

## MEDICAL POLICY

<b>POLICY TITLE</b>	<b>PARENTERAL HOME INFUSION THERAPY (INCLUDING TOTAL PARENTERAL NUTRITION)</b>
<b>POLICY NUMBER</b>	<b>MP-3.008</b>

<b>Original Issue Date (Created):</b>	<b>July 1, 2002</b>
<b>Most Recent Review Date (Revised):</b>	<b>September 24, 2013</b>
<b>Effective Date:</b>	<b>November 1, 2013</b>

### I. POLICY

**Home infusion services** may be considered **medically necessary** when all of the following criteria are met:

- Infusion services must be prescribed by a licensed physician for a covered medical condition;
- The drugs, fluids or biologicals must be appropriate to treat the member's medical condition;
- Administration of the drugs, fluids or biologicals must be given intravenously;
- Administration in the home must be safe and medically appropriate.

The member is not required to be homebound to receive home infusion services, including Total Parenteral Nutrition (TPN).

**Total parental nutrition (TPN)** may be considered **medically necessary** in the treatment of conditions resulting in impaired intestinal absorption. Such conditions include, but are not limited to:

- Inflammatory bowel syndrome, e.g., Crohn's disease;
- Obstruction secondary to stricture or neoplasm of the esophagus or stomach;
- Loss of the swallowing mechanism due to a central nervous system disorder, where the risk of aspiration is great;
- Short bowel syndrome secondary to massive small bowel resection;
- Malabsorption due to enterocolic, enterovesical, or enterocutaneous fistulas with TPN being used as a temporary treatment until the fistula is repaired;
- Motility disorder (pseudo-obstruction);
- Patients with prolonged paralytic ileus following major surgery, burns, or multiple injuries;

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- Newborn infants with catastrophic gastrointestinal anomalies such as tracheoesophageal fistula, gastroschisis, omphalocele, or massive intestinal atresia;
- Infants and young children who fail to thrive due to systemic disease or secondary to intestinal insufficiency associated with short bowel syndrome, malabsorption, or chronic idiopathic diarrhea, such as pseudo-obstruction;

The patient must meet the following criteria prior to the initial implementation of TPN:

The patient is receiving no more than thirty percent (30%) of their caloric needs orally or the patient cannot benefit from tube feedings as a result of a malabsorptive disorder.

Home infusion services are considered **not medically necessary** when:

- The drug or biological is considered investigational;
- The drug, fluid, or biological can be administered orally, topically, or self-injected.

***Cross-reference***

MP-2.015 Enteral Nutrition

MP-2.026 Intravenous Antibiotic Therapy and Associated Diagnostic Testing for Lyme Disease

MP-2.023 Immune Globulin

**II. PRODUCT VARIATIONS**

*[N] = No product variation, policy applies as stated*

*[Y] = Standard product coverage varies from application of this policy, see below*

[N] Capital Cares 4 Kids

[N] Indemnity

[N] PPO

[N] SpecialCare

[N] HMO

[N] POS

[Y] SeniorBlue HMO\*

[N] FEP PPO

[Y] SeniorBlue PPO\*

\* Refer to Durable Medical Equipment Regional Carrier (DME MAC A) Region A Local Coverage Determination (LCD) L5063, Parenteral Nutrition.

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**III. DESCRIPTION/BACKGROUND**

Home infusion therapy services are services and supplies required for administration of a home infusion therapy regimen. Infusion therapy involves the administration of pharmaceuticals, fluids, and biologicals intravenously. The broad range of home infusion therapy services includes, but is not limited to, parenteral nutrition, antibiotic therapy, intravenous pain management, chemotherapy, replacement therapy and hydration therapy. The complexity of the treatment may require services such as skilled nursing assessment and education, dispensing and delivery of medication and supplies. These are generally provided through a multidisciplinary team of health care professionals, which includes, but are not limited to, nursing personnel, registered pharmacists and patient supply technicians.

One type of home infusion therapy is total parenteral nutrition (TPN), also known as parenteral hyperalimentation. This therapy is used for patients with either a temporary or permanent medical or surgical condition in which the ability of the gastrointestinal system to absorb nutrients from food is severely impaired. TPN is an intravenous solution that contains glucose (sugar), amino acids (protein), electrolytes, vitamins and minerals. TPN may or may not include fats.

