MEDICAL POLICY STATEMENT		
Original Effective Date	**Next Annual Review Date**	**Last Review / Revision Date**
10/06/2015	**10/06/2016**	**10/06/2015**
Policy Name		**Policy Number**
Home Infusion Therapy		**SRx-0044**
Policy Type		
☒ **Medical**	☐ **Administrative**	☐ **Payment**

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

A. SUBJECT

Home Infusion Therapy

B. BACKGROUND

Home infusion therapy provides administration of prescription formulary medications via intravenous, epidural, intraspinal, or subcutaneous routes. Infusion therapy provided at a member's home must be prescribed by a licensed physician and determined by the member's CareSource plan to be 'medically necessary' with the infusion therapy supervised by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN). Home infusion providers must meet credentialing and/or eligibility requirements in order to qualify for reimbursement. The infusion therapy must be administered in the member's residence (temporary or permanent) and the home is determined the most appropriate setting for services. Home infusion therapy excludes hospitals, clinics, infusion suites, physician offices, and skilled nursing facilities.

Home infusion providers are strongly encouraged to verify that home infusion therapy benefits are available and to obtain a precertification. Depending on lines of business, specific pharmacy and infusion therapies may vary. Exclusions include non-formulary medications or other services by plan benefits, regardless if provided by a home infusion provider. All medical records to make a determination of medical necessity may be requested.

C. DEFINITIONS

- **Home Infusion Therapy:** the administration of prescription drugs and solutions in the home via one of these routes:
  1. Intravenous
  2. Intraspinal
  3. Epidural
  4. Subcutaneous

- **Per Diem:** per day allowance for filing certain HCPC codes. Per diems are recognized by the number of hours the member receives the infusion and not by the calendar day. Continuous infusions for a period longer than 24 hours, but less than 48 hours are equal to one per diem. Home infusion therapy requiring regular nursing services is to be billed in three components:
  1. **Per Diem component** (covering all home infusion services, equipment and supplies except the medications and licensed nursing services) for each day the drug is infused.
  2. **Nursing component** provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN).
  3. **Drug component** Provider agrees to only bill for the quantity of medication actually administered not unused mixed, compounded or opened quantities.
- **Participating –** Providers that are contracted to provide services
- **Non-Participating –** Providers that are not contracted to provide services

D. POLICY

All non-participating providers must obtain authorization for services and participating providers don't require an authorization if the requirements below are met:

I. Home infusion therapy services are considered medically necessary when **ALL** of the following criteria are met:
   A. Infusion services must be prescribed by a licensed provider as part of a medically necessary treatment plan with a documented diagnosis, covered as a benefit under the member's policy
   B. Investigational or other excluded medications are not covered for home infusion therapy
   C. Home infusion administration of a drug must be medically necessary. Drugs that can be administered orally, topically, or self-injected and will achieve the same or equivalent therapeutic effect are not considered medically necessary
   D. Home infusion administration must be medically appropriate and safe. Hazardous drugs requiring extensive monitoring should be administered in a facility capable of providing acute intervention
   E. Home infusion services must be cost-effective. Each member's case will be evaluated for the total number of home infusion services being requested. Some cases may require multiple services considered more cost-effective delivered in a facility (inpatient or outpatient), clinic, or physician's office

II. Home infusion therapy services will be reimbursed on a per diem basis only when an approved drug infusion is administered for the service day, which may include the following:
   A. Administrative services
   B. Pharmacy services
   C. Care coordination

Note: Routine supply charges for gauze, infusion sets, and cassettes, cleansing solutions, needles, tape, saline flushes, heparin, diluents and splints are included in the infusion reimbursement. Home infusion therapy includes the following components related to such therapy; nursing services, supplies, medications and solutions, durable medical equipment, specimen collections, pharmacy compounding and dispensing, patient and family education, delivery of medications and supplies, and the management of therapy emergencies.

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

CONDITIONS OF COVERAGE

NON-COVERED AND ALL INCLUSIVE SERVICES

The following services may **not** be billed under home infusion services:

- Oral prescription drugs (billed by pharmacy)
- Aerosolized medications (billed by pharmacy)
- Services to hospice patients being cared for by a contracting hospice provider (billed by hospice)
- Durable medical equipment not directly related to the home infusion (billed by DME provider)

The following services are considered as *included* in the per diem rate and **will not** be reimbursed separately. The per diem rate includes all services not included in the medication or nursing service component.

• Durable Medical Equipment	• Solutions, Diluents and Flushes
• Care Coordination & Patient Education	• Administrative Services
• Professional Pharmacy Services	• Medical Supplies

HCPCS **See billing info below**
CPT **See billing info below**

Billing information

- Bill with the coding that is in your contract for covered services for prescription drugs, infusion and nursing services following the standard HCPC and CPT methodology. All drug(s) billed require the NDC to be included with the proper HCPC code.
- Miscellaneous codes are valid for use only if no suitable billing code is available and appropriate documentation is included (NDC is required for all miscellaneous codes)
- Documentation Requirement: The medical record should document the medical necessity for the services, including diagnosis, proposed frequency of services, proposed duration of services, and assessment of the home situation.

AUTHORIZATION PERIOD

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued: 09/30/2015
Date Reviewed: 09/30/2015
Date Revised:

G. REFERENCES

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2. Twaddle, M., & McCormick, E. (2015, June 1). Palliative care delivery in the home. Retrieved August 18, 2015, from http://www.uptodate.com/contents/palliative-care-delivery-in-the-home?source=search_result&search=home+infusion+therapy&selectedTitle=2%7E150

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The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.