PriorityHealth

MEDICAL POLICY
No. 91414-R11

INFUSION SERVICES & EQUIPMENT

Effective Date: January 29, 2018	**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**
Date Of Origin: October 1, 1995	**Status: Current**

Summary of Changes

Clarifications:

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Deletions:

-

Additions:

- Pg. 2, Section I, Section C, Medicaid/Healthy Michigan: Drugs in Appendix A may be covered in the home, a hospital outpatient infusion center, or an alternative Priority Health-approved site of service.

I. POLICY/CRITERIA

A. External Infusion Pumps
1. 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).
2. Preauthorization may be required for certain indications as determined by the medical department.
3. External infusion pumps for outpatient use are covered at the DME/Supplies benefit level.

B. Implantable Infusion Pumps
1. Implantable infusion pumps are used for long-term site-specific drug therapy to various nervous and vascular compartments (e.g. epidural, hepatic artery, subarachnoid).
2. Implantable infusion pumps are a covered benefit for specific indications when preauthorized by the medical department. They must be FDA approved to administer the drug prescribed. The implantable device is covered at the hospital benefit level. Outpatient supplies are covered at the DME/supplies benefit level. ***Note:*** *For Code C2626 - infusion pump, nonprogrammable, temporary (implantable), prior authorization is not required.*

C. Limits/Indications

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. A list of these drugs can be found in in Appendix A of the policy. First infusions of a drug may be covered in a hospital outpatient infusion center when physician supervision is desired. This applies to **fully and self-funded commercial products**.

For Medicaid/Healthy Michigan: Drugs in Appendix A may be covered in the home, a hospital outpatient infusion center, or an alternative Priority Health-approved site of service.

Drug infusions or injections may be subject to medical appropriateness review regardless of site of care.

1. ***Insulin Pumps***:

   Both newly prescribed and replacement insulin pumps must be prior authorized and are covered according to InterQual® criteria for Ambulatory Insulin Pumps.

2. ***Chronic Pain Management***

   An implantable infusion pump to administer opioid drugs epidurally or intrathecally is a covered benefit for severe chronic malignant or non-malignant pain if *all* of the following apply:

   a. Life expectancy is at least 3 months.
   b. Unresponsive to less invasive pain control therapy (e.g. systemic opioids, behavioral intervention).
   c. Trial administration of intraspinal morphine documents adequate pain control, side effects and patient acceptance.

3. ***Intrahepatic Chemotherapy***

   Implantable infusion pumps for continuous hepatic artery infusion of chemotherapy are a covered benefit 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 a covered benefit.

II. MEDICAL NECESSITY REVIEW

☒ Required ☐ Not Required ☐ Not Applicable

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); 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. For Medical Supplies/DME/Prosthetics and Orthotics, please refer to the Michigan Medicaid Fee Schedule to verify coverage.***

IV. DESCRIPTION

External or implantable infusion pumps may be a covered benefit as defined above.

V. CODING INFORMATION

ICD-10 Codes that may apply:

E08.00 – E08.9	Diabetes mellitus due to underlying condition
E09.00 – E09.9	Drug or chemical induced diabetes mellitus
E10.10 – E10.9	Type 1 diabetes mellitus
E11.00 – E11.9	Type 2 diabetes mellitus
E13.00 – E13.9	Other specified diabetes mellitus
O24.011 – O24.93	Diabetes mellitus in pregnancy, childbirth, and the puerperium
O99.810 – O99.815	Abnormal glucose complicating pregnancy, childbirth and the puerperium
Z46.81	Encounter for fitting and adjustment of insulin pump
Z79.4	Long term (current) use of insulin
Z90.410	Acquired total absence of pancreas
Z90.411	Acquired partial absence of pancreas
Z96.41	Presence of insulin pump (external) (internal)
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	Other specified spondylopathies
M51.0 – M51.9	Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders
M54.00 – M54.9	Dorsalgia
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 Malignant neoplasm of liver and intrahepatic bile ducts

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*
All services billed by Home Infusion providers require prior authorization

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 physician's skill)

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 physician's skill
96522* Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)

C1772 Infusion pump, programmable (implantable)
C1891 Infusion pump, non-programmable, permanent (implantable)
C2626* Infusion pump, nonprogrammable, temporary (implantable)

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.)
E0786 Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)

A9274 External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories *(May only be covered under member's pharmacy benefit for some plans.)* ***(Not covered for Priority Medicaid or Medicare)***

