Outpatient IV Anti-Infective Therapy

I. Policy

University Health Alliance (UHA) will reimburse for outpatient (home or ambulatory infusion suite) IV anti-infective therapy when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

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

B. Home or ambulatory infusion suite IV 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 or ambulatory infusion suite IV 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 (due to an illness of injury, a patient is unable to leave home, or when doing so requires a considerable and taxing effort) to receive services at home.

III. Limitations/Exclusions

A. IV anti-infective 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 is noncompliant with treatment;
   4. Follow-up assessment of the patient's clinical progress is not performed;
   5. Oral antibiotic therapy becomes an effective mode of treatment;
   6. IV antibiotic has not been effective as evidenced by clinical data and tests;
   7. Appropriate culture and sensitivity tests are not ordered;
8. 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;

9. 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.;

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

**IV. Administrative Guidelines**

A. Prior authorization is not required when the therapy is ordered and supervised by a board certified infectious disease specialist (as identified by ABMS) and the above criteria are met. Prior authorization is required for all other circumstances. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination.

B. The following documentation from the medical record must be submitted with the prior authorization request:
   1. Physician orders/prescription for the antibiotic regimen including dose, frequency, route of administration and duration of therapy.
   2. Hospital medical records, if start date occurred when the patient was hospitalized.
   3. Documentation supporting that the patient is responding to treatment as demonstrated by clinical or laboratory or imaging findings. Examples include but are not limited to the following:
      a. Clinical - vital signs, temperature, respiratory status, wound and skin condition, metabolic status, pain status, urinary status, gastrointestinal status;
      b. Laboratory - culture and sensitivity of blood, urine, exudates, secretions or excretions, CBC with differential, ESR, CRP;
      c. Imaging - radiographs, CT or MRI scans, bone scans, gallium scans (abscess).
   4. Documentation supporting unresolved infection (e.g., clinical symptoms or laboratory or imaging findings).
   5. Documentation supporting appropriate modification of IV antibiotic therapy, if applicable, due to one of the following:
      a. Development of antibiotic resistant organisms;
      b. Infection with new organisms;
      c. Antibiotic dosage adjustment based on serum concentration level.
   6. Clear identification of primary and secondary diagnoses codes as applicable to requested IV anti-infective therapy.

C. To request prior authorization, please submit via UHA’s online portal. If a login has not been established, you may contact UHA at 808-532-4000 to establish one.

D. The home therapy provider is responsible for obtaining the appropriate documentation for prior authorization when it is required. This requirement is not intended to impede discharge planning. Physicians are expected to assist the home therapy provider by providing updated orders, clinical information, and any other documentation necessary to meet prior authorization requirements.
NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member’s individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

V. Policy History

Policy Number: MPP-0022-120301
Current Effective Date: 04/11/2019
Original Document Effective Date: 03/01/2012
Previous Revision Dates: 01/01/2017, 04/18/2018
PAC Approved Date: 03/01/2012
Previous Policy Title: Home IV Anti-Infective Therapy