Priority Health

MEDICAL POLICY
No. 91414-R22

INFUSION SERVICES & EQUIPMENT

Effective Date: March 1, 2025	**Review Dates: 10/95, 12/99, 12/01, 11/02, 11/03, 11/04, 10/05, 10/06, 10/07, 10/08, 10/09, 4/10, 4/11, 4/12, 4/13, 5/14, 5/15, 2/16, 2/17, 5/17, 11/17, 8/18, 8/19, 11/19, 8/20, 5/21, 11/21, 5/22, 5/23, 5/24, 11/24, 2/25**
Date Of Origin: October 1, 1995	**Status: Current**

Summary of Changes

- I.C:
  - Addition: Exemptions for site of service review may be considered for starting doses with multiple administrations, complexity of infusion, and when receiving immune checkpoint inhibitors in combination with provider-administered chemotherapy on the same day
  - Deletion: Removed age specific exemption from site of service review.
  - Formatting changes.

I. POLICY/CRITERIA

A. External Infusion Pumps

1. Preauthorization may be required for certain indications as determined by the medical department.

2. Insulin Pumps:
   a. Commercial / Medicare: Both newly prescribed and replacement insulin pumps must be prior authorized and are medically necessary when applicable InterQual® criteria are met.
   b. Medicaid: For Medicaid/Healthy Michigan Plan members, an Insulin Pump may be considered medically necessary when the criteria specified in the current Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual are met (see section Coverage Conditions and Requirements – Diabetic Equipment and Related Supplies – External Infusion (Insulin) Pump and Supplies of MDHHS manual).

B. Implantable Infusion Pumps

1. Pre-authorization for implantable infusion pumps may be required for specific indications as determined by the medical department. They must be FDA approved to administer the drug prescribed. ***Note:*** *For Code C2626 - infusion pump, nonprogrammable, temporary (implantable), prior authorization is not required.*

2. Chronic Pain Management: An implantable infusion pump to administer opioid drugs epidurally or intrathecally must be prior authorized and is medically necessary for severe chronic malignant or non-malignant pain when applicable InterQual® criteria are met.
3. Intrahepatic Chemotherapy: Implantable infusion pumps for continuous hepatic artery infusion of chemotherapy are medically necessary for primary or metastatic liver cancer if metastasis is limited to the liver and ***one*** of the following apply:
   a. Tumor is unresectable, ***or***
   b. Patient refused surgical excision of the tumor.
4. Anti–spasmodic Drugs: An implantable infusion pump to administer anti-spasmodic drugs (e.g. baclofen) intrathecally for severe chronic spasticity is a covered benefit if ***both*** of the following apply:
   a. Failure of less invasive methods (e.g. oral anti-spasmodic) either due to inadequate spasm control or side effects.
   b. Favorable response to a trial intrathecal dose of anti-spasmodic drug.
5. Thromboembolic Disease: The use of an implantable infusion pump to administer heparin for recurrent thromboembolic disease has not been proven to be safe or effective, and is not medically necessary.

C. Limits/Indications

1. Medications with site of service requirements can be found in Priority Health's Drug Information page.

2. **For Fully and Self-Funded Commercial Products:** Priority Health requires that patients receiving selected infusions or injections to have the infusion or injection in the home or office setting, or an alternative Priority Health-approved site of service.

3. An exception may be considered for:
   a. Starting dose(s) only when multiple administrations are required and provided that the medication is not subject to limited distribution. All subsequent doses will be subject to this policy.
   b. Complexity of the infusion required by an individual is such that it can only be performed safely and effectively by or under the supervision of a specialty skilled nursing personnel.
   c. History of infusion reactions leading to serious adverse events despite management with pre-medication and infusion rate control.

d. History of severe adverse event following an infusion (i.e., anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure).
e. Medically unstable situations (e.g., unstable renal function, unstable vascular access).
f. Distance (in miles) from the nearest approved site of service.
g. Members receiving immune checkpoint inhibitors in combination with provider-administered chemotherapy on the same day.

Please note: Exceptions for gene and cell therapy are excluded from the above exception criteria and will be assessed on a case-by-case basis.

For Medicaid/Healthy Michigan: Priority Health requires that patients receiving selected infusions or injections to have the infusion or injection in a Priority Health-approved site of service.

II. MEDICAL NECESSITY REVIEW

Prior authorization for certain drug, services, and procedures may or may not be required. In cases where prior authorization is required, providers will submit a request demonstrating that a drug, service, or procedure is medically necessary. For more information, please refer to the Priority Health Provider Manual.

To access InterQual guidelines: Log into Priority Health Prism → Authorizations → Authorization Criteria Lookup.

III. APPLICATION TO PRODUCTS

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

- **HMO/EPO:** ***This policy applies to insured HMO/EPO plans.***
- **POS:** ***This policy applies to insured POS plans.***
- **PPO:** ***This policy applies to insured PPO plans. Consult individual plan documents as state mandated benefits may apply. If there is a conflict between this policy and a plan document, the provisions of the plan document will govern.***
- **ASO:** ***For self-funded plans, consult individual plan documents. If there is a conflict between this policy and a self-funded plan document, the provisions of the plan document will govern.***
- **INDIVIDUAL:** ***For individual policies, consult the individual insurance policy. If there is a conflict between this medical policy and the individual insurance policy document, the provisions of the individual insurance policy will govern.***
- **MEDICARE:** ***Coverage is determined by the Centers for Medicare and Medicaid Services (CMS) and/or the Evidence of Coverage (EOC); if a coverage determination has not been adopted by CMS, this policy applies.***

- **MEDICAID/HEALTHY MICHIGAN PLAN:** ***For Medicaid/Healthy Michigan Plan members, this policy will apply. Coverage is based on medical necessity criteria being met and the appropriate code(s) from the coding section of this policy being included on the Michigan Medicaid Fee Schedule located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html, the Michigan Medicaid Provider Manual will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. If there is a discrepancy or lack of guidance in the Michigan Medicaid Provider Manual, the Priority Health contract with Michigan Medicaid will govern. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

IV. DESCRIPTION

External infusion pumps are commonly used for drug delivery to administer antibiotics, analgesia, chemotherapy, blood products, parenteral nutrition, etc. The drug delivery catheter may be inserted into a peripheral or central vein, a subcutaneous space, implanted in an artery or other compartment (e.g. epidural). Some infusion pumps are designed for stationary use while others, called ambulatory infusion pumps, are designed to be portable or wearable.

