

Policy Number	ADM1001.034
Policy Effective Date	07/01/2025
Policy End Date	12/31/2025

Specialty Medication Administration Site of Care

Table of Contents
Coverage
Policy Guidelines
Description
Rationale
Coding
References
Policy History

Related Policies (if applicable)
None

Disclaimer

Medical policies are a set of written guidelines that support current standards of practice. They are based on current peer-reviewed scientific literature. A requested therapy must be proven effective for the relevant diagnosis or procedure. For drug therapy, the proposed dose, frequency and duration of therapy must be consistent with recommendations in at least one authoritative source. This medical policy is supported by FDA-approved labeling and/or nationally recognized authoritative references to major drug compendia, peer reviewed scientific literature and acceptable standards of medical practice. These references include, but are not limited to: MCG care guidelines, DrugDex (IIa level of evidence or higher), NCCN Guidelines (IIb level of evidence or higher), NCCN Compendia (IIb level of evidence or higher), professional society guidelines, and CMS coverage policy.

Carefully check state regulations and/or the member contract.

Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

NOTE 1: The medical necessity of the infused pharmacologic or biologic agent may be separately reviewed against the appropriate criteria. This document addresses only the determination of the medical necessity of hospital outpatient level of care for the intravenous infusion and injectable therapy. Medications subject to review against this policy include, but are not limited to, those listed in Table 1 below.

NOTE 2: The first 45 days of therapy may be given at the physician's facility of choice. This includes hospital outpatient facilities, non-hospital outpatient facilities and home care. All

subsequent doses will be subject to the criteria listed below which requires the use of non-hospital outpatient facilities or home infusion when clinically appropriate.

Infusions in a hospital outpatient facility setting **may be considered medically necessary** when there is clinical documentation the member is medically unstable for infusions at alternative levels of care, such as the provider office or home setting, as noted by any of the following:

- Documented clinical history of cardiopulmonary conditions that may cause an increased risk of severe adverse reactions; OR
- An inability to safely tolerate intravenous volume loads, including from unstable renal function; OR
- Member is reinitiating therapy after not being on therapy for at least 6 months; OR
- Member has a previously documented severe or potentially life-threatening adverse event during or following infusion of the prescribed drug, and the adverse event cannot be managed through pre-medication in the home or office setting; OR
- Physical or cognitive impairments that impede safe administration and there is no home caregiver available or willing to assist with the infusion; OR
- Difficulty establishing and maintaining patent vascular access; OR
- The member's home has been determined to be inappropriate for home infusion by a social worker, case manager, or previous home nurse assessment.

EXCEPTION:

- Children (under age 18 years) receiving specialty medication infusions for which home or office-based infusions may not be safe or practical; OR
- The prescribed medical drug or supportive intravenous (IV) fluid(s) are experiencing documented drug shortages or recalls from a wholesaler, manufacturer, the ASHP (American Hospital of Health-System Pharmacist) Drug Shortage web page or the US Food and Drug Administration and infusion at an alternative level of care, such as the provider office or home setting, is not possible due to the shortage.

All other uses of outpatient infusions in the hospital outpatient department or hospital outpatient clinic level of care for the infusion of pharmacologic and biologic agents **are considered not medically necessary**.

Table 1. Medications and Codes

Code	Name	Brand
90283	Immune globulin (IVIG)	
90284	Immune globulin (SCIG)	
J1599	Immune globulin, intravenous, not otherwise specified	
J3262	Tocilizumab	Actemra®
J0791	Crizanlizumab-tmca	Adakveo
J1931	Laronidase	Aldurazyme®

J0881	Darbepoetin alfa	Aranesp®
J1554	Immune globulin	Asceniv™
Q5121	Infliximab-axxq	Avsola
J1552	Immune globulin	Alyglo™
J0490	Belimumab	Benlysta®
J1556	Immune globulin	Bivigam
Q5152	Eculizumab-aeeb	Bkemv™
J1786	Imiglucerase	Cerezyme®
J0717	Certolizumab pegol	Cimzia®
J2786	Reslizumab	Cinqair®
J0598	C-1 esterase inhibitor (human)	Cinryze®
J0584	Burosumab-twza	Crysvita
J1551	Immune globulin	Cutaquig®
J1555	Immune globulin	Cuvitru®
J1743	Idursulfase	Elaprase™
J3060	Taliglucerase alfa	Elelyso
J1302	Sutimlimab-jome	Enjaymo®
J3380	Vedolizumab	Entyvio®
J0885	Epoetin alfa	Epogen®
Q5151	Eculizumab-aagh	Epysqli®
J3111	Romosozumab-aqqg	Evenity®
J1305	Evinacumab-dgnb	Evkeeza™
J0180	Agalsidase beta	Fabrazyme®
J0517	Benralizumab	Fasenra®
J1572	Immune globulin	Flebogamma/Flebogamma dif
J1569	Immune globulin	Gammagard Liquid
J1557	Immune globulin	Gammaplex
J1561	Immune globulin	Gamunex®-C/Gammaked
J0223	Givosiran	Givlaari
J1559	Immune globulin	Hizentra®
J1575	Immune globulin/hyaluronidase	Hyqvia
J0638	Canakinumab	Ilaris
J3245	Tildrakizumab-asmn	Ilumya
J1566	Immune globulin	Immune globulin
Q5103	Infliximab-dyyb	Inflectra®
J1290	Ecallantide	Kalbitor®
J2840	Sebelipase alfa	Kanuma™
J2507	Pegloticase	Krystexxa®
J1306	Inclisiran	Leqvio®
J0221	Alglucosidase alfa	Lumizyme™

