

Corporate Medical Policy

Infusion Therapy in the Home

File Name: infusion_therapy_in_the_home
Origination: 3/1998
Last Review: 2/2024

Description of Procedure or Service

Home infusion therapy is the administration of prescription legend drugs

- through intravenous, intraspinal, epidural, or subcutaneous routes,
- under a plan prescribed by a physician, and
- determined by the Plan to be medically necessary, and
- supervised by a qualified health care professional,
- to a member in a place of temporary or permanent residence that is used as their home, excluding a hospital, skilled nursing facility, clinic settings, infusion suites and/or physician offices.

Home infusion drugs are often not readily available through standard pharmacies and are frequently high cost. Most are obtained through hospital pharmacies, licensed home infusion agencies, or mail-order discount drug supply companies which can express deliver the drugs directly to the patient's home.

Related Policies:

Place of Service for Medical Infusions
Skilled Nursing Services

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

BCBSNC will provide coverage for Home Infusion Therapy when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this medical policy.

See Covered Services, Home Infusion Therapy Services.

Home infusion providers must meet eligibility and/or credentialing requirements as defined by the Plan to be eligible for reimbursement.

The patient's individual certificate should be consulted to verify that home infusion therapy benefits are available. Many plans require precertification. Specific benefits for pharmacy and infusion therapy services may vary depending on lines of business. Non-prescription Legend Drugs (e.g., acetaminophen, aspirin) or other services excluded by plan benefits remain non-covered regardless if provided by a home infusion company.

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For more information regarding benefits for these types of services, contact our Customer Services Department.

When Home Infusion Therapy Services are covered

Home infusion services are medically necessary when they meet all of the following criteria:

1. Infusion services must be prescribed by a provider who has a current DEA (Drug Enforcement Agency) licensure as part of a treatment plan for a covered medical condition; **And**
2. The drug must be medically necessary to treat member's medical condition and be covered under the member's policy. Home infusion services to administer an investigational or an otherwise excluded drug are non-covered; **And**
3. Administration of the drug via infusion must be medically necessary. Home infusion services for drugs which can be administered orally, topically, or self-injected and achieve the same or equivalent therapeutic effect are not medically necessary; **And**
4. Administration in the home must be safe and medically appropriate. Drugs which are hazardous and require extensive monitoring should be administered in a facility which has appropriate provisions for acute intervention; **And**
5. Administration in the home must be cost-effective. Each case should be evaluated in light of the total number of home health services being requested. Some patients may require multiple services which can be more cost-effectively delivered in a facility (inpatient or outpatient) or in a physician's office.

Home infusion drugs that are considered medically necessary may fall into several categories:

A. Self-Infusion

These drugs do not require nursing supervision in the home but can be administered by the patient and/or family.

B. Limited Nursing Supervision

Some drugs require supervision by a nurse for initiation of therapy, but the patient and/or family can be trained in administration. Intermittent home health visits may be required to monitor the patient on an ongoing basis. Drugs in this category are included, but not limited to:

1. IV hydration therapy for patients with hyperemesis gravidarum (in lieu of hospitalization), or for rehydration of a chronically ill patient maintained at home. IV hydration provided as part of a continuous administration of an IV drug (e.g., anti-emetic) is considered an integral part of the drug treatment and additional reimbursement is not allowed.
2. Total parenteral nutrition (TPN)
3. Home infusion pain management in chronic disease states such as cancer, AIDS, or other end stage disease.

C. Intensive Nursing Supervision

These services require continuous monitoring for adverse reaction and/or the presence of a nurse in the home until the infusion is complete. Due to the risk of adverse consequence, a letter of medical necessity is required from the treating physician which includes a statement that home administration is appropriate for the following patients:

- IV Amphotericin B in chronically ill patients
- Blood transfusion, usually in terminal adult patients requiring chronic/frequent transfusion
- IV Dobutamine therapy for patients awaiting cardiac transplant or with end-stage cardiac disease.

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When medical necessity requirements for home infusion therapy have been met, Nursing visits may be allowed as follows:

- A. Low intensity
 1. One training visit and nursing visits of up to 2 hours per week for IV antibiotics, home TPN administered via peripheral line.
 2. One training visit and up to 4 hours of nursing visits per week for IV Chemotherapy, IV hydration, Home TPN administered via central line.
- B. High intensity
 1. One time visit with prolonged nursing supervision:
 - Blood transfusion, up to four hours
 - IV aminophylline
 2. Daily visits by RN up to 2 hours: IV dobutamine

Requests for other or additional nursing services should be reviewed on an individual basis.