TPN is infused through an implanted central venous catheter that delivers the liquid substance into the vena cava. The solution is administered using an infusion pump to assure a controlled flow of the fluid on a continuous or intermittent schedule.

TPN differs from the peripheral parenteral nutrition (PPN) in the level of concentration, mode of delivery, and duration of treatment.

**IV. DEFINITIONS**

**HOME INFUSION THERAPY SERVICE PROVIDER** is an entity that meets the necessary licensing requirements and/or is legally authorized to provide Home Infusion Therapy Services, has entered into a participating agreement with the Plan, and meets the guidelines for participation. At a minimum the provider must have all of the following criteria for participation:

- Accreditation by the Joint Commission of HealthCare Organizations or similar accrediting agency approved by the Plan;
- Current State licensure (as applicable);
- Medicare certification (as applicable); and
- Proof of Malpractice/Liability insurance.

**AMINO ACIDS** are building block of protein.

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**ASPIRATION** refers to a material or substance accidentally introduced into the respiratory tract during the act of inhaling.

**ATRIUM** means an upper portion of the heart.

**PARENTERAL** refers to administration of medication or fluid other than through the digestive tract (e.g. intravenous or intramuscular).

**VENA CAVA** refers to one of two large veins returning blood from the peripheral circulation to the right atrium of the heart.

**V. BENEFIT VARIATIONS**

The existence of this medical policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member’s individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and providers should consult the member’s benefit information or contact Capital for benefit information.

**VI. DISCLAIMER**

*Capital’s medical policies are developed to assist in administering a member’s benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member’s benefit information, the benefit information will govern. Capital considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.*

**VII. REFERENCES**

Balaguer A, González de Dios J. Home intravenous antibiotics for cystic fibrosis. *Cochrane Database Syst Rev.* 2008 Jul 16;(3):CD001917.

Brooks B, Meyers RM. Safety and efficacy of home intravenous therapy. *J Am Geriatr Soc.* 2008 Jan;56(1):177.

Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations Manual CMS Pub. 100-3 Chapter .1, Section 180.2 Rev. 55; 05/05/06/ Parenteral Nutrition Effective 8/12/05 [Website]: [http://www.cms.hhs.gov/manuals/downloads/ncd103c1\\_Part3.pdf](http://www.cms.hhs.gov/manuals/downloads/ncd103c1_Part3.pdf) Accessed June 27, 2013

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*Durable Medical Equipment Regional Carrier (DMERC) Region A Local Coverage Determination (LCD) L5063. Parenteral Nutrition. Effective 02/04/2011. [Website]:*

[http://www.medicarenhic.com/dme/medical\\_review/mr\\_lcds/mr\\_lcd\\_current/L5063\\_2011-02-04\\_rev\\_2013-04\\_PA\\_2013-05.pdf](http://www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/L5063_2011-02-04_rev_2013-04_PA_2013-05.pdf)

*Accessed June 27, 2013.*

*McGoldrick M. Preventing central line-associated bloodstream infections and the Joint Commission's Home Care National Patient Safety Goals. Home Health Nurse. 2009 Apr;27(4):220-8.*

*National Home Infusion Association (NHIA). About Infusion Therapy. [Website]:*  
<http://www.nhia.org/about-home-infusion.cfm> . *Accessed June 27, 2013.*

