Infusion Pumps (NCD 280.14)

Policy Number	280.14	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	03/13/2013

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Summary

Overview

Infusion pumps are medical devices used to deliver solutions containing parenteral drugs under pressure at a regulated flow rate. The following indications for treatment using infusion pumps are covered:

1. **External Infusion Pumps**
   - **a.** Iron Poisoning: (Effective for Services Performed On or After September 26, 1984)
   - **b.** Thromboembolic Disease: (Effective for Services Performed On or After September 26, 1984); When used in the administration of heparin for the treatment of thromboembolic disease and/or pulmonary embolism, only external infusion pumps used in an institutional setting are covered.
   - **c.** Chemotherapy for Liver Cancer: (Effective for Services Performed On or After January 29, 1985); The external chemotherapy infusion pump is covered when used in the treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is unresectable; OR, where the patient refuses surgical excision of the tumor.
   - **d.** Morphine for Intractable Cancer Pain: (Effective for Services Performed On or After April 22, 1985); Morphine infusion via an external infusion pump is covered when used in the treatment of intractable pain caused by cancer (in either an inpatient or outpatient setting, including a hospice).
   - **e.** Continuous Subcutaneous Insulin Infusion (CSII) Pumps and related drugs/supplies are covered when patients must meet specific criterion: (CSII) Pumps (Effective for Services Performed On or after December 17, 2004)

     Continuous subcutaneous insulin infusion (CSII) and related drugs/supplies are covered as medically reasonable and necessary in the home setting for the treatment of diabetic patients who: (1) either meet the updated fasting C-Peptide testing requirement, or, are beta cell autoantibody positive; and, (2) satisfy the remaining criteria for insulin pump therapy as described below. Patients must meet either Criterion A or B as follows:

     Criterion A: The patient has completed a comprehensive diabetes education program, and has been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day), with frequent self-adjustments of insulin doses for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump, and meets one or more of the following criteria while on the multiple daily injection regimen:
     - Glycosylated hemoglobin level (HbAlc) > 7.0 percent;
     - History of recurring hypoglycemia;

- Wide fluctuations in blood glucose before mealtime;
- Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl; or,
- History of severe glycemic excursions.

Criterion B: The patient with diabetes has been on a pump prior to enrollment in Medicare and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to Medicare enrollment.

2. Implantable Infusion Pumps

a. Chemotherapy for Liver Cancer: (Effective for Services Performed On or After September 26, 1984)

The implantable infusion pump is covered for intra-arterial infusion of 5-FUdR for the treatment of liver cancer for patients with primary hepatocellular carcinoma or Duke's Class D colorectal cancer, in whom the metastases are limited to the liver, and where: (1) the disease is unresectable, or (2) the patient refuses surgical excision of the tumor

b. Anti-Spasmodic Drugs for Severe Spasticity: An implantable infusion pump is covered when used to administer anti-spasmodic drugs intrathecally (e.g., baclofen) to treat chronic intractable spasticity in patients who have proven unresponsive to less invasive medical therapy as determined by the following criteria: As indicated by at least a 6-week trial, the patient cannot be maintained on noninvasive methods of spasm control, such as oral anti-spasmodic drugs, either because these methods fail to control adequately the spasticity or produce intolerable side effects, and prior to pump implantation, the patient must have responded favorably to a trial intrathecal dose of the anti-spasmodic drug.

c. Opioid Drugs for Treatment of Chronic Intractable Pain: An implantable infusion pump is covered when used to administer opioid drugs (e.g., morphine) intrathecally or epidurally for treatment of severe chronic intractable pain of malignant or nonmalignant origin in patients who have a life expectancy of at least 3 months, and who have proven unresponsive to less invasive medical therapy as determined by the following criteria:

The patient's history must indicate that he/she would not respond adequately to noninvasive methods of pain control, such as systemic opioids (including attempts to eliminate physical and behavioral abnormalities which may cause an exaggerated reaction to pain); and a preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary intrathecal/epidural catheter to substantiate adequately acceptable pain relief and degree of side effects (including effects on the activities of daily living) and patient acceptance.