External infusion pumps may be considered medically necessary under the following conditions:

- A prolonged infusion (at least 8 hours) is medically necessary, or the drug must be infused at a controlled rate to avoid toxicity and other means of accomplishing this are not acceptable. Drugs for which a pump may be considered medically necessary include Acyclovir, 5-FU, Foscarnet, Amphotericin B, Vancomycin, and Ganciclovir. Requests for pumps for other drugs should be reviewed on an individual basis.
- Pediatric requests should be reviewed on an individual basis, with consideration of volume of infusate versus body surface area.

When Home Infusion Therapy Services are not covered

1. When the medical criteria and guidelines listed above in the "When Home Infusion Services are Covered" section are not met.
2. When the infusion services are not prescribed by a provider who has a current DEA licensure as part of a treatment plan for a covered medical condition.
3. When the drug is not medically necessary to treat member's medical condition and/or is not covered under the member's policy. Home infusion services to administer an investigational or an otherwise excluded drug are non-covered.
4. When the administration of the drug via infusion is not medically necessary. Home infusion services for drugs which can be administered orally, topically, or self-injected and achieve the same or equivalent therapeutic effect are not medically necessary.
5. When administration in the home is not safe and medically appropriate. Drugs which are hazardous and require extensive monitoring should be administered in a facility which has appropriate provisions for acute intervention.
6. When administration in the home is not cost-effective. Each case should be evaluated in light of the total number of home health services being requested. Some patients may require multiple services which can be more cost-effectively delivered in a facility (inpatient or outpatient) or in a physician's office.
7. Anticoagulants. Home IV infusion of heparin for thromboembolic disease is considered investigational. IV heparin or other anticoagulants used for line maintenance are considered an integral part of home infusion services and additional reimbursement is not allowed. Self-administered subcutaneous heparin or enoxaparin (Lovenox) injections do not require limited nursing services.

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8. IV chemotherapy. Home administration of chemotherapy infused at a frequency of once daily or less and which requires direct nursing supervision is not appropriate. (This service may be delivered in an Outpatient Clinic or Physician's Office.)
9. Short term IV pain management post-operatively or for acute episodes of pain (such as following a tonsillectomy) is not medically necessary in the home. (Patient should be weaned from IV infusion prior to discharge from a facility.)

Policy Guidelines

Non-prescription Legend Drugs (e.g., acetaminophen, aspirin) or other services non-covered by the plan remain non-covered regardless if provided by a home infusion company.

Charges for routinely included supplies such as gauze, infusion sets, needles, cassettes, tape, cleansing solutions (betadine, alcohol), heparin and saline flushes, diluents for mixing drugs, and splints are included in the infusion reimbursement.

Catheter care may be reported separately when used as a stand-alone therapy, or during days not covered under per diem by another therapy. PICC line care will only be allowed as a separate charge if there is no other therapy in the last 30 days in the home.

Home infusion therapy includes all of the components related to such therapy, such as, but not limited to, nursing services, durable medical equipment, supplies, Prescription and non-Prescription Legend Drugs and solutions, pharmacy compounding and dispensing, specimen collection, patient and family education, delivery of drugs and supplies, and management of emergencies arising from said therapy.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: 99506, 99601, 99602, S5035, S5036, S5497, S5498, S5501, S5502, S5517, S5518, S5520, S5521, S5522, S5523, S9325, S9326, S9327, S9328, S9329, S9330, S9331, S9336, S9338, S9345, S9346, S9347, S9348, S9349, S9351, S9353, S9355, S9357, S9359, S9361, S9363, S9364, S9365, S9366, S9367, S9368, S9370, S9372, S9373, S9374, S9375, S9376, S9377, S9379, S9490, S9494, S9497, S9500, S9501, S9502, S9503, S9504, S9537, S9538, S9542, S9558, S9559, S9810

Diagnoses that are subject to medical necessity review: A69.20, B60.00, B60.01, B60.02, B60.03, B60.09

Documentation Requirement: The medical record should document the medical necessity for the services, including medical diagnosis, proposed frequency of services, proposed duration of services, and a social assessment of the home situation.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

8/97 - Plan Medical Director

8/97 - Plan Corporate Pharmacist

8/97 - PAG Consultant

8/97 - Consultant - Interim - Home Solutions

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9/97 - ANR comments reviewed. Minimal changes made.

