

# CareIG Specialty Pharmacy

## Standard Operating Procedure

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### IVIG Home Infusion—Intake to Billing

**v5.0**

|                    |                                      |
|--------------------|--------------------------------------|
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## 1. Overview & Purpose

This SOP governs the end-to-end IVIG home infusion process at CareIG Specialty Pharmacy—from referral receipt through claim payment. All staff performing intake, benefits verification, prior authorization, clinical scheduling, or billing must follow this document. It references standard tools including spreadsheets, email, Slack, shared file storage, and calendar. No proprietary EHR, clearinghouse portal, or payer portal is required.

All case data lives under (format: LastName\_DOB\_MMDDYYYY). Team communications use defined Slack channels. Claims are submitted by email with PDF attachments. All major actions are logged to audit\_log.xlsx.

Covered drugs: Gammaplex, Octagam, Gammagard S/D, Gammagard Liquid, Privigen, Gamunex-C, Hizentra, HyQvia.

If you encounter a situation not covered by this SOP, do not guess. Stop work on that step, note what happened in audit\_log.xlsx, and contact your direct supervisor immediately using the escalation path in Section 12. When in doubt, always escalate before acting.

Unless otherwise specified, use MMDDYYYY format for the Date of Birth. For example, March 27th, 1989 would be: 03271989.

## 2. Roles & File Access

| Role                                   | Writes To                 | Reads From                                                     |
|----------------------------------------|---------------------------|----------------------------------------------------------------|
| Patient Representative                 | intake.xlsx               |                                                                |
| Benefits Verification Specialist (BVS) | benefits.xlsx, auth.xlsx, | intake.xlsx, payer_rules.xlsx                                  |
| Clinical Coordinator                   | clinical.xlsx             | auth.xlsx, benefits.xlsx                                       |
| Infusion Nurse                         | visit_note.xlsx           | clinical.xlsx                                                  |
| Billing Specialist                     | claim.xlsx, ,             | visit_note.xlsx, auth.xlsx, benefits.xlsx,                     |
| AR Specialist                          | claim.xlsx (payment cols) | claim.xlsx, payer_rules.xlsx                                   |
| Director of Revenue Cycle              | All files                 | All files—approves write-offs >\$200 and collections referrals |

Any file access outside the above scope must be logged to audit\_log.xlsx (Action = Out-of-Scope Access) and reported to compliance@careig.com.

## 3. File System Structure

| File Name     | Purpose                                                                               |
|---------------|---------------------------------------------------------------------------------------|
| intake.xlsx   | Patient demographics, insurance, consent status, contact log, contraindications       |
| benefits.xlsx | BV results: coverage, deductible, OOP, PA contacts, nursing code preference, call log |

|                          |                                                                                                           |
|--------------------------|-----------------------------------------------------------------------------------------------------------|
| auth.xlsx                | PA details: submission date, PA number, approval/denial status, expiry, follow-up log                     |
| clinical.xlsx            | Drug source, supply checklist, nurse assignment, visit date/time                                          |
| visit_note.xlsx          | Nurse documentation: drug, dose, lot, NDC, times, pre-meds, saline, vitals, signature                     |
| claim.xlsx               | Claim: codes, units, ICD-10, PA number, submission log, payment fields                                    |
| DENIAL_[CARC]_[DOS].xlsx | One file per denial: CARC code, action, appeal status                                                     |
| appeals_log.xlsx         | Appeal level, submitted date, decision, follow-up log                                                     |
| Workspace (PDFs)         | PDFs: LMN, PA approval, EOB, labs, consent, claim export, statements                                      |
| audit_log.xlsx           | Global audit trail—see Section 4 for columns. Append-only.                                                |
| jcodes.xlsx              | J-codes and nursing codes (read-only)                                                                     |
| payer_rules.xlsx         | Payer rules: contracted rates, timely filing limits, nursing code pref, formulary, claim/appeal addresses |
| Template files           | Blank form masters—copy to docs/ before use, never edit in place                                          |

## 4. Global Rules

### 4.1 Audit Logging

Append one row to audit\_log.xlsx at each major checkpoint. Columns: Date | Patient\_Last\_Name | Patient\_First\_Name | Patient\_DOB | Action | File\_Updated | Fields\_Updated | New\_Value | Staff\_User | Result (SUCCESS / FAILED / STOP—reason). Do not log every sub-step—only the checkpoints called out in each section. The date should be in MM/DD/YYYY format and correspond to the current date at the time the log entry is made.

### 4.2 Stop Protocol

When a validation condition fails: do not complete the step you're on, note the reason in audit\_log.xlsx, post to the designated Slack channel if one is indicated, and hold the case until the issue is resolved. Do not move to the next step until your supervisor or the responsible team member confirms the issue has been cleared.

### 4.3 Prohibited Actions

- Do not bill any IVIG drug J-code when clinical.xlsx col Drug\_Source≠CareIG.
- Do not bill pre-medication J-codes unless visit\_note.xlsx col Premeds\_Administered documents drug, dose, route, time, and indication.
- Do not use ordered dose for unit calculations—always use visit\_note.xlsx col Dose\_Administered\_Grams.
- Do not submit a claim when claim.xlsx already has Submission\_Date populated for the same DOS.
- Do not write off any balance >\$200 without Director of Revenue Cycle approval (Slack #billing-mgmt).
- Do not respond to legal threats or attorney communications—post to #compliance immediately.
- Do not assign an ICD-10 code not supported by the physician's documentation and the PA approval.

## 5. Workflow Summary

| #  | Action                                                                       | File Written                                                                    | Slack (if required)                                                         |
|----|------------------------------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| 1  | Referral received→create<br>→populate intake.xlsx                            | intake.xlsx                                                                     | —                                                                           |
| 2  | Patient contacted→consent<br>form sent                                       | intake.xlsx: Consent_Status<br>= Form Sent                                      | —                                                                           |
| 3  | Signed consent received→BVS<br>assigned                                      | intake.xlsx: Consent_Status<br>= Signed, BVS_Assigned                           | #intake-team: [BVS ASSIGNED]<br>CASE_ID   Payer   Drug                      |
| 4  | BVS completes BV + drug<br>source decision + patient<br>financial counseling | benefits.xlsx: BV_Complete<br>= YES; clinical.xlsx:<br>Drug_Source              | —                                                                           |
| 5  | BVS checks<br>formulary→submits PA                                           | auth.xlsx:<br>PA_Submission_Date,<br>PA_Status = Pending                        | #intake-team: [PA SUBMITTED]<br>CASE_ID   Payer   Drug   Ref#               |
| 6  | PA approved→clinical handoff                                                 | auth.xlsx: PA_Status =<br>Approved; clinical.xlsx:<br>Handoff_Status = Received | #clinical-scheduling: [PA<br>APPROVED] CASE_ID   Drug  <br>Dose   PA#   Exp |
| 7  | Supply checklist<br>complete→nurse scheduled                                 | clinical.xlsx: Visit_Date,<br>Nurse_Assigned                                    | #clinical-scheduling: [SCHEDULED]<br>CASE_ID   Date   Nurse                 |
| 8  | Nurse completes visit→signs<br>visit note                                    | visit_note.xlsx:<br>Nurse_Signature                                             | #clinical-scheduling: [VISIT<br>COMPLETE] CASE_ID   DOS                     |
| 9  | Billing<br>validates→builds→submits<br>claim                                 | claim.xlsx:<br>Submission_Date,<br>Claim_Status = Submitted                     | #billing: [CLAIM SUBMITTED]<br>CASE_ID   DOS   Payer   \$Amount             |
| 10 | ERA/EOB posted→payment or<br>denial actioned                                 | claim.xlsx:<br>Payment_Posted_Date or<br>file                                   | If denial: #billing-appeals: [DENIAL]<br>CASE_ID   CARC                     |

