I. Description

Home infusion therapy for pain management is used when all other pain control methods of administration are no longer effective and when patient-controlled analgesia can be effectively administered for palliative treatment of severe pain.

Drugs used in pain management infusion include opioid analgesics such as morphine, hydromorphone, meperidine and fentanyl. Local anesthetics may be used in combination with opioid analgesics in epidural infusions.

The following are two types of home infusion therapy for pain management:

A. Intravenous (IV) patient-controlled analgesia (PCA) allows the patient to self-administer opioid analgesics by using a pre-programmed mechanical infusion device that delivers the medication through an IV or subcutaneous needle or catheter to minimize or relieve pain. The PCA pump can provide a continuous infusion and/or intermittent preset doses of medication. Lockout periods can also be established to control the amount of opioid analgesic the patient can receive within a predetermined period of time. This type of pain control is generally used for postoperative purposes but can also be used for the management of severe chronic pain due to cancer.

B. Patient-controlled epidural or intrathecal analgesia involves the insertion of an epidural or intrathecal catheter in conjunction with a pump to deliver small doses of local anesthetics or opioid analgesics directly into the epidural or subarachnoid space. Side effects such as nausea, sedation and respiratory depression can be minimized because of the low doses needed to obtain pain relief and the effect on peripheral versus central receptors. This method of pain management requires experienced professionals, use of meticulous technique, availability of significant family support systems and timely professional follow-up evaluations. It can be used
effectively in pain management for terminal cancer patients and for patients with chronic intractable pain of noncancerous origin.

II. Criteria/Guidelines

A. Home infusion pain management therapy to deliver FDA-approved drugs is covered (subject to Limitations/Exclusions and Administrative Guidelines) for any of the following indications:

1. Patients with terminal cancer
   a. When pain is unresponsive to standard pain management interventions; or
   b. When rapid onset of analgesia and a sustained consistent level of drug is needed to prevent pain.

2. Patients with chronic, nonmalignant pain
   a. When there is an acute exacerbation of pain requiring short-term (two to three weeks) treatment as an adjunct to usual pain management regimen; or
   b. When pain is not effectively controlled with analgesics administered by oral, transdermal, subcutaneous or intravenous routes and patient has been evaluated by a multidisciplinary team.

B. Patients must meet the definition of homebound found in the Glossary to receive this service.

III. Limitations/Exclusions

Home infusion pain management therapy is not covered under the following conditions:

A. The patient or caregiver is unwilling or unable to manage or continue with the home infusion program
B. The patient or caregiver is noncompliant with treatment and follow-up with prescribing physician or has a history of noncompliant behavior
C. Evaluation of clinical data, tests and symptoms indicate that home infusion pain management is no longer effective
D. The drugs or routes of administration are not approved by the FDA.
E. There is no meaningful trial to determine failure of previous pain control regimens by other routes of administration for patients with chronic, nonmalignant pain

IV. Administrative Guidelines

Precertification is not required. HMSA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria.
V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References