*Mosby's Medical, Nursing, & Allied Health Dictionary, 6th edition.*

*Taber's Cyclopedic Medical Dictionary, 20th edition.*

## VIII. CODING INFORMATION

**Note:** This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

### Covered when medically necessary:

CPT Codes®							
99601	99602						

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HCPCS Code	Description
B4164	PARENTERAL NUTRITION SOLUTION; CARBOHYDRATES (DEXTROSE), 50% OR LESS (500 ML = 1 UNIT) - HOME MIX
B4168	PARENTERAL NUTRITION SOLUTION; AMINO ACID, 3.5%, (500 ML = 1 UNIT) - HOME MIX
B4172	PARENTERAL NUTRITION SOLUTION; AMINO ACID, 5.5% THROUGH 7%, (500 ML = 1 UNIT) - HOME MIX
B4176	PARENTERAL NUTRITION SOLUTION; AMINO ACID, 7% THROUGH 8.5%, (500 ML = 1 UNIT) - HOME MIX
B4178	PARENTERAL NUTRITION SOLUTION; AMINO ACID, GREATER THAN 8.5% (500 ML = 1 UNIT) - HOME MIX
B4180	PARENTERAL NUTRITION SOLUTION; CARBOHYDRATES (DEXTROSE), GREATER THAN 50% (500 ML = 1 UNIT) - HOME MIX
B4185	PARENTERAL NUTRITION SOLUTION, PER 10 GRAMS LIPIDS

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<b>HCPCS Code</b>	<b>Description</b>
B4189	PARNTRAL NUT SOL; AMINO ACID&CARB 10-51 GMS PROT
B4193	PARNTRAL NUT SOL; AMINO ACID&CARB 52-73 GMS PROT
B4197	PARNTRAL NUT SOL; AMINO ACID&CARB 74-100 GM PROT
B4199	PARNTRAL NUT SOL; AMINO ACID&CARB > 100 GMS PROT
B4216	PARENTERAL NUTRITION; ADDITIVES (VITAMINS, TRACE ELEMENTS, HEPARIN, ELECTROLYTES) - HOME MIX, PER DAY
B4220	PARENTERAL NUTRITION SUPPLY KIT; PREMIX, PER DAY
B4224	PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY
B5000	PARNTRAL NUT SOL; AMINO ACID&CARBS RENL-AMIROSYN
B5100	PARNTRAL NUT SOL; AMINO ACID&CARBS HEP-FREAMINE
B5200	PARNTRAL NUT SOL; AMINO ACID&CARB STRSS-BR CHAIN
B9004	PARENTERAL NUTRITION INFUSION PUMP, PORTABLE
B9006	PARENTERAL NUTRITION INFUSION PUMP, STATIONARY
E0791	PARENTERAL INFUSION PUMP, STATIONARY, SINGLE OR MULTICHANNEL
J7799	NOC DRUGS, OTHER THAN INHALATION DRUGS, ADMINISTERED THROUGH DME HOME INFUSION THERAPY, ROUTINE SERVICE OF INFUSION DEVICE (E.G., PUMP MAINTENANCE)
S5035	HOME INFUSION THERAPY, REPAIR OF INFUSION DEVICE (E.G., PUMP REPAIR)
S5036	HOME INFUSION THERAPY, REPAIR OF INFUSION DEVICE (E.G., PUMP REPAIR)
S5497	HOME INFUS TX CATH CARE/MAINT NOC; PER DIEM
S5498	HOME INFUS TX CATH CARE/MAINT SIMPLE PER DIEM
S5501	HOME INFUS TX CATH CARE/MAINT COMPLEX PER DIEM
S5502	HOME INFUS TX CATH CARE IMPL ACCESS DEVC DIEM
S5517	HOME INFUSION THERAPY, ALL SUPPLIES NECESSARY FOR RESTORATION OF CATHETER PATENCY OR DECLOTTING
S5518	HOME INFUSION THERAPY, ALL SUPPLIES NECESSARY FOR CATHETER REPAIR
S5520	HOME INFUSION TX ALL SPL NECES PICC LINE INSERT
S5521	HOME INFUSION THERAPY, ALL SUPPLIES (INCLUDING CATHETER) NECESSARY FOR A MIDLINE CATHETER INSERTION
S5522	HOM INFUS TX INSRTION PICC NRS SRVC ONLY
S5523	HOME INFUSION THERAPY, INSERTION OF MIDLINE VENOUS CATHETER, NURSING SERVICES ONLY (NO SUPPLIES OR CATHETER INCLUDED)
S9325	HIT PAIN MANAGEMENT INFUSION; PER DIEM
S9326	HIT CONT PAIN MGMT INFUS; CARE COORD PER DIEM
S9327	HIT INTERMIT PAIN MGMT INFUS; CARE COORD DIEM
S9328	HIT IMPLANTED PUMP PAIN MGMT INFUS; PER DIEM
S9329	HOME INFUSION TX CHEMOTHERAPY INFUSION; PER DIEM