d. Coverage of Other Uses of Implanted Infusion Pumps: Determinations may be made on coverage of other uses of implanted infusion pumps if the contractor's medical staff verifies that:

- The drug is reasonable and necessary for the treatment of the individual patient;
- It is medically necessary that the drug be administered by an implanted infusion pump; and,
- The Food and Drug Administration (FDA)-approved labeling for the pump must specify that the drug being administered and the purpose for which it is administered is an indicated use for the pump

e. Implantation of Infusion Pump Is Contraindicated in specific patients: The implantation of an infusion pump is contraindicated in the following patients:

- With a known allergy or hypersensitivity to the drug being used (e.g., oral baclofen, morphine, etc.);
- Who have an infection;
- Whose body size is insufficient to support the weight and bulk of the device; and,
- With other implanted programmable devices since crosstalk between devices may inadvertently change the prescription.

NOTE: Payment may also be made for drugs necessary for the effective use of an implantable infusion pump as long as the drug being used with the pump is itself reasonable and necessary for the patient's treatment

Reimbursement Guidelines

Payment may also be made for drugs necessary for the effective use of an implantable infusion pump as long as the drug being used with the pump is itself reasonable and necessary for the patient's treatment.

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The following indications for treatment using infusion pumps are **not covered** under Medicare:

1. External Infusion Pumps: Vancomycin
2. Implantable Infusion Pump
   a. Thromboembolic Disease: The use of an **implantable** infusion pump for infusion of heparin in the treatment of recurrent thromboembolic disease is not covered.
   b. Diabetes: An **implanted** infusion pump for the infusion of insulin to treat diabetes is not covered.

CPT/HCPCS Codes

Code	Description
Supplies	
A4221	Supplies for maintenance of drug infusion catheter, per week (list drug separately)
A4222	Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately)
A4223	Infusion supplies not used with external infusion pump, per cassette or bag (list drugs separately)
A4305	Disposable drug delivery system, flow rate of less than 50 ml per hour
A4306	Disposable drug delivery system, flow rate of less than 50 ml per hour
A9270	Non-covered item or service (Not covered by Medicare)
A9274	External ambulatory insulin delivery system, disposable, each, includes all supplies and accessories (Not covered by Medicare)
K0552	Supplies for external drug infusion pump, syringe type cartridge, sterile, each
K0601	Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each
K0602	Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each
K0603	Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each
K0604	Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each
K0605	Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each
Equipment	
E0776	IV pole
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.
E0784	External ambulatory infusion pump, insulin
E0785	Implantable intraspinal (epidural/intrathecal) catheter used with implantable infusion pump, replacement
E0786	Implantable programmable infusion pump, replacement (excludes implantable intraspinal catheter)
E0791	Parenteral infusion pump, stationary, single or multi-channel
E1399	Durable medical equipment, miscellaneous
K0455	Infusion pump used for uninterrupted parenteral administration of medication, (e.g., epoprostenol or treprostinol)

