fee for each claim. The Program will reverse any claims found to be improperly submitted. Special attention will be given to billing errors associated with wrong quantities or units billed due to misunderstanding of dosage form (powder or liquid), drug concentration or vial potency and package size.

Other types of IV drug claims that will adjudicate on-line involve anti-infective, antiviral, antifungal agents and miscellaneous drugs (i.e. Milrinone, Desferal, etc. ) used as single active ingredient therapies that are diluted in large volume diluents (Dextrose 5% in Water or Normal Saline). Claims for these may be submitted as non-compound prescriptions with the non-compound code 0 or 1 to generate a paid claim.

Although the drug portion of the IV compound claim can now adjudicate on-line, providers must continue to complete the "Pharmacy Invoice and Record of Home Intravenous Therapy (HIT) and DME/DMS Supplies Dispensed" Form and mail it to the Program within 60 days of the date of service along with a copy of the prescriber's IV order for a post-payment review. This must be done also when the premix or commercial IV products are dispensed in order to facilitate post-payment review by the Program. On the form, providers must document the date of service, units billed, and the specific IV supply HCPC codes billed under DME/DMS in relation to the IV drug NDCs with units and days supply billed under Pharmacy Services. Providers are encouraged to double-check units billed for accuracy to avoid claim reversals by the Program or any potential rebate dispute by drug manufacturers.

Supply Portion: Providers must bill the supplies under the DMS/DME, using the HCPCS codes. The codes A4222, A4305, A4223, E0779, E0780 include reimbursement for the diluents, the IV tubings, all supplies and materials used in preparing and administrating the IV therapy including all professional fees associated with the dispensing, clinical monitoring, care coordination, and other administrative support costs. **NOTE: Under no circumstances should providers bill for any diluent NDC under Pharmacy Service whenever the following codes are billed under DMS/DME Service: A4222, A4223, A4305, A4213, and B4222. These codes include reimbursement of all diluents used in compounding IV admixtures. Similarly, the following codes should not be billed under DME/DMS for diluents used in connection with the compounding of IV admixtures: A4216 (Sterile Water, Saline and/or Dextrose, 10ml; A4217 (Sterile Water/Saline, 500ml); A4218 (Sterile saline or water, metered dose dispenser, 10ml).**

Invoice Requirement: Providers are to send a copy of the "Pharmacy Invoice and Record of HIT and DMS/DME Supplies Dispensed" along with a copy of the IV order to the Pharmacy Program for review and for release of the drug portion of the true IV compound.

## FEE-FOR-SERVICE PRIMARY ADULT CARE (PAC) HOME IV THERAPY CLAIMS

IV compound claims for fee-for-service recipients enrolled under the Primary Adult Care (PAC) Program will be processed in the same manner as nursing home claims since this patient population has no coverage benefits for any DME/DMS supply used in compounding or administering the drug. These claims need to deny for manual pricing and payment release under the Maryland Pharmacy Program.

## BILLING OF PROPER HCPC CODES

### Use of HCPCS code A4222

Please note that the Program considers the billing of HCPCS code A4222 for payment of infusion supplies as it relates to the use of an external infusion pump justified and medically necessary only for the administration of any of the following medications based on Medicare and on most commercial health plans' guidelines:

1. Deferoxamine for the treatment of acute iron poisoning and iron overload; or
2. Heparin for the treatment of thromboembolic disease and/or pulmonary embolism; or

**Use of HCPCS code A4222 (Cont'd)**

3. Heparin to adequately anticoagulate women throughout pregnancy (warfarin compounds are not routinely used for this indication); or
4. Chemotherapy for primary hepatocellular carcinoma or colorectal cancer where the tumor is unresectable or the member refuses surgical excision of the tumor; or
5. Morphine or other narcotic analgesics (except meperidine) for intractable pain caused by cancer; or
6. Parenteral inotropic therapy with dobutamine, milrinone, and/or dopamine; or
7. Parenteral epoprostenol or treprostinil for persons with pulmonary hypertension; or
8. Certain parenteral antifungal or antiviral drugs (e.g., acyclovir, foscarnet, amphotericin B, or ganciclovir); or
9. Certain parenteral anticancer chemotherapy drugs (e.g. cladribine, fluorouracil, cytarabine, bleomycin, floxuridine, doxorubicin, vincristine, vinblastine, cisplatin, paclitaxel) if the drug is part of an evidence-based chemotherapy regimen and parenteral infusion of the drug is administered by either continuous infusion over 8 hours or by intermittent infusions lasting less than 8 hours that do not require the person to return to the physician's office prior to the beginning of each infusion; or
10. Insulin for persons with diabetes mellitus who meet the selection criteria for external insulin infusion pumps for diabetes set forth below; or
11. Other parenteral administered drugs where an infusion pump is necessary to safely administer the drug at home when the following 2 sets of criteria are met: (1) The drug must be administered by a prolonged infusion of at least 8 hrs because of proven clinical efficacy and has significant advantages over intermittent bolus administration regimens or infusions lasting less than 8 hrs.; or (2) The drug is administered by intermittent infusion, each episode lasting less than 8 hrs which does not require the patient to return to the physician's office prior to the beginning of each infusion and Systemic toxicity or adverse effects of the drug is
unavoidable without infusing it at a strictly controlled rate as indicated in either the Physician's Desk Reference, the Micromedex Drugdex or the US Pharmacopeia Drug Information official compendium.