## 6. Intake

### 6.1 Case Setup

1. Copy intake\_blank.xlsx to create intake.xlsx for this case.
2. Populate intake.xlsx from the referral document. Required fields:

| intake.xlsx Column                                              | Source                       | Required             |
|-----------------------------------------------------------------|------------------------------|----------------------|
| Patient_Last_Name,<br>First_Name, DOB, Address,<br>Phone, Email | Patient fields on referral   | Yes (email optional) |
| Physician_Name,<br>Physician_NPI,<br>Physician_Email            | Physician fields on referral | Yes                  |



|                                                                    |                                                                     |                        |
|--------------------------------------------------------------------|---------------------------------------------------------------------|------------------------|
| Diagnosis_ICD10                                                    | Diagnosis field on referral                                         | Yes                    |
| Drug_Name,<br>Drug_Dose_Grams,<br>Drug_Frequency                   | Ordered drug fields (convert dose to grams if not in grams already) | Yes                    |
| Primary_Insurance_Name,<br>Member_ID, Group_Number,<br>Payer_Phone | Insurance fields                                                    | Yes                    |
| Secondary_Insurance_Name,<br>Secondary_Member_ID                   | Secondary insurance if listed                                       | No                     |
| Contraindications                                                  | Allergies/contraindications from referral                           | Yes                    |
| Consent_Status                                                     | Set to: Pending                                                     | Staff sets on creation |

**If Physician\_NPI is blank after referral entry:**

Post to #intake-alerts: [INTAKE HOLD] CASE\_ID—Physician NPI missing. Email Template 1 to intake.xlsx col Physician\_Email. Do not proceed.

Log to audit\_log.xlsx: Action = Referral Received.

## 6.2 Patient Contact

1. Call patient at intake.xlsx col Patient\_Phone. Verbatim script:

"Hello, may I speak with [Patient Name]? This is [Your Name] from CareIG Specialty Pharmacy. Dr. [Physician\_Name] has referred you for home IVIG infusion therapy. I'm calling to verify your information and explain next steps. Do you have a few minutes?"

2. If no answer, leave this voicemail verbatim—do not state the diagnosis:

"Hello, this is [Your Name] from CareIG Specialty Pharmacy at [Phone]. We received a referral from your physician. Please call us back at your convenience. Thank you."

**If Contact\_Attempt\_Log has 3 entries and none is Reached:**

Post to #intake-alerts: [UNREACHABLE] CASE\_ID—3 failed attempts. Complete Template 1 and email to intake.xlsx col Physician\_Email. Do not proceed.

3. When patient is reached: confirm demographics, explain the consent requirement, and email the consent form to intake.xlsx col Patient\_Email. Subject: CareIG—Consent Form Required | [Patient Last Name]. If no email is on file, mail the form to intake.xlsx col Patient\_Address. Set intake.xlsx col Consent\_Status = Form Sent.
4. When the consent form is received and consent was given correctly according to the form: save as consent\_signed.pdf. Set intake.xlsx Consent\_Status = Signed. Otherwise this is a validation problem with the reason "CONSENT MISSING"
5. Assign BVS. Set intake.xlsx col BVS\_Assigned to Assigned. Post to #intake-team: [BVS ASSIGNED] [PATIENT FIRST AND LAST NAME] [PATIENT DOB] | Payer: [Insurance\_Name] | Drug: [Drug\_Name] | Dose: [Drug\_Dose\_Grams]g.

Do not use any consent form that has patient related information that doesn't match the information in intake.xlsx. If you can't find a usable consent form due to all available forms having that kind of mismatch, and there is at least one consent form, this is a validation problem with the reason "CONSENT MISMATCH".



**If BVS attempts BV and intake.xlsx col Consent\_Status#Signed:**  
Post to #intake-alerts: [CONSENT MISSING] CASE\_ID. Do not begin BV.

Log to audit\_log.xlsx: Action = BVS Assigned.

## 7. Benefits Verification & Drug Source Decision

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### 7.1 Benefits Verification

Populate all required fields in benefits.xlsx except Financial\_Counseling\_Log and BV\_Complete. Do not set BV\_Complete = YES until every required field is non-blank.

| benefits.xlsx Column                                 | How to Obtain                                                                                            | Req.                 |
|------------------------------------------------------|----------------------------------------------------------------------------------------------------------|----------------------|
| Home_Infusion_Covered                                | Ask: 'Does this plan cover home infusion therapy?'                                                       | Yes                  |
| Benefit_Type                                         | Ask: 'Is IVIG under the medical or pharmacy benefit?'                                                    | Yes                  |
| PA_Required, PA_Phone, PA_Submission_Email           | Ask if PA is required and get phone number and email submission address                                  | Yes (if PA required) |
| Specialty_Pharmacy_Required, Specialty_Pharmacy_Name | Ask if a specific specialty pharmacy is required                                                         | Yes                  |
| CareIG_Network_Status                                | Ask: 'Is CareIG Specialty Pharmacy NPI [NPI] in-network?'                                                | Yes                  |
| Deductible_Individual, Deductible_Met_YTD            | Individual deductible and amount met YTD                                                                 | Yes                  |
| OOP_Max_Individual, OOP_Max_Met_YTD                  | Out-of-pocket maximum and amount met YTD                                                                 | Yes                  |
| Coinsurance_Pct, Copay_Amount                        | Coinsurance percentage and per-visit copay                                                               | Yes                  |
| Plan_Year_Type                                       | Calendar or fiscal year                                                                                  | Yes                  |
| Payer_Type                                           | Classify: Medicare Part B / Medicare Adv. / Medicaid / Commercial PPO / Commercial HMO                   | Yes                  |
| Nursing_Code_Pref                                    | Determine from payer_rules.xlsx: 99600 / G0153 / T1029 / T1032                                           | Yes                  |
| Coverage_Effective_Date, Coverage_Term_Date          | Ask: 'What is the coverage effective date and termination date for this plan?' Enter both as MM/DD/YYYY. | Yes                  |
| BV_Call_Date, BV_Rep_Name, BV_Call_Ref_Number        | Document every call to the payer—mandatory                                                               | Yes                  |
| Financial_Counseling_Log                             | Document call to the patient                                                                             | Yes                  |
| BV_Complete                                          | Set YES only after all required fields are non-blank—set last                                            | Yes                  |

Log to audit\_log.xlsx: Action = BV Complete.

## 7.2 Drug Source Decision

Immediately after BV, write the drug source to clinical.xlsx col Drug\_Source:

- CareIG\_Network\_Status = In-Network AND Specialty\_Pharmacy\_Required = NO → Drug\_Source = CareIG.