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<b>HCPCS Code</b>	<b>Description</b>
S9330	HIT CONT CHEMOTHAPY INFUS; CARE COORD PER DIEM
S9331	HIT INTERMIT CHEMOTHAPY INFUS; CARE COORD-DIEM
S9336	HOME INFUS TX CONT ANTICOAGULANT INFUS TX DIEM
S9338	HIT IMMUOTHAPY; CARE COORDINATION PER DIEM
S9345	HOME INFUSION TX ANTI-HEMOPHILIC AGENT; PER DIEM
S9346	HOME INFUS TX ALPHA-1-PROTEINASE INHIBITOR; DIEM
S9347	HIT UNINTRPED LNG-TERM CNTRL RATE IV/SUBQ; -DIEM
S9348	HIT SYMPATHOMIMETIC/INOTROPIC AGENT PER DIEM
S9349	HOME INFUSION THERAPY TOCOLYTIC; PER DIEM
S9351	HOME INFUSION THERAPY CONT ANTI-EMETIC; PER DIEM
S9353	HOME INFUSION THERAPY CONT INSULIN; PER DIEM
S9355	HOME INFUSION THERAPY CHELATION; PER DIEM
S9357	HOME INFUSION TX ENZYME REPL IV TX; PER DIEM
S9359	HIT ANTI-TUMOR NECROS FACTOR IV TX; PER DIEM
S9361	HOME INFUSION THERAPY DIURETIC IV TX; PER DIEM
S9363	HIT ANTI-SPASMOTIC TX; CARE SPL&EQP PER DIEM
S9364	HIT TOTAL PARENTERAL NUTRITION; CARE COORD DIEM
S9365	HOM INFUS TX TPN; 1 LITER-DAY DIEM
S9366	HIT TPN; > 1 LITER BUT NOT > 2 LITERS-DA-DIEM
S9367	HIT TPN; > 2 LITERS BUT NOT > 3 LITERS-DA -DIEM
S9368	HIT TOTAL PARENTERAL NUTRIT; > 3 LITERS-DA -DIEM
S9373	HOME INFUSION THERAPY HYDRATION TX; PER DIEM
S9374	HOME INFUSION THERAPY HYDRATION TX; 1 LITER DAY
S9375	HIT HYDRATION TX; >1 LITER NO>2 LITERS DAY
S9376	HIT HYDRATION TX; >2 LITERS NO>3 LITERS DAY
S9377	HOME INFUS THERAPY HYDRATION TX; >3 LITERS DAY
S9379	HOME INFUSION THERAPY INFUSION THERAPY NOC; DIEM
S9490	HIT CORTICOSTEROID INFUS; ADMN SRVC PROF PHRM SR
S9494	HIT ABX ANTIVIRAL/ANTIFUNGAL THERAPY; PER DIEM
S9497	HIT ABX ANTIVIRAL/ANTIFUNGAL TX; Q3 HRS DIEM
S9500	HIT ABX ANTIVIRAL/ANTIFUNGAL TX; Q24 HRS DIEM
S9501	HIT ABX ANTIVIRAL/ANTIFUNGAL TX; Q12 HRS DIEM
S9502	HIT ABX ANTIVIRAL/ANTIFUNGAL; Q8 HRS PER DIEM
S9503	HIT ANTIBIOTC ANTIVIRAL/ANTIFUNGAL; Q6 HRS; DIEM

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<b>HCPCS Code</b>	<b>Description</b>
S9504	HIT ABX ANTIVIRAL/ANTIFUNGAL; Q4 HRS; PER DIEM
S9542	HOME INJ TX NOC W/CARE COORDINATION PER DIEM
S9558	HIT GROWTH HORMONE W/CARE COORDINATION PER DIEM
S9559	HIT INTERFERON W/CARE COORDINATION PER DIEM
S9560	HOME INJECTABLE THERAPY; HORMONAL THERAPY DIEM
S9562	HOM INJ TX PALIVIZUMAB W/ADMN PHRM CARE-PER DIEM
S9590	HOM TX IRRIG TX; W/ADMN PHRM SRVC CARE-PER DIEM
S9810	HOME THERAPY; NOT OTHERWISE CLASSIFIED PER HOUR