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)***

A4224* Supplies for maintenance of insulin infusion catheter, per week ***(Not covered for Priority Medicaid)***
A4225* Supplies for external insulin infusion pump, syringe type cartridge, sterile, each ***(Not covered for Priority Medicaid)***
A4230* Infusion set for external insulin pump, nonneedle cannula type
A4231* Infusion set for external insulin pump, needle type
A4232* Syringe with needle for external insulin pump, sterile, 3 cc

E0784 External ambulatory infusion pump, insulin
(***PA for Priority Medicare effective Jan 1, 2018)***

K0455 Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol)

Not Covered:

S1034 Artificial pancreas device system (e.g., low glucose suspend [LGS] feature) including continuous glucose monitor, blood glucose device, insulin pump and computer algorithm that communicates with all of the devices
S1035 Sensor; invasive (e.g., subcutaneous), disposable, for use with artificial pancreas device system
S1036 Transmitter; external, for use with artificial pancreas device system
S1037 Receiver (monitor); external, for use with artificial pancreas device system

S9145 Insulin pump initiation, instruction in initial use of pump (pump not included)

VI. REFERENCES

Implantable Infusion Pumps, Cigna Healthcare coverage Position, 6/15/2006. Available on the World Wide Web @ http://www.cigna.com/health/provider/medical/procedural/coverage_positions/medical/index.html#I (Retrieved August 10, 2006 ,September 13, 2007, February 29, 2012, February 20, 2013, March 13, 2014 & March 13, 2015)

Implantable Infusion Pump for Non-Musculoskeletal Conditions, Cigna Medical Coverage Policy 0370, Effective Date: January 1, 2016. Available on the World Wide Web @ https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0370_coveragepositioncriteria_implantable_infusion_pumps.pdf (Retrieved January 3, 2017).

Fully Implantable Infusion Pump, the Regence Group Medical Policy, 4/5/2005. Available on the World Wide Web @ http://www.regence.com/trgmedpol/surgery/sur18.html (Retrieved August 10, 2006 and September 13, 2007)

Infusion Pumps, Aetna Clinical Policy Bulletins, March 31, 2006. Available on the World Wide Web @ http://www.aetna.com/cpb/data/CPBA0161.html (Retrieved August 10, 2006 , September 13, 2007 - February 29, 2012, February 20, 2013, March 13, 2014 & March 13, 2015) Updated web address: http://www.aetna.com/cpb/medical/data/100_199/0161.html (Retrieved January 3, 2017)

NCD for Infusion Pumps (280.14), Medicare Coverage Database, 2/18/2005. Available on the World Wide Web @ http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=280.14&ncd_version=2&basket=ncd%3A280%2E14%3A2%3AInfusion+Pumps (Retrieved August 10, 2006, September 13, 2007, February 20, 2013, March 13, 2014 & March 13, 2015) Updated web address: https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=223&ncdver=2&DocID=280.14&ncd_id=280.14&ncd

_version=2&basket=ncd*3a%24280.14*3a%242*3a%24Infusion+Pumps&bc=gAAAABAAAAAAAA%3d%3d&
(Retrieved January 3, 2017)

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APPENDIX A
Last Update: 7/2018

For the drugs listed below, Priority Health requires patients to receive the infusion or injection in the home or office setting, or an alternative Priority Health-approved site of service as of the effective date shown below. First infusions of a drug may be covered in a hospital outpatient infusion center when physician supervision is desired. This applies to **fully and self-funded commercial products**.

For Medicaid/Healthy Michigan: For the drugs listed below Priority Health requires patients to receive the infusion or injection in the home or hospital outpatient infusion center or an alternative Priority Health- approved site of service.