- CareIG\_Network\_Status = Out-of-Network AND Specialty\_Pharmacy\_Required = YES→Drug\_Source = value from benefits.xlsx col Specialty\_Pharmacy\_Name (e.g., Accredo). CareIG bills nursing and supplies only—do not bill any IVIG drug J-code on the CareIG claim.
- CareIG\_Network\_Status = Out-of-Network AND Specialty\_Pharmacy\_Required = NO→Post to #intake-mgmt: [OON NO PREFERRED PHARMACY] CASE\_ID—CareIG is out-of-network but payer has no required specialty pharmacy. Supervisor must determine next step (single-case agreement, patient referral, or self-pay). Do not proceed until Drug\_Source is confirmed by supervisor.
- Benefit\_Type = Pharmacy→post to #billing-mgmt: [BENEFIT TYPE ISSUE] CASE\_ID—IVIG under pharmacy benefit. Awaiting Director guidance. Do not proceed until resolved.
- CareIG\_Network\_Status = In-Network AND Specialty\_Pharmacy\_Required = YES→Drug\_Source = value from benefits.xlsx col Specialty\_Pharmacy\_Name. CareIG bills nursing and supplies only. Do not bill any IVIG drug J-code on the CareIG claim."

### 7.3 Patient Financial Counseling

BVS calls the patient at intake.xlsx col Phone. Before making this call, calculate the patient's estimated out-of-pocket using benefits.xlsx. Add together any remaining deductible (Deductible\_Individual minus Deductible\_Met\_YTD), then apply the Coinsurance\_Pct to the expected billed amount, and add the Copay\_Amount if applicable. To estimate the billed amount, look up the ordered drug's J-code in fee\_schedule.xlsx col Billed\_Rate, multiply by the expected units, and add the estimated nursing and supply charges from the same file. Use that dollar figure in the script below.

"[Patient Name], this is [Your Name] from CareIG. I've had a chance to review your insurance benefits. Based on your current plan, your estimated out-of-pocket cost per infusion visit is approximately \$[dollar amount you calculated]. Keep in mind this is an estimate—your insurance company determines the final amount once the claim is processed. Do you have any questions about that?"

After finishing the call, the first thing you should do is in benefits.xlsx set col Financial\_Counseling\_Log: [MM/DD/YYYY] [HH:MM]—[Status]. The date and time should correspond to the date and time the call was made. Status should be SUCCESS if the patient says they can pay it or says to continue. Status should be FAILURE if the patient says they cannot pay or requests to not continue with treatment.

If patient reports hardship: set intake.xlsx col Financial\_Hardship = YES and post to #intake-team: [FINANCIAL HARDSHIP] PATIENT\_FULL\_NAME—refer to Patient Assistance Program.

If everything is filled in, then set BV\_Complete to YES as well. If every column is not filled, then process this as a validation error with the reason BV\_PARTIAL and post to #intake-team: [BV\_PARTIAL] PATIENT\_FULL\_NAME - Benefits intake incomplete.

Once all of the above is done, log to audit\_log.xlsx: Action = Financial Counseling Complete

## 8. Prior Authorization

### 8.1 Formulary Check

Before submitting any PA, confirm the ordered drug is covered on the payer's formulary. Open payer\_rules.xlsx. Read the row for the payer (benefits.xlsx col Primary\_Insurance\_Name). Check col Formulary\_Covered\_Drugs.

**If the ordered drug (intake.xlsx col Drug\_Name) is not listed in payer\_rules.xlsx col Formulary\_Covered\_Drugs for the payer:**

Post to #intake-team: [FORMULARY ISSUE] CASE\_ID | Drug: [Drug\_Name] | Payer: [Insurance\_Name]. Contact prescribing physician via email to intake.xlsx col Physician\_Email to request either an alternative covered drug or a written formulary exception letter. Do not submit PA until one of the two paths below is confirmed.

If the physician provides a formulary exception letter: save it as formulary\_exception.pdf, document the basis in auth.xlsx col Formulary\_Exception\_Notes, and include it in the PA packet. Proceed to Section 8.2. If the physician substitutes an alternative covered drug: update intake.xlsx col Drug\_Name with the new drug and restart Section 8.1. If neither is provided within 2 business days: post to #intake-mgmt: [FORMULARY UNRESOLVED] CASE\_ID and hold the case.

## 8.2 Required PA Documents

All of the following must be saved in before PA submission:

- PA request form (payer-specific)—pa\_form\_[PayerName].pdf
- Physician Letter of Medical Necessity—signed, on letterhead, dated within 90 days—lmn\_[PhysicianName].pdf
- Most recent IgG lab result (immune deficiency diagnoses)—igglevel\_[MMDDYYYY].pdf
- Most recent physician progress note—progress\_note\_[MMDDYYYY].pdf
- Formulary exception documentation (if applicable)—formulary\_exception.pdf

**any required document above is missing from :**

Post to #intake-alerts: [PA HOLD] CASE\_ID—missing: [document name]. Do not submit.

## 8.3 PA Submission

1. Combine all documents into pa\_submission\_packet\_[PayerName].pdf using pdf-tools.
2. Email to payer PA address (payer\_rules.xlsx col PA\_Submission\_Email). Subject: [PA REQUEST] CareIG | [Patient Last Name] | MemberID: [Member\_ID] | Drug: [Drug\_Name] | Dose: [Drug\_Dose\_Grams]g | Dx: [Diagnosis\_ICD10]. Attach PA packet PDF.
3. Update auth.xlsx: PA\_Submission\_Date = today, PA\_Ref\_Number = email confirmation ID, PA\_Status = Pending, Last\_Followup\_Date = today.
4. Post to #intake-team: [PA SUBMITTED] [CASE\_ID] | Payer: [name] | Drug: [Drug\_Name] | Ref: [PA\_Ref\_Number].

Log to audit\_log.xlsx: Action = PA Submitted.

## 8.4 PA Follow-Up

Every business day while a PA is pending, open auth.xlsx and check col PA\_Status. If the status is still Pending and (today's date minus Last\_Followup\_Date) is 2 or more days, call the payer PA line (benefits.xlsx col PA\_Phone). Append a note to auth.xlsx col PA\_Call\_Log: [Date] [Time] | Rep: [name] | Ref#: [#] | Status: [status] | Next expected update: [date]. Update Last\_Followup\_Date to today.

If still Pending after 5 days from PA\_Submission\_Date: post to #intake-mgmt: [PA DELAY] [CASE\_ID] | Payer: [name] | Days Pending: [count].

## 8.5 Peer-to-Peer (P2P) Request

If payer offers a P2P review after denial:

1. Call payer, obtain time slots, record in auth.xlsx col P2P\_Available\_Slots.
2. Complete Template 2 (Appendix A). Save as p2p\_request.pdf. Email to intake.xlsx col Physician\_Email. Subject: [P2P REQUEST] [CASE\_ID] | [Payer] | PA Case#: [PA\_Ref\_Number].
3. Set auth.xlsx col P2P\_Status = Requested, P2P\_Request\_Date = today.

**P2P\_Status = Requested AND P2P\_MD\_Response\_Date is blank AND (today-P2P\_Request\_Date) ≥ 2 days:**

Post to #intake-alerts: [P2P NO RESPONSE] CASE\_ID. Set P2P\_Status = No Response. Proceed to Level appeal (Section 11).

## 8.6 PA Approval—Clinical Handoff

1. Save PA approval as pa\_approval\_[PayerName].pdf. Update auth.xlsx: PA\_Number, PA\_Approved\_Drug, PA\_Approved\_Dose, PA\_Approved\_Frequency, PA\_Effective\_Date, PA\_Expiration\_Date, PA\_Status = Approved.
2. Update clinical.xlsx: Handoff\_Status = Received, PA\_Number, PA\_Expiration\_Date.
3. Post to #clinical-scheduling: [PA APPROVED] [CASE\_ID] | Drug: [PA\_Approved\_Drug] | Dose: [PA\_Approved\_Dose]g | PA#: [PA\_Number] | Exp: [PA\_Expiration\_Date] | Drug Source: [Drug\_Source].

