

## The Department of Vermont Health Access Medical Policy

**Subject:** External Infusion Pumps

**Last Review:** May 20, 2011

**Revision 3:**

**Revision 2:**

**Revision 1:**

**Original Effective:** 2006

### Description of Service or Procedure

An external infusion pump operates by electrical or battery power and provides parenteral medications under pressure at a regulated flow rate. This may be either a portable or a stationary unit.

### Disclaimer

Coverage is limited to that outlined in Medicaid Rule that pertains to the beneficiary's aid category. Prior Authorization (PA) is only valid if the beneficiary is eligible for the applicable item or service on the date of service.

### Medicaid Rule

[7102.2](#) Prior Authorization Determination

[7103](#) Medical Necessity

Medicaid Rules can be found at <http://humanservices.vermont.gov/on-line-rules>

### Coverage Position

An external infusion pump may be covered for those individuals:

- When the external infusion pump is prescribed by a licensed medical provider enrolled in the VT Medicaid program who is knowledgeable in the use of external infusion pump and who provides medical care to the beneficiary AND
- Who meet the clinical guidelines below.



## **Coverage Guidelines**

The Department of Vermont Health Access (DVHA) considers external infusion pumps a medically necessary DME for the administration of any of the following medications:

1. Parenteral anticancer chemotherapy drugs (bleomycin, cladribine, cytarabine, doxorubicin (non-liposomal), floxuridine, fluorouracil, vinblastine, vincristine, etc.) in providing an evidence-based chemotherapy regimen. **OR**
2. Certain parenteral antifungal/antiviral and antimicrobial drugs (acyclovir, amphotericin B, foscarnet, ganciclovir, vancomycin, etc.). **OR**
3. Chemotherapy primary hepatocellular carcinoma or colorectal cancer where the tumor is unresectable or the member refuses surgical excision of the tumor. **OR**
4. Deferoxamine for the treatment of chronic iron overload. **OR**
5. Heparin to adequately anticoagulate women through pregnancy (warfarin compounds are not routinely used for this indication). **OR**
6. Morphine/narcotic analgesics (except meperidine) for intractable pain caused by cancer and the patient have not responded adequately to oral/transdermal therapeutic regimen and/or the patient is unable to tolerate oral/transdermal narcotic analgesic. **OR**
7. Parenteral epoprostenol or treprostinil for persons with pulmonary hypertension, **OR**
8. Parenteral inotropic therapy with dobutamine, dopamine, milrinone, and other agents in patients with congestive heart failure and depressed cardiac function. **OR**
9. Ziconotide is covered for the management of severe chronic pain when intrathecal therapy is warranted and who are intolerant of other therapies. **OR**
10. Other parenteral drugs, that must be titrated or must have the infusion strictly controlled for patient safety and efficacy of treatment and can be safely administered at home using an infusion pump

An external infusion pump may be appropriate for an individual who requires infusion for the above indications and when:

1. An infusion pump is necessary to safely administer the drug. **AND**
2. The drug requires a prolonged infusion because of proven clinical efficacy over other forms of administration, or there are safety risks including systemic toxicity or adverse effects with other forms of administration as evidenced by supportive documentation. **AND**
3. The drug does not require the individual to return to a physician's office before the beginning of each infusion. **AND**
4. The individual and/or caregiver demonstrate follow-through in other areas of disease management (such as nutrition, exercise, lifestyle changes, smoking cessation) to improve disease/symptom control, if appropriate. **AND**
5. The infusion pump has been approved by the FDA for infusion of the particular drug that is to be administered. **AND**
6. The therapeutic regimen is proven to have significant advantage over intermittent bolus administration regimens or infusions lasting less than 8 hours.

## **Clinical guidelines for repeat service or procedure**

Documentation of continued medical necessity of the external infusion pump requires that the beneficiary be seen and evaluated by the treating physician for each episode of care.

## **Type of service or procedure not covered (this list may not be all inclusive)**

The DVHA considers external infusion pumps experimental and investigational for all other indications not listed in the Coverage Guidelines.

## **References**

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