Implantable infusion pumps are used for long-term site-specific drug therapy to various nervous and vascular compartments (e.g. epidural, hepatic artery, subarachnoid). Implantable infusion pumps are surgically implanted and able to provide a constant or a variable rate of infusion. These types of pumps allow long-term access and site-specific drug delivery, thereby allowing more mobility. An adverse event or suspected adverse reaction is considered "serious" if, in the view of Priority Health, it results in any of the following outcomes: Death, a life-threatening adverse event, inpatient hospitalization or prolongation of existing hospitalization, a persistent or significant incapacity or substantial disruption of the ability to conduct normal life functions, or a congenital anomaly/birth defect. Important medical events that may not result in death, be life-threatening, or require hospitalization may be considered serious when, based upon appropriate medical judgment, they may jeopardize the member and may require medical or surgical intervention to prevent one of the outcomes listed.

V. CODING INFORMATION

ICD-10 Codes that may apply:

G89.0	Central pain syndrome
G89.21 – G89.29	Chronic pain due to trauma
G89.3	Neoplasm related pain (acute) (chronic)
G89.4	Chronic pain syndrome

R52	Pain, unspecified
G90.50 – G90.9	Complex regional pain syndrome I
G95.11	Acute infarction of spinal cord (embolic) (nonembolic)
G95.19	Other vascular myelopathies
M08.1	Juvenile ankylosing spondylitis
M45.0 – M45.9	Ankylosing spondylitis
M48.00 – M48.9	Spinal Stenosis
M51.0 – M51.9	Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders with myelopathy
M54.00 – M54.9	Panniculitis affecting regions of neck and back
I27.0	Primary pulmonary hypertension
I27.20	Pulmonary hypertension, unspecified
I27.21	Secondary pulmonary arterial hypertension
I27.22	Pulmonary hypertension due to left heart disease
I27.23	Pulmonary hypertension due to lung diseases and hypoxia
I27.24	Chronic thromboembolic pulmonary hypertension
I27.29	Other secondary pulmonary hypertension
I27.83	Eisenmenger's syndrome
C22.0 – C22.9	Liver cell carcinoma
Z51.11	Encounter for antineoplastic chemotherapy
Z51.12	Encounter for antineoplastic immunotherapy
R25.0 – R25.9	Abnormal involuntary movements
G04.1	Tropical spastic paraplegia
G35	Multiple sclerosis
G80.0 – G80.9	Cerebral palsy
G81.10 – G81.14	Spastic hemiplegia

PT/HCPCS Codes:

***Prior authorization **not** required unless charge exceed $1,000 for Commercial or Medicare members, $500 for Medicaid members.*

All services and devices billed by Home Infusion providers require prior authorization

External pumps (except insulin pumps) are rental only.

36260	Insertion of implantable intra-arterial infusion pump (e.g., for chemotherapy of liver)
36261	Revision of implanted intra-arterial infusion pump
36262*	Removal of implanted intra-arterial infusion pump
61215	Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to Ventricular catheter

62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; non-programmable pump
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming
62365*	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion
62367*	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill
62368*	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming
62369*	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill
62370*	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)
95990*	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;
95991*	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional
96522*	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)
A4221*	Supplies for maintenance of non-insulin drug infusion catheter, per week (list drug separately) ***(Not covered for Priority Medicaid)***
A4222*	Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately) ***(Not covered for Priority Medicaid)***
A4223*	Infusion supplies not used with external infusion pump, per cassette or bag (list drugs separately) ***(Not covered for Priority Medicaid)***
C1772	Infusion pump, programmable (implantable)
C1891	Infusion pump, non-programmable, permanent (implantable)
C2626*	Infusion pump, nonprogrammable, temporary (implantable)
C9804	Elastomeric infusion pump (e.g., On-Q* pump with bolus), including catheter and all disposable system components, nonopioid medical device (must be a qualifying Medicare nonopioid medical device for postsurgical pain relief in accordance with Section 4135 of the CAA, 2023) *(Not Separately payable for Fully Funded and Self Funded)*

C9806	Rotary peristaltic infusion pump (e.g., ambIT pump), including catheter and all disposable system components, nonopioid medical device (must be a qualifying Medicare nonopioid medical device for postsurgical pain relief in accordance with Section 4135 of the CAA, 2023) *(Not Separately payable for Fully Funded and Self Funded)*
E0779*	Ambulatory infusion pump mechanical reusable for infusion 8 hours or greater
E0780*	Ambulatory infusion pump mechanical reusable for infusion less than 8 hours
E0781*	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient
E0782	Infusion pump, implantable, nonprogrammable (includes all components, e.g., pump, catheter, connectors, etc.)
E0783	Infusion pump system, implantable, programmable (includes all components, e.g., pump, catheter, connectors, etc.)
E0785*	Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement
E0786	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)
K0455	Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol)

VI. REFERENCES

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