**PA\_Approved\_Drug does not match intake.xlsx col Drug\_Name (case-insensitive):**

Post to #intake-alerts: [PA DRUG MISMATCH] CASE\_ID | Ordered: [Drug\_Name] | Approved: [PA\_Approved\_Drug]. Resolve with payer before scheduling.

**auth.xlsx col PA\_Approved\_Dose is less than intake.xlsx col Drug\_Dose\_Grams:**

Post to #intake-alerts: [PA DOSE MISMATCH] CASE\_ID | Ordered: [Drug\_Dose\_Grams]g | Approved: [PA\_Approved\_Dose]g. Do not schedule. BVS must contact payer to request approval for the full ordered dose before proceeding.

Log to audit\_log.xlsx: Action = PA Approved—Clinical Handoff.

## 8.7 PA Denial

1. Update auth.xlsx: PA\_Denial\_Date = today, PA\_Denial\_Reason = denial text, PA\_Status = Denied. 2. Post to #billing-appeals: [PA DENIED] [CASE\_ID] | Payer: [name] | Reason: [PA\_Denial\_Reason]. Proceed to Section 11 for appeal.

Log to audit\_log.xlsx: Action = PA Denied.

# 9. Clinical Scheduling & Visit Documentation

## 9.1 Supply Checklist

Before scheduling the nurse visit, confirm all items below are completed in clinical.xlsx. All columns except NS\_500mL\_Qty\_Ordered should contain YES. NS\_500mL\_Qty\_Ordered must contain a number (integer) of 2 or more:

| clinical.xlsx Column         | Requirement                                                                                                                                                        |
|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Drug_Order_Placed            | Drug ordered from CareIG or partner pharmacy per Drug_Source                                                                                                       |
| Drug_Delivery_Confirmed      | Delivery confirmed at patient address—record delivery date                                                                                                         |
| Drug_Lot_Number,<br>Drug_NDC | Lot number and NDC received from dispensing pharmacy                                                                                                               |
| NS_500mL_Qty_Ordered         | Enter the number of 500 mL NS bags ordered (integer), minimum 2. If the ordered drug is Gammaplex, enter 0 and order 500 mL 10% Dextrose bags instead (minimum 2). |

|                           |                                                                                    |
|---------------------------|------------------------------------------------------------------------------------|
| Filter_Tubing_Ordered     | 0.2-micron IV filter set ordered (required for all IVIG)                           |
| Benadryl_Available        | Diphenhydramine 50 mg/mL vial available if ordered as pre-med (N/A if not ordered) |
| Supplies_Other            | Gloves, alcohol swabs, dressing kit, sharps container confirmed                    |
| Supply_Checklist_Complete | Set YES only after all above fields are confirmed                                  |

**Supply\_Checklist\_Complete#YES when nurse scheduling is attempted:**

Post to #clinical-scheduling: [SUPPLY HOLD] CASE\_ID—checklist incomplete. Do not schedule until resolved.

## 9.2 Nurse Scheduling

1. Select nurse matching patient zip code and credential (RN required for first visit; verify state rules in payer\_rules.xlsx col Nursing\_Credential\_Requirement for subsequent visits).
2. Create calendar event: Title = IVIG Visit—[CASE\_ID]. Include nurse.
3. Set duration using the estimated infusion times in infusion\_duration.xlsx. Look up the row matching the ordered drug and dose range to find the estimated visit length in hours.
4. Confirm visit with patient. Script:  
 Hello [Patient Name], this is [Your Name] from CarelG. Your insurance has approved your IVIG infusion. We have availability on [Date] at [Time]—does that work for you? The visit will take approximately [X] hours."
5. Update clinical.xlsx: Visit\_Date, Visit\_Time, Nurse\_Assigned. Post to #clinical-scheduling: [SCHEDULED] [CASE\_ID] | Date: [Visit\_Date] | Nurse: [Nurse\_Assigned].
6. Email assigned nurse. Subject: [VISIT ASSIGNMENT] [CASE\_ID] | [Date]. Include: patient address, drug name, dose, lot number, NDC, infusion rate, pre-med orders, emergency contact, and contraindications from intake.xlsx.

## 9.3 Visit Documentation

The nurse must complete all fields below in visit\_note.xlsx and set col Nurse\_Signature within 4 hours of visit completion. A claim cannot be initiated if Nurse\_Signature is blank.

| visit_note.xlsx Column                          | Description                                            | Required |
|-------------------------------------------------|--------------------------------------------------------|----------|
| Visit_Date, Visit_Start_Time, Visit_End_Time    | Date and exact start/end times                         | Yes      |
| Visit_Duration_Minutes                          | End time–Start time in minutes                         | Yes      |
| Drug_Name_Trade, Drug_Name_Generic              | E.g., Gammaplex 5% and Immune Globulin Intravenous     | Yes      |
| Drug_NDC, Drug_Lot_Number, Drug_Expiration_Date | Transcribed from vial label                            | Yes      |
| Dose_Ordered_Grams, Dose_Administered_Grams     | Ordered vs actual. Claims use Dose_Administered_Grams. | Yes      |
| Route                                           | IV or SQ—must match MD order                           | Yes      |

|                                                          |                                                                                                                              |                                   |
|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| Infusion_Start_Rate_mL_hr,<br>Infusion_Rate_Adjustments  | Initial rate and all changes with timestamps. If no changes: None.                                                           | Yes                               |
| Premeds_Administered                                     | Format: [Drug] [Dose][unit] [Route] at [Time] for [Indication]. If none: None administered.                                  | Yes                               |
| NS_500mL_Bags_Used,<br>NS_250mL_Bags_Used                | Count of bags actually used                                                                                                  | Yes                               |
| Pump_Used                                                | YES or NO                                                                                                                    | Yes                               |
| Vital_Signs_Pre,<br>Vital_Signs_Mid,<br>Vital_Signs_Post | BP, HR, Temp, RR at each point. Mid: N/A if no rate changes.                                                                 | Yes                               |
| Patient_Response                                         | Clinical response. If uneventful: Patient tolerated infusion without adverse events.                                         | Yes                               |
| Education_Provided                                       | Education given. SQ patients: document self-infusion training if performed. If none: None.                                   | Yes                               |
| Nurse_Signature                                          | Full name and credential (e.g., Jane Smith, RN)                                                                              | Yes—blocks claim if blank         |
| Dextrose_500mL_Bags_Used                                 | For Gammaplex cases only: number of 500 mL 10% Dextrose bags actually used during the visit. For all other drugs, enter N/A. | Yes for Gammaplex, N/A otherwise. |

### **Nurse\_Signature is blank:**

Post to #clinical-scheduling: [UNSIGNED NOTE] CASE\_ID—claim on hold until signed.

Post to #clinical-scheduling: [VISIT COMPLETE] [CASE\_ID] | DOS: [Visit\_Date]. Log to audit\_log.xlsx: Action = Visit Note Signed.