<b>ICD-9-CM Diagnosis Code*</b>	<b>Description</b>
150.0	MALIGNANT NEOPLASM OF CERVICAL ESOPHAGUS
151.0	MALIGNANT NEOPLASM OF CARDIA
209.23	MALIGNANT CARCINOID TUMOR OF THE STOMACH
209.63	BENIGN CARCINOID TUMOR OF THE STOMACH
211.0	BENIGN NEOPLASM OF ESOPHAGUS
211.1	BENIGN NEOPLASM OF STOMACH
230.1	CARCINOMA IN SITU OF ESOPHAGUS
230.2	CARCINOMA IN SITU OF STOMACH
530.3	STRICTURE AND STENOSIS OF ESOPHAGUS
536.42	MECHANICAL COMPLICATION OF GASTROSTOMY
537.0	ACQUIRED HYPERTROPHIC PYLORIC STENOSIS
537.6	HOURLASS STRICTURE OR STENOSIS OF STOMACH
537.89	OTHER SPECIFIED DISORDER OF STOMACH AND DUODENUM
555.0	REGIONAL ENTERITIS OF SMALL INTESTINE
555.1	REGIONAL ENTERITIS OF LARGE INTESTINE
555.9	REGIONAL ENTERITIS OF UNSPECIFIED SITE
560.1	PARALYTIC ILEUS
560.81	INTESTINAL OR PERITONEAL ADHESIONS WITH OBSTRUCTION (POSTOPERATIVE) (POSTINFECTION)
560.89	OTHER SPECIFIED INTESTINAL OBSTRUCTION
564.89	OTHER FUNCTIONAL DISORDERS OF INTESTINE
569.81	FISTULA OF INTESTINE, EXCLUDING RECTUM AND ANUS

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<b>ICD-9-CM Diagnosis Code*</b>	<b>Description</b>
579.3	OTHER AND UNSPECIFIED POSTSURGICAL NONABSORPTION
596.1	INTESTINOVESICAL FISTULA
750.3	CONGENITAL TRACHEOESOPHAGEAL FISTULA, ESOPHAGEAL ATRESIA AND STENOSIS
751.1	CONGENITAL ATRESIA AND STENOSIS OF SMALL INTESTINE
751.2	CONGENITAL ATRESIA AND STENOSIS OF LARGE INTESTINE, RECTUM, AND ANAL CANAL
756.72	OMPHALOCELE
756.73	GASTROSCHISIS
777.4	TRANSITORY ILEUS OF NEWBORN
777.50	NECROTIZING ENTEROCOLITIS IN NEWBORN, UNSPECIFIED
777.51	STAGE I NECROTIZING ENTEROCOLITIS IN NEWBORN
777.52	STAGE II NECROTIZING ENTEROCOLITIS IN NEWBORN
777.53	STAGE III NECROTIZING ENTEROCOLITIS IN NEWBORN
777.6	PERINATAL INTESTINAL PERFORATION
777.8	OTHER SPECIFIED PERINATAL DISORDER OF DIGESTIVE SYSTEM
777.9	UNSPECIFIED PERINATAL DISORDER OF DIGESTIVE SYSTEM
779.32	BILIOUS VOMITING IN NEWBORN
779.34	FAILURE TO THRIVE IN NEWBORN
787.29	OTHER DYSPHAGIA

\*If applicable, please see Medicare LCD or NCD for additional covered diagnoses.

## IX. POLICY HISTORY

<b>MP 3.008</b>	<b>CAC 6/29/04</b>
	<b>CAC 9/28/04</b>
	<b>CAC 11/30/04</b>
	<b>CAC 11/29/05</b>
	<b>CAC 11/28/06</b>

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	<b>CAC 11/27/07</b>
	<b>CAC 9/30/08</b>
	<b>CAC 1/27/09</b>
	<b>CAC 11/24/09</b> Medicare variation added
	<b>CAC 11/30/10</b> Consensus review. No change in policy statements. References updated.
	<b>CAC 11/22/11</b> Consensus Review
	<b>7/24/13</b> Admin coding review complete
	<b>CAC 9/24/13</b> Consensus. No change to policy statements. References updated

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