Home Infusion Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render home infusion services to members of the CarePartners of Connecticut plans selected above.

Note: Audit and disclaimer information is located at the end of this document.

Policy

CarePartners of Connecticut reimburses contracted home infusion therapy agencies for medically necessary home infusion therapy services, in accordance with the member's benefits.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

Use of non-contracted labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the non-participating lab that has been selected.

Referral/Prior Authorization/Notification Requirements

Referrals are not required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

Certain home infusion drugs may require prior authorization. Refer to the Pharmacy section of the public Provider website for additional information.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Other Information

- DME that is not related to infusion therapy must be billed separately from infusion services and must be provided by a contracted DME provider.
- Submit each drug/product using standard CPT/HCPCS codes, National Drug Code (NDC) number of the covered medication, description of product, dosage, and units administered.
- For multiple dates of service (DOS), report a separate line for each DOS with the applicable procedure code(s) and the number of units.
- Submit the following modifiers when billing multiple home infusion therapies:
  - SH identifies the second concurrently administered infusion therapy.
  - SJ identifies the third or more concurrently administered infusion therapy.
  - **Note:** Effective for DOS beginning Dec. 1, 2025, subsequent concurrent infusions (identified by SH or SJ) will be reimbursed at 50% of the standard rate/fee schedule amount.
- Some home infusion drugs may be subject to a maximum number of units per day, in accordance with the Maximum Units Policy.

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules.

Coding

This list is not all inclusive.

Code	Description	Notes
S9379	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	Documentation required with claim. Should only be billed for a service or procedure that does not have a valid specific therapy code available and should only be billed if the actual medication is infused separately from any other service being provided on the same date of service.

Home infusion therapy services are reimbursed on a per diem basis only when an actual drug infusion is administered that day, which is inclusive of:

- Administrative services
- Professional pharmacy services
- Care coordination
- All necessary supplies and equipment for the effective administration of infusion, specialty drug and nutrition therapies. Including but not limited to:
  - DME (pumps, poles and accessories) for drug and nutrition administration, equipment maintenance and repair (excluding patient owned equipment)
  - Short peripheral vascular access devices, needles, gauze, non-implanted sterile tubing, catheters, dressing kits, and flushing solutions, including heparin and saline
  - Delivery and removal of supplies and equipment

The following services are reimbursed separately from the per diem rate:

- Nursing visits related to infusion services
- Enteral formula when administered via gravity, pump or bolus only (does not apply to nutritional formulas taken orally)
- Covered DME not related to infusion therapy (billed separately from infusion services) when provided by a contracted DME provider
- Drugs and biologicals, based on CarePartners of Connecticut's drug fee schedule
  - Reimbursement for listed and unlisted drugs will not exceed CarePartners of Connecticut's drug fee schedule allowable amounts
  - CarePartners of Connecticut's drug fee schedule is periodically updated based on Average Sale Price (ASP), Average Wholesale Price (AWP), CarePartners of Connecticut Specialty Pharmacy Program, and Medicare, as applicable.

For home infusion therapy services provided in conjunction with home hospice services, refer to the Hospice Services Payment Policy.

Additional Resources

- Drugs and Biologicals Payment Policy
- Durable Medical Equipment Payment Policy
- Home Health Care Payment Policy
- Hospice Services Payment Policy

Document History

- December 2025: Annual policy review; clarified existing compensation/reimbursement information and billing requirements; administrative edits
- November 2024: Annual policy review; removed references to Novologix, added content for modifiers SH and SJ, effective for DOS on or after Feb. 1, 2025
- December 2023: Annual policy review; administrative updates
- February 2023: Updated specialty pharmacy claims submission information effective for DOS on or after April 1, 2023
- December 2022: Annual policy review; no changes
- July 2021: Policy reviewed by committee; no changes
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- May 2020: Policy reviewed by committee; removed home infusion procedure codes; clarified authorization and billing instructions
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.