Home IV Anti-Infective Therapy

Policy Number: MM.08.004
Original Effective Date: 05/21/1999
Line(s) of Business: HMO; PPO; QUEST
Current Effective Date: 11/01/2011
Section: Home Therapies
Place(s) of Service: Home

I. Criteria/Guidelines

A. Home anti-infective therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) when the patient has an infectious disease that has stabilized and home therapy can be effectively and safely administered in lieu of a new or continued hospitalization for the treatment of the infection.

B. Home anti-infective therapy is covered (subject to Limitations/Exclusions and Administrative Guidelines) when one or more of the following criteria are met:
   1. Therapeutically equivalent oral antibiotics are not available.
   2. Oral antibiotic therapy has failed.
   3. The patient cannot swallow or absorb oral medications.

C. Continuation of home anti-infective therapy beyond the standard duration is covered (subject to Limitations/Exclusions and Administrative Guidelines) when all of the following criteria are met:
   1. The patient is responding to current therapy.
   2. There is evidence of an unresolved infection (e.g., clinical symptoms or laboratory or imaging findings)

D. The patient does not need to meet the definition of homebound (as found in the Glossary) to receive services at home.

II. Limitations/Exclusions

A. Extension of therapy is not covered when:
   1. The goals of therapy have been achieved (e.g., resolution of infection, normal clinical data and tests).
   2. The patient or caregiver is unwilling or unable to manage or continue with the home infusion program.
   3. The patient or caregiver is noncompliant with treatment.
Follow-up assessment of the patient’s clinical progress is not performed.

Oral antibiotic therapy becomes an effective mode of treatment.

IV antibiotic has not been effective as evidenced by clinical data and tests.

Appropriate culture and sensitivity tests are not ordered.

Surgical intervention is necessary such as incision and drainage of abscess, debridement, removal of any foreign body that may be the source of infection (prosthesis, intravenous catheter, surgical stitches), or revascularization.

Complications or side effects result from prolonged IV anti-infective therapy such as clostridium difficile diarrhea, drug fever, delayed allergic drug reactions (erythematous, morbilliform drug rashes, urticarial reactions), agranulocytosis (bone marrow suppression), acute interstitial nephritis (AIN) due to nephrotoxicity, neuropathies due to neurotoxicity, hepatotoxicity, bacterial resistance, etc.

Hospitalization is necessary due to the development of unstable medical conditions.

III. Administrative Guidelines

A. 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.

B. The following guidelines are used when determining the standard duration of treatment:

1. Duration of treatment starts on the initial day of therapy. This includes days while the patient was hospitalized.

2. If the patient is readmitted to the hospital and is continued on the same antibiotic(s), the initial start date of therapy does not change.

3. If an antibiotic regimen is appropriate but changed secondary to allergy or intolerance or for ease of administration at the time of discharge, the initial start date of therapy does not change.

4. A new start date applies when one of the following occurs:
   a. Infection has resolved and antibiotic treatment has been discontinued, then restarted with the same or different antibiotic(s) for a recurrent or relapsing infection.
   b. When current antibiotic therapy is ineffective and a new antibiotic regimen is started

<table>
<thead>
<tr>
<th>Condition</th>
<th>Standard Duration of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute pericarditis</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Endocarditis (bacterial)</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Septic (pyogenic) arthritis</td>
<td>4 weeks</td>
</tr>
<tr>
<td>CMV retinitis in HIV patients</td>
<td>12 weeks</td>
</tr>
<tr>
<td>Infection involving retained orthopedic hardware</td>
<td>6 weeks</td>
</tr>
<tr>
<td>All other conditions</td>
<td>2 weeks</td>
</tr>
</tbody>
</table>

C. If payment determination is requested, medical documentation must be submitted to support the above criteria.

D. Skilled nursing visits after day 28 of therapy is limited to one per week unless medically necessary. Documentation in the medical record should be kept to support the additional skilled nursing visit.

E. For administrative information, including billing instructions, examples and code information, see Home IV Anti-Infective Therapy - Administrative Information

IV. 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.
V. References