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Drugs	
J0133	Injection, acyclovir, 5 mg
J0285	Injection, amphotericin B, 50 mg
J0287	Injection, amphotericin B lipid complex, 10 mg
J0288	Injection, amphotericin B cholesteryl sulfate complex, 10 mg
J0289	Injection, amphotericin B liposome, 10 mg
J0895	Injection, deferoxamine mesylate, 500 mg
J1170	Injection, hydromorphone, up to 4 mg
J1250	Injection, Dobutamine HCl, per 250 mg
J1265	Injection, dopamine HCl, 40 mg
J1325	Injection, epoprostenol, 0.5 mg
J1455	Injection, foscarnet sodium, per 1,000 mg
J1457	Injection, gallium nitrate, 1 mg
J1559	Injection, immune globulin (Hizentra), 100 mg
J1561	Injection, immune globulin, (Gamunex/Gamunex-C/Gammaked), nonlyophilized (e.g., liquid), 500 mg
J1562	Injection, immune globulin (Vivaglobin), 100 mg
J1569	Injection, immune globulin, (Gammagard liquid), nonlyophilized, (e.g., liquid), 500 mg
J1570	Injection, ganciclovir sodium, 500 mg
J1817	Insulin for administration through DME (i.e., insulin pump) per 50 units
J2175	Injection, meperidine HCl, per 100 mg
J2260	Injection, milrinone lactate, 5 mg
J2270	Injection, morphine sulfate, up to 10 mg
J2271	Injection, morphine sulfate, 100 mg
J2275	Injection, morphine sulfate (preservative-free sterile solution), per 10 mg
J2278	Injection, ziconotide, 1 mcg
J3010	Injection, fentanyl citrate, 0.1 mg
J3285	Injection, treprostinil, 1 mg
J3370	Injection, Vancomycin HCl, 500 mg *(Medicare coverage of Vancomycin as a durable medical equipment infusion pump is not covered)*
J3490	Unclassified drugs
J7799	NOC drugs, other than inhalation drugs, administered through DME
J9000	Injection, doxorubicin HCl, 10 mg
J9040	Injection, bleomycin sulfate, 15 units
J9065	Injection, cladribine, per 1 mg
J9100	Injection, cytarabine, 100 mg
J9190	Injection, fluorouracil, 500 mg
J9200	Injection, floxuridine, 500 mg
J9360	Injection, vinblastine sulfate, 1 mg
J9370	Vincristine sulfate, 1 mg
J9999	Not otherwise classified, antineoplastic drugs

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Modifiers	
Code	**Description**
EY	No physician or other licensed health care provider order for this item or service
GA	Waiver of liability statement issued as required by payer policy, individual case
GY	Item or service statutorily excluded or does not meet the definition of any Medicare benefit
GZ	Item or service expected to be denied as not reasonable and necessary
JB	Administered subcutaneously
KD	Drug or biological infused through DME
KX	Requirements specified in the medical policy have been met

Questions and Answers	
Q:	Are disposable pumps covered by Medicare?
A:	No. Medicare covers pumps that are considered durable medical equipment (DME). According to Medicare, durable medical equipment must withstand repeated use, be primarily and customarily used to serve a medical purpose; not useful to a person in the absence of an illness or injury; and be appropriate for use in the home. A disposable pump does not meet the durable medical equipment criteria; therefore, disposable pumps are not covered by the Medicare program. Drugs administered by pump are generally covered only if the pump itself is covered, so the drugs administered through disposable pumps would also not be covered.

References Included (but not limited to):

CMS NCD

NCD 280.14 Infusion Pumps

CMS LCD(s)

Numerous LCDs

CMS Article(s)

Numerous articles

CMS Benefit Policy Manual

Chapter 15; § 50-50.4 Drugs and Biologicals - Reasonableness and Necessity

CMS Claims Processing Manual

Chapter 4; § 20 Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)

Chapter 17; § 80.6 Intravenous Immune Globulin

CMS Transmittals

Transmittal 513, Change Request 3705, Dated 03/30/2005 (Infusion Pumps: C-Peptide Levels as A Criterion for Use)

Transmittal 1599, Change Request 6196, Dated 09/19/2008 (October 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS))

Transmittal 2427, Change Request 7679, Dated 03/23/2012 (Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction)

UnitedHealthcare Medicare Advantage Coverage Summaries

Diabetes Management, Equipment and Supplies

Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid

Infusion Pump Therapy

Medications/Drugs (Outpatient/Part B)

Nutrition Therapy- Enteral and Parenteral Nutritional Therapy

UnitedHealthcare Reimbursement Policies

Primacor (Milrinone)

Infusion Pumps (NCD 280.14)

UnitedHealthcare Medical Policies

Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes

MLN Matters

Article 006840, Diabetes-Related Services

Others

DME MAC Jurisdiction C Supplier Manual, Chapter 16 Coding, CGS Medicare Website

History

Date	Revisions
10/15/2013	Updated information under External Infusion Pumps letter C (Chemotherapy for Liver Cancer) in the Overview to include verbiage regarding colorectal cancer
05/09/2013	Administrative updates
04/04/2013	Administrative updates
03/20/2013	Administrative updates
03/13/2013	Annual review for MRP Committee presentation; approved
03/28/2012	Annual review: LCDs reviewed
09/24/2009	Administrative updates

