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 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.

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/0,1607,7-132-2945-42542-42543-42546-42551-139815--00.html](http://www.michigan.gov/mdch/0,1607,7-132-2945-42542-42543-42546-42551-139815--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](http://www.michigan.gov/mdch/0,1607,7-132-2945-5100-87572--00.html), the Michigan Medicaid Provider Manual 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
- 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


AMA CPT Copyright Statement:
All Current Procedure Terminology (CPT) codes, descriptions, and other data are copyrighted by the American Medical Association.

This document is for informational purposes only. 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. 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. 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.

The name “Priority Health” and the term “plan” mean Priority Health, Priority Health Managed Benefits, Inc., Priority Health Insurance Company and Priority Health Government Programs, Inc.
APPENDIX A
Last Update: 4/2017

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.

<table>
<thead>
<tr>
<th>Drug / applicable HCPCS code</th>
<th>Effective date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IVIG – immune globulin</strong></td>
<td>5/1/2016</td>
</tr>
<tr>
<td>• J1459 Injection, immune globulin (Privigen), intravenous, nonlyophilized (e.g., liquid), 500 mg</td>
<td></td>
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<tr>
<td>• J1556 Injection, immune globulin (Bivigam), 500 mg</td>
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<tr>
<td>• J1557 Injection, immune globulin, (Gammaplex), intravenous, nonlyophilized (e.g., liquid), 500 mg</td>
<td></td>
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<tr>
<td>• J1559 Injection, immune globulin (Hizentra), 100 mg</td>
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<tr>
<td>• J1561 Injection, immune globulin, (Gamunex/Gamunex-C/Gammaked), nonlyophilized (e.g., liquid), 500 mg</td>
<td></td>
</tr>
<tr>
<td>• J1562 Injection, immune globulin (Vivaglobin), 100 mg</td>
<td></td>
</tr>
<tr>
<td>• J1566 Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg Use for: Gammar-P, Panglobulin, Polygam, Carimune, Gammagard S/D</td>
<td></td>
</tr>
<tr>
<td>• J1568 Injection, immune globulin, (Octagam), intravenous, nonlyophilized (e.g., liquid), 500 mg</td>
<td></td>
</tr>
<tr>
<td>• J1569 Injection, immune globulin, (Gammagard liquid), nonlyophilized, (e.g., liquid), 500 mg</td>
<td></td>
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<tr>
<td>• J1572 Injection, immune globulin, (Flebogamma/Flebogamma Dif), intravenous, nonlyophilized (e.g.,</td>
<td></td>
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<tr>
<td>Liquid) 500 mg</td>
<td>J1575</td>
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<td>J1599</td>
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<table>
<thead>
<tr>
<th>Remicade – infliximab</th>
<th>J1745</th>
<th>Injection infliximab, 10 mg</th>
<th>5/1/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soliris – eculizumab</td>
<td>J1300</td>
<td>Injection eculizumab, 10 mg</td>
<td>1/1/2017</td>
</tr>
<tr>
<td>Inflectra – (infliximab-dyyb)</td>
<td>Q5102</td>
<td>Injection, infliximab, biosimilar, 10 mg</td>
<td>4/1/2017</td>
</tr>
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