## 10. Billing & Payment Posting

### 10.1 Pre-Billing Validation

Before building claim.xlsx, confirm every condition below is TRUE. If any is FALSE: post to #billing with the specific failure and do not proceed.

| Condition                                                         | If FALSE—Post to #billing                                               |
|-------------------------------------------------------------------|-------------------------------------------------------------------------|
| visit_note.xlsx col Nurse_Signature is non-blank                  | [BILLING HOLD—UNSIGNED NOTE] CASE_ID                                    |
| auth.xlsx col PA_Status = Approved                                | [BILLING HOLD—NO PA APPROVAL] CASE_ID                                   |
| auth.xlsx col PA_Number is non-blank                              | [BILLING HOLD—PA NUMBER MISSING] CASE_ID                                |
| auth.xlsx col PA_Expiration_Date ≥ visit_note.xlsx col Visit_Date | [BILLING HOLD—PA EXPIRED ON DOS] CASE_ID   PA Exp: [date]   DOS: [date] |

|                                                                                                                |                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| auth.xlsx col PA_Approved_Drug matches visit_note.xlsx col Drug_Name_Trade (case-insensitive)                  | [BILLING HOLD—DRUG MISMATCH] CASE_ID   PA: [drug]   Administered: [drug]                                                                                                                             |
| auth.xlsx col PA_Approved_Dose (grams) is greater than or equal to visit_note.xlsx col Dose_Administered_Grams | [BILLING HOLD—DOSE EXCEEDS PA] CASE_ID   PA approved: [PA_Approved_Dose]g   Administered: [Dose_Administered_Grams]g. Post to #billing and escalate to BVS to obtain a revised PA before submitting. |
| intake.xlsx col Diagnosis_ICD10 is consistent with PA approval (verify in auth.xlsx)                           | [BILLING HOLD—ICD10 INCONSISTENT] CASE_ID                                                                                                                                                            |
| visit_note.xlsx col Dose_Administered_Grams is non-blank and > 0                                               | [BILLING HOLD—DOSE NOT DOCUMENTED] CASE_ID                                                                                                                                                           |
| claim.xlsx has no Submission_Date for this DOS (duplicate check)                                               | [DUPLICATE CLAIM RISK] CASE_ID   DOS: [date]                                                                                                                                                         |
| benefits.xlsx confirms active coverage on DOS                                                                  | [BILLING HOLD—COVERAGE NOT CONFIRMED] CASE_ID                                                                                                                                                        |

## 10.2 Claim Construction

Copy claim\_blank.xlsx to create claim.xlsx for this case. Use the following rules:

| Claim Component          | Rule                                                                                                                                                                                                                                                                                                                                  |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Drug J-Code              | Look up J-code in jcodes.xlsx for Drug_Name_Trade. Units = (Dose_Administered_Grams×1000)÷unit size. See Section 13 for full table and examples. If the result is not a whole number, round down to the nearest integer. Example: 25.3g Privigen = 50,600mg÷500 = 101.2→bill 101 units.                                               |
| Nursing Code             | If Visit_Duration_Minutes is 60 or less, bill 99600×1 only. Do not bill 99603. Read benefits.xlsx col Nursing_Code_Pref. Blank or 99600: bill 99600×1 + 99603× floor((Visit_Duration_Minutes-60)÷60). G0153 (Medicare Part B): bill G0153×1 only. T1029/T1032: verify per state in payer_rules.xlsx.                                  |
| Saline                   | J7030×NS_500mL_Bags_Used. J7050×NS_250mL_Bags_Used. Both from visit_note.xlsx. For Gammaplex cases: do not bill J7030 or J7050. Instead bill A4221 for the Dextrose supply as part of the general infusion supplies line. Read Dextrose_500mL_Bags_Used from visit_note.xlsx to confirm administration was documented before billing. |
| Pre-Medications          | Parse visit_note.xlsx col Premeds_Administered. Diphenhydramine: J0171×(mg÷50). Promethazine: J2550×(mg÷25). If None administered: leave blank.                                                                                                                                                                                       |
| Supplies                 | A4221×1 per visit. If Pump_Used = YES: also A4222×1.                                                                                                                                                                                                                                                                                  |
| Header / Auth Fields     | PA_Number = auth.xlsx col PA_Number. Physician_NPI = intake.xlsx col Physician_NPI. CareIG_NPI and Tax_ID from payer_rules.xlsx. DOS = visit_note.xlsx col Visit_Date. ICD10 = intake.xlsx col Diagnosis_ICD10. CareIG Taxonomy Code from org_identifiers.xlsx.                                                                       |
| Split-Bill (OON partner) | If clinical.xlsx col Drug_Source≠CareIG: leave all IVIG drug J-code fields blank. Set claim.xlsx col Billing_Model = Split—Drug billed by [Drug_Source].                                                                                                                                                                              |



|                      |                                                                                                                                                                                                                            |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Claim_Frequency_Code | Enter 1 for all original claim submissions. Enter 7 when resubmitting a corrected claim. Enter 8 when voiding a duplicate. Write value to claim.xlsx col Claim_Frequency_Code.                                             |
| Modifier             | Read visit_note.xlsx col Route. If Route = IV: no modifier required on the drug J-code line. If Route = SQ: append modifier SC to the drug J-code line in claim.xlsx col Drug_Modifier. Write Drug_Modifier to claim.xlsx. |

### 10.3 Claim Submission

1. Export claim.xlsx to PDF→claim\_[DOS].pdf.
2. Email to payer billing address (payer\_rules.xlsx col Claim\_Submission\_Email). Subject: [CLAIM SUBMISSION] CareIG NPI: [NPI] | [Patient Last Name] | MemberID: [Member\_ID] | DOS: [Visit\_Date]. Attach claim\_[DOS].pdf.
3. Update claim.xlsx: Submission\_Date = today, Submission\_Ref\_Number = email confirmation ID, Claim\_Status = Submitted.
4. Post to #billing: [CLAIM SUBMITTED] [CASE\_ID] | DOS: [Visit\_Date] | Payer: [name] | Billed: \$[Total\_Billed].

Log to audit\_log.xlsx: Action = Claim Submitted.

### 10.4 ERA & Payment Posting

1. ERA and EOB documents arrive by email to [billing@careig.com](mailto:billing@careig.com) from the payer. When received, download the attachment and save it as era\_[DOS]\_[Payer].pdf.
2. Compare Paid\_Amount to payer\_rules.xlsx col Contracted\_Rate. If Paid\_Amount < Contracted\_Rate: post to #billing-mgmt: [UNDERPAYMENT] CASE\_ID | Payer: [name] | Expected: \$[rate] | Received: \$[paid]. Do not write off.
3. If ERA contains a denial (any CARC-coded line with \$0 paid): copy denial\_blank.xlsx to create DENIAL\_[CARC]\_[DOS].xlsx. Populate CARC\_Code, Denial\_Date, DOS, Denied\_Code, Denied\_Amount. Follow Section 11.
4. Update claim.xlsx: Payment\_Posted\_Date = today, Claim\_Status = Paid / Partially Paid / Denied. 5. If Patient\_Responsibility > 0: complete patient\_statement\_template.docx with patient name, DOS, billed amount, insurance payment, and patient balance. Save as statement\_[DOS].pdf. Email to patient at intake.xlsx col Patient\_Email. Subject: CareIG Statement of Account | DOS: [Visit\_Date].

