Marketplace Benefit Interpretation

Marketplace National Regional Benefit Interpretation Document

Benefit Name	HOME INFUSION THERAPY
Applicable State	California, Florida, Idaho, Illinois, Kentucky, Michigan, Mississippi, New Mexico, Ohio, South Carolina, Texas, Utah, Washington, Wisconsin
Benefit Definition	This policy address home infusion therapy. Covered benefits are listed in three (3) Sections - A, B and C. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern. **Essential Health Benefits for Individuals and Small Groups** For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs"). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit document to determine benefit coverage. **A. FEDERAL/STATE MANDATED REGULATIONS** **Note: The most current federal/state mandated regulations for each state can be found in the links below.** **CALIFORNIA:** 28 CCR § 1300.67- Infusion Therapy **B. STATE MARKET PLAN ENHANCEMENTS**

None

C. COVERED BENEFITS

IMPORTANT NOTE: Covered benefits are listed in Sections A, B and C. Always refer to Sections A and B for additional covered benefits not listed in this Section.

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

HOME INFUSION THERAPY

CALIFORNIA, FLORIDA, IDAHO, ILLINOIS, MICHIGAN, MISSISSIPPI, NEW MEXICO, SOUTH CAROLINA, TEXAS, UTAH, WASHINGTON, WISCONSIN:
Molina covers Home Infusion Therapy

KENTUCKY:
Passport covers home infusion therapy

OHIO:
Molina covers home infusion therapy include a combination of nursing, durable medical equipment, and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes, but is not limited to, injections (intra-muscular, subcutaneous, and continuous subcutaneous), total parenteral nutrition, enteral nutrition therapy, antibiotic therapy, pain management, and chemotherapy.

Refer to the Benefit Interpretation Policy titled **Home Health Services**

D. NOT COVERED

Refer to the member's Evidence of Coverage (EOC) and Schedule of Benefits (SOB) to determine coverage eligibility.

E. DEFINITIONS

See Glossary

F. POLICY HISTORY/REVISION INFORMATION

Date	Action/Description

Procedure Codes (Internal Use Only)	BI Policy Configuration Home Infusion Therapy **Coding Disclaimer:** Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.
Prior Authorization	For the MHI PA Matrix, if a code is NOT listed, it could EITHER be: a. Covered and No PA Required b. Not Covered You cannot use the MHI PA Matrix to make coverage determinations. PA Lookup Tool
Approval	

Departments	Product	CIM	Clinical Management
Date	2/18/2021	5/10/2021	4/7/2021
Revised (for 1/1/2022)	11/2/2021	3/11/2022	11/5/2021
Revised (for 1/1/2023)	11/18/2022		11/10/2022