NO. 91414-R23

INFUSION SERVICES AND EQUIPMENT

Effective date: 03/01/2026 **Last reviewed**: 02/2026

Instructions for use: This document is for informational purposes only. Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable. Eligibility and benefit coverage are determined in accordance with the terms of the member's plan in effect as of the date services are rendered. It is not an authorization, certification, explanation of benefits, or contract. Receipt of benefits is subject to satisfaction of all terms and conditions of coverage. Priority Health's medical policies are developed with the assistance of medical professionals and are based upon a review of published and unpublished information including, but not limited to, current medical literature, guidelines published by public health and health research agencies, and community medical practices in the treatment and diagnosis of disease. Because medical practice, information, and technology are constantly changing, Priority Health reserves the right to review and update its medical policies at its discretion. Priority Health's medical policies are intended to serve as a resource to the plan. They are not intended to limit the plan's ability to interpret plan language as deemed appropriate. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment they choose to provide.

Policy scope: This policy addresses Infusion services including external and implantable infusion pumps.

Related policies:

- Continuous Glucose Monitoring and Insulin Pumps # 91466

SUMMARY OF CHANGES – R23

Additions:

- New Medical/Professional Society Guidelines section
- New Government Regulations section listing applicable CMS NCDs or LCDs
- New Policy Scope Section
- New FDA/Regulatory section

Clarifications:

- Added in conditions for clarification that external infusion pumps may be covered for
- Updated references

Deletions:

- Deleted exemptions for site of service review.
- Deleted Medicaid MDHHS Provider Manual link regarding Insulin Pumps.

I. MEDICAL NECESSITY CRITERIA

A. External Infusion Pumps

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

2. An external infusion pump may be considered medically necessary for infusion of an FDA approved drug for treatment of *any* of the following conditions:
   a. Severe chronic pain or post procedural pain
   b. Chemotherapy for cancer
   c. Intractable cancer pain
   d. Fungal or viral infection
   e. Heart failure
   f. Pulmonary Hypertension
   g. Symptomatic hypercalcemia due to cancer
   h. Primary immune deficiency disorder
   i. Chronic inflammatory demyelinating polyneuropathy
   j. Idiopathic Parkinson Disease
   k. Chronic iron overload

3. 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. (see medical policy Continuous Glucose Monitoring and Insulin Pumps Policy No. 91466).

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.

II. CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) COVERAGE DETERMINATION

Any applicable federal or state mandates will take precedence over this medical coverage policy.

Medicare: Refer to the CMS Online Manual System (IOMs) and Transmittals.
For the most current applicable CMS National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) refer to CMS Medicare Coverage Database.

The information below is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document. MAC jurisdiction for purposes of local coverage determinations is governed by the geographic service area where the Medicare Advantage plan is contracted to provide the service. Please refer to the Medicare Coverage Database website for the most current applicable NCD, LCD, LCA, and CMS Online Manual System/Transmittals.

National Coverage Determinations (NCDs)	
NCD - Infusion Pumps (280.14)	
Local Coverage Determinations (LCDs)	
CGS Administrators, LLC	LCD - External Infusion Pumps (L33794)
First Coast Service Options, Inc.	None identified
National Government Services, Inc.	None identified
Noridian Healthcare Solutions	LCD - External Infusion Pumps (L33794)
Novitas Solutions, Inc.	None identified
Palmetto GBA	LCD - Implantable Infusion Pump (L33461)
WPS Insurance Corporation	None identified

III. BACKGROUND

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.

IV. GUIDELINES / POSITION STATEMENTS

Medical/Professional Society	Guideline
National Comprehensive Cancer Network (NCCN)	pain.pdf ped_all.pdf all.pdf
International Society for Heart and Lung Transplantation (ISHLT)	International Society for Heart and Lung Transplantation Guidelines for the Evaluation and Care of Cardiac Transplant Candidates—2024
National Institute for Health and Care Excellence (NICE).	Foslevodopa–foscarbidopa for treating advanced Parkinson’s with motor symptoms
Infusion Nurses Society	Infusion Therapy Standards of Practice, 9th Edition - PubMed
American Society of Clinical Oncology	JPR_A_315585 2139..2164

V. REGULATORY (US FOOD AND DRUG ADMINISTRATION)

See U.S. Food & Drug Administration (FDA) Medical Device Databases for the most current information.

Device	Premarket Approval, 513(f)(2)(De Novo), or 510(k) Number	Notice date
Moog CURLIN 8000 Ambulatory Infusion System (Moog Medical)	K242660	10/3/2024
CADD®- Solis Ambulatory Infusion Pump	K170982	08/24/2017
Nipro Surefuser Ambulatory infusion pump	K051828	12/15/2005
AutoFuser Ambulatory Infusion Pump (ALGOS, LC)	K041585	08/26/2004

ambIT® PIB PCA V1.5 Pump	K162165	11/18/2016
ON-Q* Pump with Bolus (Avanos Medical)	K181360	3/22/2019
The ambITTM Pump (Sorenson Medical, Inc.)	K033325	11/06/2003
FreedomEdge® Syringe Infusion System (KORU Medical Systems)	K214045	04/29/2022
Sapphire Infusion Pump (Q Core Medical LTD)	K123049	10/16/2013
VLV Associates Disposable Ambulatory Infusion Pump (VLV Associates, INC.)	K940406	09/02/1994
Prometra® Programmable Pump System (Flowonix Medical)	P080012/S068	01/12/2022
Synchromed (Medtronic) SynchroMed™ II SynchroMed™ III	P860004	09/10/1996 09/12/2003 10/06/2023 02/12/2026
Arrow International 3000 Series Pump Codman/Arrow	P890055	01/11/1999
Implantable Remodulin® Infusion System (Medtronic)	P140032	12/22/2017

VI. CODING

See Also Priority Health Infusion Services Supplies Billing Policy # 041

ICD-10 Codes that may support medical necessity

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) (non-embolic)
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

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

VII. MEDICAL NECESSITY REVIEW

Prior authorization for certain drugs, devices, 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, refer to the Priority Health Provider Manual.

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

Individual case review may allow coverage for care or treatment that is investigational yet promising for the conditions described. Requests for individual consideration require prior plan approval. All determinations of coverage for experimental, investigational, or unproven treatment will be made by a Priority Health medical director or clinical pharmacist. The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is either a terminal illness, or a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration.

VIII. APPLICATION TO PRODUCTS

Coverage is subject to the 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); 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. If there is a discrepancy between this policy and the Michigan Medicaid Provider Manual, 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. For Medical Supplies/DME/Prosthetics and

Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.

IX. REFERENCES

General

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Chronic Pain

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