12/99 Medical Policy Advisory Group

Specialty Matched Consultant Advisory Panel - 10/2000

Medical Policy Advisory Group - 10/2000

Specialty Matched Consultant Advisory Panel - 8/2002

Specialty Matched Consultant Advisory Panel - 8/2004

Specialty Matched Consultant Advisory Panel - 8/30/2006

Specialty Matched Consultant Advisory Panel- 3/2011

Specialty Matched Consultant Advisory Panel- 2/2012

Specialty Matched Consultant Advisory Panel- 2/2013

Specialty Matched Consultant Advisory Panel- 2/2014

Specialty Matched Consultant Advisory Panel- 2/2015

Specialty Matched Consultant Advisory Panel- 2/2016

Aeschlimann FA, Hofer KD, Schneider EC, Schroeder S, Saurenmann RK, et al. Infliximab in pediatric rheumatology patients: a retrospective analysis of infusion reactions and severe adverse events during 2246 infusions over 12 years. *J Rheumatol.* 2014;41(7):1409-1415

American Academy of Allergy Asthma and Immunology. Guidelines for the Site of Care for Administration of IGIV Therapy.

<https://www.aaaai.org/Aaaai/media/MediaLibrary/PDF%20Documents/Practice%20Resources/Guidelines-for-the-site-of-care-for-administration-of-IGIV-therapy.pdf>

American Society of Health-System Pharmacists. ASHP Guidelines on Home Infusion Pharmacy Services. *Am J Health-Syst Pharm.* 2014; 71:325–41. <http://docplayer.net/17653372-Ashp-guidelines-on-home-infusion-pharmacy-services.html>

Assuring Quality for Non-hospital–based Biologic Infusions in Pediatric Inflammatory Bowel Disease: A Clinical Report from the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition

https://journals.lww.com/jpgn/fulltext/2018/04000/Assuring_Quality_for_Non_hospital_based_Biologic.27.aspx

Bhole, M. V., Burton, J., & Chapel, H. M. (2008). Self-infusion programmes for immunoglobulin replacement at home: Feasibility, safety and efficacy. *Immunology and Allergy Clinics of North America*, 28(4), 821-832.

<https://www.ncbi.nlm.nih.gov/pubmed/24833759>

MCGTMCare Guidelines, 22nd edition, 2018, Home Infusion Therapy: CMT: CMT-0009 (SR).

National Home Infusion Association. <http://www.nhia.org/about-home-infusion.cfm>

Polinski JM, Kowal MK, Gagnon M, et al. Home infusion: safe clinically effective, patient preferred, and cost saving. *Healthcare.* 2016.

<https://www.sciencedirect.com/science/article/pii/S2213076415300555?via%3Dihub>

Souayah N, Hasan A, Khan H, et. al. The Safety Profile of Home Infusion of Intravenous Immunoglobulin in Patients with Neuroimmunologic Disorders. *J Clin Neuromusc Dis* 2011; 12:S1-

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<https://www.ncbi.nlm.nih.gov/pubmed?term=souayah%20n.%20hasan%20a.%20khan%20h.%20et.%20al.%20the%20safety%20profile%20of%20home%20infusion%20of%20intravenous%20immunoglobulin%20in%20patients%20with%20neuro%20immunologic%20disorders&cmd>

Specialty Matched Consultant Advisory Panel review 2/2020

Specialty Matched Consultant Advisory Panel review 2/2021

Specialty Matched Consultant Advisory Panel review 2/2022

Medical Director review 2/2022

Specialty Matched Consultant Advisory Panel review 2/2023

Medical Director review 2/2023

Specialty Matched Consultant Advisory Panel review 2/2024

Medical Director review 2/2024

Policy Implementation/Update Information

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| 3/98 | Original Policy issued |
| 9/99 | Reformatted, Medical Term Definitions added. |
| 12/99 | Medical Policy Advisory Group |
| 4/00 | Removed indications stating that the patient must be homebound. Corrected typographical errors. |
| 10/00 | Specialty Matched Consultant Advisory Panel review. Removed criteria for Total parenteral Nutrition. Instructed reader to reference the TPN policy. Removed IV antibiotics from list of noncovered services and included IV antibiotics in list of covered services. System coding changes. Medical Policy Advisory Group review. No further changes. Approve. |
| 4/01 | Coding line revised. |
| 5/01 | Changes in formatting. |
| 7/01 | Changed name of policy from Home Infusion Therapy to Infusion Therapy in the Home. |
| 10/02 | Specialty Matched Consultant Advisory Panel review 8/15/2002. No changes recommended. System coding changes. |
| 7/03 | Additional information added to Policy Guideline section of the policy regarding items that are included in the reimbursement and PICC lines. Removed reference to a specific policy for TPN. Have added subcutaneous as a route of infusion therapy in the discussion section of the policy. New July 2003 CPT codes 99601 and 99602 added to policy. CPT codes 99551, 99552, 99553, 99554, 99555, 99556, 99557, 99558, 99561, 99562, 99564, 99565, 99566, 99567, 99568, 99569 removed from billing and coding section of policy. Codes not valid for dates of service after 6/30/03. Codes deleted by CPT effective 6/30/03. |
| 4/04 | Billing/Coding section updated for consistency. |
| 9/9/04 | Specialty Matched Consultant Advisory Panel review 8/27/04. No changes to criteria. Added "clinic settings, infusion suites and/or physician offices" to "Description" section, at end of last sentence in first paragraph. Codes S9524 and S9546 removed from "Billing/Coding" section. These codes are no longer valid. |