**Billing of HCPCS code A4223**

The code A4223 should not be mistaken for Code 4222 that reimburses providers for the cost of each cassette or each bag when used in connection with an external pump for infusing an IV therapy over at least an 8 hour period.
Code A4223 reimburses the provider for supplies not used with external pump such as the diluents, IV tubings or administration sets, supplies and materials for compounding and/or administering gravity bags or premix/commercial bags that can be run by gravity without the need of an external pump. An example of the type of therapy that is infused by gravity is anti-infective therapy such as vancomycin, tobramycin, etc.

DME/DMS Services will be setting the reimbursement rate for this code at $8.67 per unit to match that for the supply gravity bag dispensed to nursing home recipients. For codes without a rate, such as B9999 (Misc. parenteral supplies), providers are to contact DME/DMS for instructions on claim submission, purchase invoice requirements and payment release based on individual case consideration.

**Insulin External Infusion Pumps**

The Program follows Medicare guidelines for the coverage of external insulin infusion pumps which are considered medically necessary DME for persons with diabetes who are beta cell auto-antibody positive or have a documented fasting serum C-peptide level that is less than or equal to 110% of the lower limit of normal of the laboratory's measurement method, and who meet the criteria in above Section 1 or Section 2. Refer to CMS guidelines on coverage of insulin infusion pumps under the Diabetes Programs and Supplies for the external infusion pumps.

The billing of any HCPCS codes for insulin external infusion pumps must be documented on this form along with the NDC billed for the associated drug for which the pump was needed. Providers are to complete and forward this form to the Program within 60 days of providing the service. Select the box for "other HCPCS codes" and fill in the correct code for the pump used.

## Implantable Infusion Pumps

The Program follows Medicare guidelines for coverage of implantable infusion pumps and considered them medically necessary DME for the FDA-approved infusion of the following drugs via intrathecal administration:

A. Anti-spasmodic drugs (e.g., baclofen) to treat chronic intractable spasticity in persons who have proven unresponsive to less invasive medical therapy;
B. Opioid drugs for treatment of chronic intractable pain;
C. Intrahepatic chemotherapy infusion (e.g., floxuridine) in a hospital setting to members with liver metastases from colorectal cancer.

The Program does not pay for experimental and investigational uses of implanted infusion pumps when used for the following indications:

1. Infusion of insulin to treat diabetes;
2. Infusion of heparin for recurrent thromboembolic disease; or
3. Intrahepatic administration of chemotherapy for indications other than listed in C. above, including treatment of primary hepatocellular carcinoma or hepatic metastases from cancers other than colorectal cancer.

The billing of any HCPCS codes for implantable infusion pumps must be documented on this form along with the NDC billed for the associated drug for which the pump was needed. Providers are to complete and forward this form to the Program within 60 days of providing the service. Select the box for "other HCPCS code" and fill in the correct code for the pump used.

## Description of DMS/DME IV Supply HCPCS Codes

Following is a detailed explanation of the HCPCS codes that may be billed under DMS/DME Services in connection with compounded or non-compounded IV therapy billable by homecare HIT providers. Reimbursement amounts are determined in accordance with COMAR 10.09.12.

- □ A4213 Syringe, sterile, 20 cc or greater, per syringe- Max 100/month.
- □ A4209 Syringe w/needle, 5cc or greater , per syringe - Max 100/month.
- □ A4221 Supplies for drug infusion catheter- This code does not apply to orders for drugs given by IV push, IM, or SQ administration. It reimburses for dressings for the catheter site, flush solutions such as saline and heparin flushes, catheter insertion devices, cannulas, needles, and infusion supplies. Allowance: 2 units per week (or 8 per month). Quantities above 2 units per week require prior-authorization by DME/DMS. Providers must justify billing for more than 2 units per week by providing documentation as to the number of lumen, number of drugs, frequency of flushings, or number of flush syringes or vials sent per day as prescribed for the covered length of IV therapy. A copy of the doctor's treatment order in regards to catheter care prescribed for the recipient for the duration of IV therapy must be kept on file to support the number of units billed. Note that other supplies used such as extension sets, IV administration sets, are covered under other codes, A222, A2223, A4305, A4306, etc.
- □ A4222 Drug infusion supplies for use with external pump- Includes reimbursement for the cassette or bag, diluting solutions, IV tubings (or IV administration sets or extension sets) and other administration supplies, port cap changes, compounding charges. Unit is per bag or per cassette and not per day of therapy. For ex, bill quantity of 1 for 1 bag infused every 28 days and not quantity of 28 (Max. 42/wk.)
- □ A4223 Infusion supplies **not used** w/external infusion pump- Includes reimbursement for the diluents, tubings, supplies and materials for the compounding and/or administering of gravity bags or premix/commercial bags- per bag or per unit. Max 84/wk.
- □ A4305 Disposable drug delivery system, including but not limited to elastomeric infusion pumps, flow rate of 50ml or > per hr. – per home pump- Max 42/wk
- □ A4306 Same as A 4305, but for flow rate of 5ml or < per hr.(i.e. baclofen infusion)- Max 42 per wk.
- □ B9004 Parenteral nutrition pump, portable-# Unit: __ □ Rental-□ Purchase- DOS_____fr_____to_____
- □ B9006 Parenteral nutrition pump, stationary-# Unit:__ □ Rental-□ Purchase- DOS_____fr_____to_____