Drug / applicable HCPCS code	Effective date
IVIG – immune globulin	
• J1459 Injection, immune globulin (Privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg	5/1/2016
• J1555 Injection, immune globulin (cuvitru), 100 mg	1/1/2018
• J1556 Injection, immune globulin (Bivigam), 500 mg	5/1/2016
• J1557 Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg	5/1/2016
• J1559 Injection, immune globulin (Hizentra), 100 mg	5/1/2016
• J1561 Injection, immune globulin, (Gamunex/Gamunex-C/Gammaked), nonlyophilized (e.g., liquid), 500 mg	5/1/2016
• J1562 Injection, immune globulin (Vivaglobin), 100 mg	5/1/2016
• J1566 Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg *Use for: Gammar-P, Panglobulin, Polygam, Carimune, Gammagard S/D*	5/1/2016
• J1568 Injection, immune globulin,	5/1/2016

(Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg • J1569 Injection, immune globulin, (Gammagard liquid), nonlyophilized, (e.g., liquid), 500 mg • J1572 Injection, immune globulin, (Flebogamma/Flebogamma Dif), intravenous, nonlyophilized (e.g., liquid), 500 mg • J1575 Injection, immune globulin/hyaluronidase, 100 mg immunoglobulin *use for* HyQvia • J1599 Injection, immune globulin, intravenous, nonlyophilized (e.g., liquid), not otherwise specified, 500 mg *Use for Gammagard SD* • 90283 Immune globulin (IgIV), human, for intravenous use (*Use for Iveegam; alternative for J1459, J1557, J1561, J1566, J1568, J1569, J1572 and J1599 – specify med in claim notes)* • 90284 Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each *(alternative for J1559, J1561, and J1562 specify in claim notes)*	 5/1/2016 5/1/2016 5/1/2016 5/1/2016 5/1/2016 5/1/2016
Remicade – infliximab • J1745 Injection infliximab, 10 mg	5/1/2016
Soliris – eculizumab • J1300 Injection eculizumab, 10 mg	1/1/2017
Inflectra – infliximab-dyyb • Q5103 Injection, infliximab, biosimilar, 10 mg	4/1/2017
Benlysta – belimumab • J0490 Injection, belimumab, 10 mg	10/1/2017
Renflexis – infliximab-abda • Q5104 Injection, Infliximab, Biosimilar, 10 mg	1/1/2018

Orencia IV – abatacept • J0129 Injection, abatacept, 10 mg (*Not covered for Medicaid)*	7/1/2018
Simponi Aria – golimumab • J1602 Injection, golimumab, 1 mg	7/1/2018
Actemra IV – tocilizumab • J3262 Injection, tocilizumab, 1 mg (*Not covered for Medicaid)*	7/1/2018
Cimzia – certolizumab pegol • J0717 Injection, certolizumab pegol, 1 mg (*Not covered for Medicaid)*	7/1/2018
Entyvio - vedolizumab • C9026 Injection, vedolizumab, 1 mg	7/1/2018
Ilaris - canakinumab • J0638 Injection, canakinumab, 1 mg	7/1/2018
Aralast NP - $Alpha_1$-Proteinase Inhibitor • J0256 Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg	7/1/2018
Glassia – $Alpha_1$-Proteinase Inhibitor • J0257 Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	7/1/2018
Prolastin C - $Alpha_1$-Proteinase Inhibitor • J0256 Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg	7/1/2018
Zemaira - $Alpha_1$-Proteinase Inhibitor • J0256 Injection, alpha 1 proteinase inhibitor (human), not otherwise specified, 10 mg	7/1/2018
Aldurazyme - laronidase • J1931 Injection, laronidase, 0.1 mg	7/1/2018
Cerezyme - Imiglucerase • J1786 Injection, imiglucerase, 10 units	7/1/2018
Elaprase - Idursulfase • J1743 Injection, idursulfase, 1 mg	7/1/2018
Elelyso – taliglucerase alfa • J3060 Injection, taliglucerase alfa, 10 units	7/1/2018
Fabrazyme - agalsidase beta • J0180 Injection, agalsidase beta, 1 mg	7/1/2018

Naglazyme - galsulfase • J1458 Injection, galsulfase, 1 mg	7/1/2018
Vimizim - elosulfase alfa • C9022 Injection, elosulfase alfa, 1mg (*Not covered for Medicaid)*	7/1/2018
VPRIV - velaglucerase alfa • J3385 Injection, velaglucerase alfa, 100 units	7/1/2018
Flolan - epoprostenol • J1325 Injection, epoprostenol, 0.5 mg	7/1/2018
Remodulin - treprostinil • J3285 Injection, treprostinil, 1 mg	7/1/2018
Tyvaso – treprostinil • J7686 Treprostinil, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, 1.74 mg	7/1/2018
Veletri – epoprostenol • J1325 Injection, epoprostenol, 0.5 mg	7/1/2018
Ventavis – iloprost • Q4074 Iloprost, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, up to 20 micrograms (*Not covered for Medicaid)*	7/1/2018