## 11. Denial Management & Appeals

### 11.1 Denial Actions by CARC Code

| CARC  | Denial Reason                          | Action                                                                                                                                                                                                                                                                                                                                                                         |
|-------|----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CO-4  | Procedure code / modifier inconsistent | Correct modifier per visit_note.xlsx col Route. Resubmit.                                                                                                                                                                                                                                                                                                                      |
| CO-11 | Diagnosis inconsistent with procedure  | Confirm ICD-10 in claim.xlsx matches PA approval in auth.xlsx. If mismatch: email intake.xlsx col Physician_Email. Subject: [ICD10 CLARIFICATION NEEDED] CASE_ID   DOS: [date]. Body: state the ICD-10 on the claim, the ICD-10 on the PA, and ask the physician to confirm the correct code in writing. Do not resubmit until written confirmation is received and saved to . |

|                          |                                     |                                                                                                                                                                                                                                                                                                                                                                                                                     |
|--------------------------|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CO-16                    | Claim lacks required information    | Identify missing field from denial detail (NPI, taxonomy, PA number). Update claim.xlsx. Resubmit.                                                                                                                                                                                                                                                                                                                  |
| CO-18                    | Duplicate claim                     | Check claim.xlsx Submission_Log for prior submission on same DOS. If confirmed duplicate: resubmit the original claim with claim frequency code 8 (void/cancel) via email to the payer billing address. Update claim.xlsx col Claim_Status = Voided. Do not delete the original row. If not: resubmit with frequency code 7.                                                                                        |
| CO-22                    | COB—other payer may be primary      | CO-22 means another payer is primary. Check benefits.xlsx col Secondary_Insurance. If a primary payer is listed that was not yet billed: submit a new claim to that payer first. When their EOB is received, save it as era_[DOS]_[PrimaryPayer].pdf and resubmit to the original payer with COB fields populated: COB_Other_Payer_Name, COB_Other_Payer_Member_ID, COB_Other_Payer_Paid, COB_Other_Payer_EOB_Date. |
| CO-50                    | Non-covered service                 | File Level 1 appeal per Section 11.2.                                                                                                                                                                                                                                                                                                                                                                               |
| CO-96                    | Non-covered charge                  | Compare to payer_rules.xlsx contracted rate. If dispute: post to #billing-mgmt. Write-off requires Director approval.                                                                                                                                                                                                                                                                                               |
| CO-97                    | Benefit not assigned                | Open benefits.xlsx col Benefit_Type. If the benefit tier on the original claim does not match what is listed in benefits.xlsx (e.g., billed under pharmacy benefit but should be medical): correct claim.xlsx and resubmit. If the benefit tier on the claim matches benefits.xlsx and the payer still denies: file a Level 1 appeal per Section 11.2.                                                              |
| PR-1 /<br>PR-2 /<br>PR-3 | Deductible /<br>Coinsurance / Copay | Read the patient responsibility amount directly from the ERA line item for this denial. Write that amount to claim.xlsx col Patient_Responsibility. Generate and send patient statement per Section 10.4.                                                                                                                                                                                                           |
| OA-23                    | Charge exceeds fee schedule         | Compare Paid_Amount to contracted rate. If underpaid: post to #billing-mgmt per Section 12.                                                                                                                                                                                                                                                                                                                         |
| PI-204                   | Not medically necessary             | Gather PA approval, LMN, clinical notes, IgG labs from . File Level 1 appeal per Section 11.2.                                                                                                                                                                                                                                                                                                                      |

## 11.2 Appeal Submission

1. Gather from : original claim PDF, PA approval, physician LMN, visit\_note export, and ERA/EOB showing the denial.
2. Complete appeal\_template.docx. Save as appeal\_L[1 or 2]\_[DOS].pdf.
3. Email appeal to payer\_rules.xlsx col Appeal\_Submission\_Email. Subject: [APPEAL L[1/2]] CareIG | [Patient Last Name] | MemberID: [Member\_ID] | DOS: [DOS] | Claim: [Submission\_Ref\_Number] | CARC: [code]. Attach all documents.
4. Update appeals/appeals\_log.xlsx: DOS, CARC\_Code, Appeal\_Level, Appeal\_Submitted\_Date, Appeal\_Status = Submitted.
5. Post to #billing-appeals: [APPEAL FILED L[1/2]] [CASE\_ID] | DOS | Payer | CARC.

Follow-up: if (today–Appeal\_Submitted\_Date)≥15 days and Appeal\_Status = Submitted, call payer appeal department. Log in col Followup\_Log: [Date] [Time] | Rep: [name] | Ref#: [#] | Next: [date].

If Level 2 denied: post to #billing-mgmt: [L2 DENIED] CASE\_ID. Director of Revenue Cycle determines next action (write-off, IRO request, or state commissioner complaint).

Log to audit\_log.xlsx: Action = Appeal Submitted.

## 12. Escalation & Monitoring

### 12.1 Escalation Paths

| Scenario                                  | Slack Channel        | Action                                                                                                                                             |
|-------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| PA pending > 5 days                       | #intake-mgmt         | Post: [PA DELAY] CASE_ID   Payer   Days Pending. Supervisor follows up with payer.                                                                 |
| Claim unpaid, no ERA                      | #billing             | Post: [AR FOLLOWUP] CASE_ID   [days] outstanding   [Payer]. Log payer call in claim.xlsx col AR_Followup_Log.                                      |
| Payer underpaid vs contract               | #billing-mgmt        | Post: [UNDERPAYMENT] CASE_ID   Expected: \$[rate]   Received: \$[paid]. Director or contracting team reviews contract terms.                       |
| Patient balance >\$500, unresolved        | #billing-mgmt        | Confirm 3 contact attempts in intake.xlsx. If <3: email patient. If 3+: post to #billing-mgmt requesting collections authorization from Director.  |
| Write-off request >\$200                  | #billing-mgmt        | Post: [WRITE-OFF REQUEST] CASE_ID   Amount: \$[amount]   Reason: [reason]. Requires Director approval before actioning.                            |
| Level 2 appeal denied                     | #billing-mgmt        | Post: [L2 DENIED] CASE_ID. Director determines: write-off, IRO, or state complaint.                                                                |
| Legal threat or attorney communication    | #compliance          | STOP. Do not respond or modify case files. Post: [LEGAL THREAT] CASE_ID. Director of Operations and legal@careig.com must be notified immediately. |
| Suspected fraud or billing abuse          | #compliance          | STOP. Do not discuss elsewhere or modify files. Post: [COMPLIANCE REPORT] CASE_ID. Call Compliance Hotline.                                        |
| Wrong drug lot/dose from partner pharmacy | #clinical-scheduling | Do not administer. Document in clinical.xlsx col Drug_Issue_Notes. Post: [DRUG ISSUE] CASE_ID—visit on hold. Contact partner pharmacy.             |

### 12.2 Workflow Monitoring

The intake supervisor, billing supervisor, or designated lead is responsible for reviewing open cases each morning. For each active case, check the condition in the left column against the relevant file. If the condition is true and the Slack message has not yet been sent, send it now. Do not wait for the assigned staff member to flag it—this review is a supervisory responsibility.