**INSTRUCTIONS FOR COMPLETION OF THE**
**PHARMACY INVOICE AND RECORD**
**OF HOME IV THERAPY (HIT) AND DME/DMS SUPPLIES DISPENSED**


**Description of DMS/DME IV Supply HCPCS Codes (Cont'd)**

- B4220 Parenteral nutrition supply kit, premix, per day- # units:____DOS_____fr:_____to_____
- B4224 Parenteral nutrition administration kit, per day- # units:____DOS_____fr:_____to_____
- E0776 IV pole, durable or disposable- Not covered when billing E0779, E0780, E0781, E0784
- E0779 Ambulatory infusion pump, mechanical, reusable, for infusion > 8hrs.
- E0780 Ambulatory infusion pump, mechanical, reusable, for infusion < 8 hrs.
- E0781 External ambulatory infusion pump and supplies, electrical or battery operated, for delivering solutions containing a parenteral drug under pressure at a regulated low rate.
- E0784 External ambulatory infusion pump, insulin.
- E0791 External parenteral stationary infusion pump, covered if Medicare criteria are met: 1/drug must be administered over 8 hrs; 2/ drug must be considered toxic enough to require a controlled infusion rate that can only be provided by a pump. Maryland Medicaid follows Medicare guidelines for coverage of the pump used in connection with the 20 drugs under Medicare benefit. Providers are to send the gravity bags that may be hung without the need of a pump if the drugs are not among these 20 drugs. Exceptions will be made to special cases requiring review by the Program.

## UNITS ACCURACY

Providers must be careful about the units billed to avoid common errors resulting in the wrong quantity billed. This helps avoid any dispute related to the rebate amount billed to the drug manufacturers. If the unreconstituted vials come in the liquid form, the unit is "cc" or "ml". If it comes in a powder form, the unit is "each". Providers must calculate the total number of "mg" required to make a batch of IV therapy and then divide that number by the strength or concentration of the vial to arrive at the number of units to be billed on-line for a particular NDC. **Note**: Providers must bill **fractional units** if partial multi-dose vials are dispensed. Do not round-up to the next whole unit, except for single-dose vials. Do not ship more than a 7-day supply per batch at a time. Bill per delivery per batch at reasonable intervals.

**Example # 1**: A 7-day supply of vancomycin 500mg given IV every 24 hours should be billed with the quantities of:
0.7 unit if the 5 gram vial NDC is used (500mg x 7 days = 3500mg:5000mg = 0.7) or
0.35 unit if the 10 gram vial NDC is used (500mg x 7 days = 3500mg:10,000mg = 0.35) or
3.5 units if the 1 gram vial NDC is used (500mg x 7 days = 3500mg:1,000mg = 3.5)

**Example #2:** A 7-day supply of gentamicin 80mg given IV every 24 hours should be billed with the quantities of:
14 units if the 40mg/ml adult strength vial NDC is used (80mg x 7 days = 560mg : 40mg/ml = 14 ml) or
56 units if the 10mg/ml pediatric strength vial NDC is used (80mg x 7 days = 560mg : 10mg/ml = 56 ml)

**Example #3**: A month supply of Neupogen ordered as 480 mcg SC daily should be billed with quantity of 48 (30x 1.6ml) if the Neupogen 480mcg/1.6ml vials are dispensed for one month supply. Billers have tendency to bill erroneously for quantity of 30 for 30 doses or quantity of 60 if they round up the quantity of each vial to 2ml x 30 days = 60, which is incorrect in both cases. If providers should need to prefill the syringes for odd dosages or pediatric dosages under sterile conditions, only the actual amount of drug used is billable. Providers may round up the units to the next whole lowest strength single dose whole vial. Providers may not claim for unreasonable and unnecessary drug wastage. Providers should be aware of the various strengths that Neupogen comes in (300mcg/ml single-dose vials, or 480mcg/1.6ml single-dose vials, or 300 mcg/0.5ml Singleject syringes or 480mcg/0.8ml Singleject syringes) when billing for this product to avoid frequent quantity errors.

Since providers may not be aware that the system can handle fractional units, the Program reserves the rights to reverse any drug claim that have been billed erroneously, in which case, providers will be notified of such reversals and allowed the opportunity to resubmit the claim.

Any claims for IV supplies dispensed to homecare fee-for service recipients and submitted under Pharmacy Services will not be processed as these have been strictly covered under DMS/DME Services since August 1, 2006.