BlueCross BlueShield of Vermont

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Home Infusion Therapy
Corporate Medical Policy

File Name: Home Infusion Therapy
File Code: 8.03.VT201
Origination: 10/2004
Last Review: 10/2026
Next Review: 10/2027
Effective Date: 02/01/2027

Description/Summary

Infusion therapy involves the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "infusion therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord).

"Traditional" prescription drug therapies commonly administered via infusion include antibiotic, antifungal, antiviral, chemotherapy, hydration, pain management, and parenteral nutrition. Infusion therapy is also provided to patients for treating a wide assortment of often chronic and sometimes rare diseases for which "specialty" infusion medications are effective.

Policy

When a service may be considered medically necessary

Home infusion therapy via Intravenous (IV) solutions and/or injectable (given either subcutaneous or intramuscular) medications may be considered **medically necessary** by the Plan when **ALL** of the following criteria are met:

- Prescription drug is FDA approved; **AND**
- Therapy regimen is prescribed by a medical doctor (MD or DO), physician assistant (PA) or nurse practitioner (NP); **AND**
- Therapy is managed by a medical doctor (MD or DO), physician assistant (PA), nurse practitioner (NP) or registered nurse (RN) in the home; **AND**
- Treatment can be safely administered in the home; **AND**
- The prescribed home infusion therapy regimen is for a period of time not to exceed the standard of care for the condition being treated; **AND**
- Services are provided by a network/preferred home infusion therapy provider

NOTE: Certain drugs may require prior approval. Please refer to the Blue Cross VT Drug Prior Approval Listing

When a service is considered not medically necessary

- Home infusion therapy that does not meet the above medical necessity criteria.

Reference Resources

1. About Home and Specialty Infusion. National Home Infusion Association. https://www.nhia.org/about-infusion-therapy/. Accessed 10/2026.
2. Blue Cross and Blue Shield Association Medical Policy – 1.02.01 (01/2003). Total Parenteral Nutrition and Enteral Nutrition in the Home. Archived 06/2009.
3. Guidelines for the Medical Management of the Home Care Patient. AMA Practice Parameters (1998 March): 1-26.

Document Precedence

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, Blue Cross VT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, Blue Cross VT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is not required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered compete, see policy guidelines above.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm

benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not al groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Service s Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Related Policies

CPP_14 Home Infusion Policy (including enteral nutrition and total parenteral nutrition) Payment Policy
Enteral Nutrition
Total Parenteral Nutrition (TPN) in the Home Setting
Nutritional Counseling Metabolic Food for Inherited Metabolic Disorders

Policy Implementation/Update information

10/2004	New Policy
12/2005	Reviewed with minor wording changes and new CPT and HCPCS codes
12/2006	Reviewed. HCPCS code changes
03/2007	Reviewed and approved by the BCBSVT Clinical Advisory Committee
05/2008	Format changes made. To be reviewed by CAC 07/2008
11/2016	Updated coding table to remove TPN and enteral codes, refer to separate medical policies. Updated format and language to include when home infusion is not medically necessary.
3/2018	Changed headers, reorganized medical necessity criteria, removed criteria bullets for PA/certifying every 6 months/acute care/treatment plan. Removed HCPCS Codes A4220 &A4221 from coding table as requiring PA- Per the DME medical PA list these codes do not require PA.
05/2019	Policy reviewed no changes to policy statement. Policy will be archived and new policy posted to website for State of Vermont Members Only.
08/2019	Policy removed from archived status. Policy statements remain unchanged. Removed codes: B4164, B4168, B4172, B4176, B4178, B4180, B4185, B4189, B4193, B4197, B4199, B4216, B4220, B4222, B4224, B5000, B5100, B5200, B9004, B9006, E0791. Codes are on the Corporate TPN Medical Policy the codes require PA per the PA list.
07/2020	Policy reviewed no changes to policy statement. Minor Description language changes. References updated.

10/2020	Policy reviewed no changes to policy statements. Added Related Policy section to policy. Codes G0088, G0089, G0090 new codes effective 01/01/2021 require prior approval.
07/2021	Removed codes G0299, G0300 from medical policy as not being applicable.
09/2022	Policy Reviewed. Minor formatting changes. No change to policy statement.
03/2023	Adaptive Maintenance Effective 04/01/2023: Revised code descriptor S9562 added code S9563 as medically necessary to coding table.
03/2024	Policy reviewed. No changes to policy statement. Minor formatting changes for clarity and consistency.
09/2025	Policy reviewed. No changes to policy statement. Minor formatting changes. Removed coding table from policy.
10/2026	Policy reviewed. No changes to policy statement. References updated.

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by Blue Cross VT Medical Directors

Tom Weigel, MD, MBA
Vice President and Chief Medical Officer