| Condition                                                                  | Slack Notification                                    |
|----------------------------------------------------------------------------|-------------------------------------------------------|
| audit_log.xlsx has Referral Received for CASE_ID but no BVS Assigned entry | #intake-alerts: [UNASSIGNED] CASE_ID—no BVS assigned. |
| benefits.xlsx col BV_Complete is blank after BVS Assigned log entry        | #intake-alerts: [BV OVERDUE] CASE_ID.                 |
| auth.xlsx col PA_Submission_Date is blank after BV_Complete = YES          | #intake-alerts: [PA NOT SUBMITTED] CASE_ID.           |

|                                                                                                                                       |                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| auth.xlsx col PA_Status = Pending AND Last_Followup_Date is 2+ days old                                                               | Call payer. Update PA_Call_Log and Last_Followup_Date in auth.xlsx.                                          |
| clinical.xlsx col Handoff_Status is blank after auth.xlsx col PA_Status = Approved                                                    | #clinical-scheduling: [HANDOFF MISSING] CASE_ID.                                                             |
| clinical.xlsx col Visit_Date is blank after Handoff_Status = Received                                                                 | #clinical-scheduling: [UNSCHEDULED] CASE_ID.                                                                 |
| visit_note.xlsx col Nurse_Signature is blank after Visit_Date is populated                                                            | #clinical-scheduling: [UNSIGNED NOTE] CASE_ID.                                                               |
| claim.xlsx col Submission_Date is blank after Nurse_Signature is populated                                                            | #billing: [CLAIM NOT SUBMITTED] CASE_ID.                                                                     |
| claim.xlsx col ERA_Received_Date is populated AND Payment_Posted_Date is blank                                                        | #billing: [ERA UNPOSTED] CASE_ID.                                                                            |
| A file in has Appeal_Submitted = blank                                                                                                | #billing-appeals: [DENIAL UNWORKED] CASE_ID.                                                                 |
| (today-claim.xlsx col DOS) in days exceeds 80% of payer_rules.xlsx col Timely_Filing_Days AND claim.xlsx col Submission_Date is blank | #billing: [TIMELY FILING RISK] CASE_ID   [days elapsed] of [limit] days   [Payer]. Submit claim immediately. |

## 13. Reference Tables

### 13.1 HCPCS / J-Code Reference

Source: jcodes.xlsx. Always use visit\_note.xlsx col Dose\_Administered\_Grams—never the ordered dose. Billed rates for each code are stored in fee\_schedule.xlsx col Billed\_Rate. To calculate Total\_Billed for a claim: multiply each code's units by its Billed\_Rate and sum all lines. Write the result to claim.xlsx col Total\_Billed.

| HCPCS | Description                        | Unit   | Formula                    |
|-------|------------------------------------|--------|----------------------------|
| J1459 | IVIG—Privigen, Gammagard (IV)      | 500 mg | $(g \times 1000) \div 500$ |
| J1557 | IVIG—Gammaplex (IV)                | 500 mg | $(g \times 1000) \div 500$ |
| J1559 | IVIG—Hizentra (SQ)                 | 100 mg | $(g \times 1000) \div 100$ |
| J1560 | IVIG—Octagam (IV)                  | 500 mg | $(g \times 1000) \div 500$ |
| J1561 | IVIG—Gamunex-C (IV or SQ)          | 500 mg | $(g \times 1000) \div 500$ |
| J1569 | IVIG—Gammagard Liquid (IV)         | 500 mg | $(g \times 1000) \div 500$ |
| J1575 | IVIG—HyQvia (SQ)                   | 100 mg | $(g \times 1000) \div 100$ |
| J7030 | Normal Saline 0.9%, per 500 mL bag | 500 mL | Units = NS_500mL_Bags_Used |

|       |                                           |                |                                                                                                 |
|-------|-------------------------------------------|----------------|-------------------------------------------------------------------------------------------------|
| J7050 | Normal Saline 0.9%, per 250 mL bag        | 250 mL         | Units = NS_250mL_Bags_Used                                                                      |
| J0171 | Diphenhydramine (Benadryl), per 50 mg     | 50 mg          | Units = mg administered+50. Requires documentation in Premeds_Administered.                     |
| J2550 | Promethazine injection, per 25 mg         | 25 mg          | Units = mg administered+25. Same documentation rule as J0171.                                   |
| A4221 | IV infusion supplies, per visit           | Per visit      | Bill 1 unit per visit regardless of whether a pump is used.                                     |
| A4222 | Infusion pump supplies, per visit         | Per visit      | Bill 1 additional unit per visit when Pump_Used = YES. Bill alongside A4221, not instead of it. |
| 99600 | Home infusion nursing—first hour          | Per visit      | 1 unit. Default for non-Medicare.                                                               |
| 99603 | Home infusion nursing—each add'l hour     | Per add'l hour | $\text{floor}((\text{Visit\_Duration\_Minutes}-60)\div 60)$ units.                              |
| G0153 | Skilled nursing, home infusion (Medicare) | Per visit      | 1 unit. Medicare Part B only. Replaces 99600/99603.                                             |
| T1029 | Nursing assessment, per visit             | Per visit      | Use when Nursing_Code_Pref = T1029. Verify by state.                                            |
| T1032 | Nursing visit, per diem                   | Per diem       | Use when Nursing_Code_Pref = T1032. Verify by state.                                            |

### 13.2 Unit Calculation Examples

| Scenario                                     | Result                                                                                            |
|----------------------------------------------|---------------------------------------------------------------------------------------------------|
| 30g Gammaplex 5% IV→J1557                    | $30 \times 1000 \div 500 = 60$ units                                                              |
| 40g Privigen 10% IV→J1459                    | $40 \times 1000 \div 500 = 80$ units                                                              |
| 6g Hizentra 20% SQ→J1559                     | $6 \times 1000 \div 100 = 60$ units                                                               |
| 10g HyQvia 10% SQ→J1575                      | $10 \times 1000 \div 100 = 100$ units                                                             |
| Partial: ordered 30g, administered 20g→J1557 | Use 20g only: $20 \times 1000 \div 500 = 40$ units. Note in claim.xlsx col Partial_Infusion_Note. |
| 270-minute visit, non-Medicare               | $99600 \times 1 + 99603 \times \text{floor}((270-60)\div 60) = 99600 \times 1 + 99603 \times 3$   |
| 270-minute visit, Medicare Part B            | G0153×1 only                                                                                      |

### 13.3 Drug Reference

| Drug | Route | J-Code | Units/g | Notes |
|------|-------|--------|---------|-------|
|------|-------|--------|---------|-------|

|                      |          |       |    |                                                                                                                                                                                        |
|----------------------|----------|-------|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Gammaflex 5% / 10%   | IV       | J1557 | 2  | Diluent: 10% Dextrose—do NOT use NS. Refrigerate until 1 hr before use. Document bags used in visit_note.xlsx col Dextrose_500mL_Bags_Used. Bill via A4221—do not bill J7030 or J7050. |
| Octagam 5% / 10%     | IV       | J1560 | 2  | Do NOT shake. Confirm MD-ordered rate for 10%.                                                                                                                                         |
| Gammagard S/D        | IV       | J1459 | 2  | Reconstitute per package insert. Latex-free.                                                                                                                                           |
| Gammagard Liquid 10% | IV       | J1569 | 2  | Off-label SQ use requires a separate MD order in .                                                                                                                                     |
| Privigen 10%         | IV       | J1459 | 2  | Contraindicated in hyperprolinemia. Check intake.xlsx col Contraindications.                                                                                                           |
| Gamunex-C 10%        | IV or SQ | J1561 | 2  | Document route in visit_note.xlsx. Same J-code for both routes.                                                                                                                        |
| Hizentra 20%         | SQ       | J1559 | 10 | Document self-infusion training on first visit in Education_Provided.                                                                                                                  |
| HyQvia 10%           | SQ       | J1575 | 10 | Check payer_rules.xlsx for hyaluronidase co-billing requirement.                                                                                                                       |

### 13.4 ICD-10 Reference

ICD-10 codes come from intake.xlsx col Diagnosis\_ICD10. Confirm the code is in this table as written here when processing the intake. If there is no match, add a stop entry to the audit log with the reason “ICD Validation Error”. Also make sure the required documentation exists in the PA submission packet before submitting any PA or claim.