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- 1/06/05 First quarter 2005 HCPCS codes G0345, G0346, G0347, G0348, G0349, G0350, G0351, G0353, G0354, G0355, G0356, G0357, G0358, G0359, G0360, G0361, G0362, G0363 added to Billing/Coding section of policy.
- 10/2/06 Added key word and reference source. HCPCS deleted codes G0345, G0346, G0347, G0348, G0349, G0350, G0351, G0353, G0354, G0355, G0356, G0357, G0358, G0359, G0360, G0361, G0362, G0363 removed from "Billing/Coding" section. No changes to criteria. (pmo)
- 9/22/08 The following statement deleted from Item A. in the When Covered section: "For Managed Care Products (those products which allow direct reimbursement to the pharmacist for covered drugs), the following drugs are available under the Pharmacy benefit: Growth hormone, Factor XIII." Deleted HCPCS Codes S9543 and S9800 from the Billing/Coding Section. Specialty Matched Consultant Advisory Panel review 8/25/08. No change to policy statement. (adn)
- 6/22/10 Policy Number(s) removed (amw)
- 10/26/10 Added diagnoses codes 088.81 and 088.82 to the "Billing/Coding" section.
- 4/12/11 Specialty Matched Consultant Advisory Panel review meeting 3/31/2011. No changes in policy statement. (lpr)
- 4/17/12 Specialty Matched Consultant Advisory Panel review meeting 2/29/2012. Under "When Covered" section C: removed bullet #4, indication for IV antibiotics." Also under "When Covered" section, statement 1. and "When Not Covered" statement 2. changed "licensed physician (MD, DO) to "a provider who has a current (DEA) Drug Enforcement Agency licensure." Moved the following statement from the Description section to Policy Guidelines: "Home infusion therapy includes all of the components related to such therapy, such as, but not limited to, nursing services, durable medical equipment, supplies, Prescription and non-Prescription Legend Drugs and solutions, pharmacy compounding and dispensing, specimen collection, patient and family education, delivery of drugs and supplies, and management of emergencies arising from said therapy." (lpr)
- 3/12/13 Specialty Matched Consultant Advisory Panel review meeting 2/20/2013. No change to policy statement. (lpr)
- 7/1/13 ICD-10 diagnosis codes added to "Billing/Coding" section. (lpr)
- 3/11/14 Specialty Matched Consultant Advisory Panel review meeting 2/25/2014. No change to policy statement. (lpr)
- 4/28/15 Specialty matched consultant advisory panel review meeting 2/25/15. No change to policy statement. Removed ICD-10 effective date from "Billing/Coding" section. (lpr)
- 4/1/16 Specialty Matched Consultant Advisory Panel review 2/24/2016. No change to policy. (an)
- 3/31/17 Specialty Matched Consultant Advisory Panel review 2/22/2017. No change to policy statement. (an)
- 3/29/18 Added cross reference to policy titled "Place of Service for Medical Infusions." Deleted ICD-9 codes. Specialty Matched Consultant Advisory Panel review 2/28/2018. No change to policy statement. (an)
- 5/11/18 Description section reformatted and revised. The terms "licensed registered nurse" and "licensed practical nurse" changed to "qualified health care professional". Added related policy: Skilled Nursing Services. (an)
- 6/29/18 References added. (an)
- 3/12/19 Specialty Matched Consultant Advisory Panel review 2/20/2019. No change to policy. (an)
- 3/10/20 Specialty Matched Consultant Advisory Panel review 2/19/2020. No change to policy. (eel)

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- 3/23/21 Specialty Matched Consultant Advisory Panel review 2/17/2021. No change to policy. (bb)
- 3/8/22 Specialty Matched Consultant Advisory Panel review 2/2022. Medical Director review 2/2022. No change to policy. (tt)
- 3/7/23 Minor edit to When Covered section for clarity. References updated. Specialty Matched Consultant Advisory Panel review 2/2023. Medical Director review 2/2023. No change to policy. (tt)
- 3/6/24 References updated. Specialty Matched Consultant Advisory Panel review 2/2024. Updated Billing/Coding section to remove ICD-10 code B60.0 and add B60.00, B60.01, B60.02, B60.03, B60.09. Medical Director review 2/2024. No change to policy statement. (tt)

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and BCBSNC reserves the right to review and revise its medical policies periodically.