| ICD-10 | Diagnosis                               | Required Documentation in                             |
|--------|-----------------------------------------|-------------------------------------------------------|
| D83.9  | CVID, unspecified                       | MD progress note; IgG < 400 mg/dL within 6 months     |
| D80.0  | Hereditary hypogammaglobulinemia        | MD note with hereditary basis; IgG level              |
| D80.1  | Nonfamilial hypogammaglobulinemia       | IgG < 400 mg/dL lab result; MD progress note          |
| D80.6  | Antibody deficiency w/ near-normal Ig   | Clinical notes; specialist consult preferred          |
| D89.3  | Immune reconstitution syndrome          | Transplant documentation; oncology/hematology consult |
| G61.0  | Guillain-Barré Syndrome                 | Neurology consult; NCS/EMG results; MD LMN            |
| G70.00 | Myasthenia gravis, without exacerbation | EMG/NCS; neurology note                               |
| G70.01 | Myasthenia gravis, with exacerbation    | Crisis history; set auth.xlsx col Urgency = STAT      |
| D69.3  | Immune thrombocytopenic purpura         | Platelet count labs; MD diagnosis note                |

|             |                   |                                                 |
|-------------|-------------------|-------------------------------------------------|
| B20         | HIV disease       | CD4 count; viral load; HIV diagnosis; MD LMN    |
| Z94.0–Z94.9 | Transplant status | Transplant surgical record or discharge summary |

### 13.5 Payer Guidelines

| Payer Type            | Claim Format              | Key Rules                                                                                   |
|-----------------------|---------------------------|---------------------------------------------------------------------------------------------|
| Medicare Part B       | Email (PDF)               | Use G0153 for nursing. Apply MSP rules. Verify MAC in payer_rules.xlsx.                     |
| Medicare Advantage    | Email (PDF) per plan      | Confirm IVIG benefit placement (medical vs pharmacy) in benefits.xlsx col Benefit_Type.     |
| Medicaid              | Email (PDF) per state     | PA required in most states. Check formulary and nursing code per state in payer_rules.xlsx. |
| Commercial PPO        | Email (PDF)               | Confirm CareIG_Network_Status = In-Network before scheduling.                               |
| Commercial HMO        | Email (PDF)               | PCP referral may be required. Document in benefits.xlsx col Referral_Required.              |
| Accredo / Coram (OON) | CareIG bills nursing only | Do NOT bill drug J-code. Bill: 99600/99603, A4221/A4222, pre-med J-codes, saline only.      |

## 14. Appendix A—Scripts & Templates

### Template Reference

| File                            | Used In                             |
|---------------------------------|-------------------------------------|
| intake_blank.xlsx               | Section 6.1                         |
| unable_to_reach_template.docx   | Section 6.2—Template 1              |
| p2p_request_email_template.docx | Section 8.5—Template 2              |
| appeal_template.docx            | Section 11.2—Template 3             |
| patient_statement_template.docx | Section 10.4                        |
| pa_cover_blank.docx             | Section 8.3                         |
| claim_blank.xlsx                | Section 10.2                        |
| denial_blank.xlsx               | Section 10.4                        |
| appeals_log_blank.xlsx          | Section 11.2                        |
| letter_cover_blank.docx         | All outbound document transmissions |

## Template 1: Unable to Reach Patient—Email to Referring Physician

DATE: [today]  
TO: Dr. [Physician\_Name] | EMAIL: [intake.xlsx col Physician\_Email]  
FROM: CareIG Specialty Pharmacy – Intake | EMAIL: intake@careig.com  
RE: Unable to Contact Patient | CASE\_ID: [CASE\_ID]

Dear Dr. [Physician\_Name],

We received a referral for [Patient First Last] (DOB: [Patient\_DOB]).  
After 3 contact attempts, we have been unable to reach the patient  
at the number on file: [Patient\_Phone].

Attempt 1: [intake.xlsx Contact\_Attempt\_Log entry 1]  
Attempt 2: [intake.xlsx Contact\_Attempt\_Log entry 2]  
Attempt 3: [intake.xlsx Contact\_Attempt\_Log entry 3]

Please provide an alternate contact or assist in connecting the patient  
with our team. We cannot proceed until contact is established.

Email: intake@careig.com

[Patient Rep Name] – CareIG Specialty Pharmacy, Intake

## Template 2: Peer-to-Peer Request Email to Physician

DATE: [today]  
TO: Dr. [Physician\_Name] | EMAIL: [intake.xlsx col Physician\_Email]  
FROM: CareIG Specialty Pharmacy – Prior Authorization  
RE: P2P Review Request | CASE\_ID: [CASE\_ID]  
Patient: [First Last] | DOB: [Patient\_DOB]

Dear Dr. [Physician\_Name],

[Patient\_Last\_Name]'s PA for [auth.xlsx PA\_Drug\_Submitted] [PA\_Dose\_Submitted]g was  
denied by [Payer] with reason: [auth.xlsx PA\_Denial\_Reason].

The payer has offered a peer-to-peer review. Available slots:  
[auth.xlsx P2P\_Available\_Slots – one per line]  
To schedule: call [benefits.xlsx PA\_Phone] | PA Case#: [auth.xlsx PA\_Ref\_Number] No  
response within 2 business days = CareIG will file a Level 1 written appeal.

Reply to: pa@careig.com

[BVS Name] – CareIG Specialty Pharmacy, Prior Authorization

## Template 3: Appeal Letter—Level 1 and Level 2

DATE: [today]  
TO: [Payer] Appeals Dept.  
[payer\_rules.xlsx col Appeal\_Submission\_Email]  
FROM: CareIG Specialty Pharmacy | NPI: [CareIG\_NPI] | Tax ID: [CareIG\_Tax\_ID]



APPEAL LEVEL: [1 / 2]  
Patient: [Last Name, First Name]  
Member ID: [intake.xlsx Primary\_Member\_ID]  
DOS: [claim.xlsx DOS]  
Claim #: [claim.xlsx Submission\_Ref\_Number] CARC:  
[code] – [description]  
Billed: \${claim.xlsx Total\_Billed}

Dear Appeals Department,

CareIG Specialty Pharmacy submits this Level [1/2] appeal for [Patient Name].  
The claim was denied with CARC [code]: [description].

Basis for Appeal:  
PA #[auth.xlsx PA Number] was approved for [PA\_Approved\_Drug] [PA\_Approved\_Dose]g,  
effective [PA\_Effective\_Date] through [PA\_Expiration\_Date]. The service on [DOS]  
is consistent with the approved authorization and ICD-10 [Diagnosis\_ICD10].  
[Add specific clinical basis referencing attached documents.]

Attached:

1. Original claim – claim\_[DOS].pdf
2. PA approval – pa\_approval\_[Payer].pdf (PA#: [PA\_Number])
3. Physician LMN – lmn\_[PhysicianName].pdf
4. Nursing visit note (exported from visit\_note.xlsx)
5. Lab results – igglevel\_[MMDDYYYY].pdf
6. ERA/EOB – era\_[DOS]\_[Payer].pdf

CareIG requests reconsideration at contracted rate: \${payer\_rules.xlsx  
Contracted\_Rate}.

Contact: billing@careig.com | [CareIG Billing Phone]

[Billing Specialist Name, Credential] – CareIG Specialty Pharmacy, Billing

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—END OF DOCUMENT—CareIG-SOP-BILL-001 v5.0—