J3397	Vestronidase alfa-vjbk	Mepsevii
J1458	Galsulfase	Naglazyme®
J0219	Avalglucosidase alfa-ngpt	Nexviazyme®
J2796	Romiplostim	Nplate®
J0485	Belatacept	Nulojix®
J2182	Mepolizumab	Nucala®
J2350	Ocrelizumab	Ocrevus®
J2351	Ocrelizumab and hyaluronidase-ocsq	Ocrevus Zunovo™
J1568	Immune globulin	Octagam®
J0222	Patisiran	Onpattro
J0129	Abatacept	Orencia®
Q9999	Ustekinumab-aaaz	Otulfy™
J0224	Lumasiran	Oxlumo®
J1576	Immune Globulin	Panzyga®
J1459	Immune globulin	Privigen®
Q9997	Ustekinumab-ttwe	Pyzchiva®
J1301	Edaravone	Radicava™
J1745	Infliximab	Remicade®
Q5104	Infliximab-abda	Renflexis®
Q5106	Epoetin alfa-epbx	Retacrit®
Q5123	Rituximab-arrx	Riabni®
J9312	Rituximab	Rituxan®
Q5119	Rituximab-pvvr	Ruxience®
J2353	Octreotide (depot)	Sandostatin LAR®
J2354	Octreotide (non-depot)	Sandostatin®
J0491	Anifrolumab-fnia	Saphnelo®
Q9998	Ustekinumab-aekn	Selarsdi™
J1602	Golimumab	Simponi Aria®
J1299	Ecilizumab	Soliris®
J1930	Lanreotide	Somatuline Depot®
J3358	Ustekinumab	Stelara®
J3241	Teprotumumab-trbw	Tepezza
J2356	Tezepelumab-ekko	Tezspire®
Q5133	Tocilizumab-bavi	Tofidence™
J1746	Ibalizumab-uiyk	Trogarzo
Q5115	Rituximab-abbs	Truxima®
Q5135	Tocilizumab-aazg	Tyenne®
Q5134	Natalizumab-sztn	Tyruko®
J2323	Natalizumab	Tysabri®

J1303	Ravulizumab-cwvz	Ultomiris
J1823	Inebilizumab-cdon	Uplizna®
J1322	Elosulfase alfa	Vimizim™
J1562	Immune globulin	Vivaglobin®
J3385	Velaglucerase alfa	VPRIV
J3032	Eptinezumab-jjmr	Vyepti
J9332	Efgartigimod alfa-fcab	Vyvgart®
Q5138	Ustekinumab-auub	Wezlana™
J7183	Von willebrand factor complex	Wilate®
J1558	Immune globulin	Xembify
J2357	Omalizumab	Xolair®

Policy Guidelines

None.

Description

Site of care refers to the choice for physical location for infusion administration of medications, and can include the following settings: inpatient hospital, outpatient hospital, provider office, ambulatory infusion suite or home.

New technologies and pharmaceuticals allow therapeutic services, such as infusion therapy, to be administered safely and effectively outside of hospital-based infusion centers. Sites of care such as physician offices, ambulatory infusion centers and home infusion services are well accepted places of service for medication infusion services.

Rationale

Infusions of medications in the home setting are appropriate for medically stable patients who do not require close observation or daily nursing care. According to the 2022 MCG™ Care Guidelines for Home Infusion Management and Caregiver Resources Evaluation, the patient or caregiver should demonstrate the ability and willingness to participate in the therapy and perform the infusion procedure. (1, 2)

A 2017 systematic review by Polinski et al., which included 13 relevant studies identified through MEDLINE, EMBASE and Science Citation index search, concluded that patients receiving home infusions were no more likely to experience adverse drug events or side effects (all $p > 0.05$). Patients overwhelmingly preferred receiving infusion at home rather than in a health care facility. The review also showed that home infusion is well suited to medication delivery in clinical areas such as neurology, oncology, hematology, rheumatology and gastroenterology. (3)

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	90283, 90284
HCPCS Codes	J0129, J0180, J0219, J0221, J0222, J0223, J0224, J0485, J0490, J0491, J0517, J0584, J0598, J0638, J0717, J0791, J0881, J0885, J1290, J1299, J1301, J1302, J1303, J1305, J1306, J1322, J1458, J1459, J1551, J1552, J1554, J1555, J1556, J1557, J1558, J1559, J1561, J1562, J1566, J1568, J1569, J1572, J1575, J1576, J1599, J1602, J1743, J1745, J1746, J1786, J1823, J1930, J1931, J2182, J2323, J2350, J2351, J2353, J2354, J2356, J2357, J2507, J2786, J2796, J2840, J3032, J3060, J3111, J3241, J3245, J3262, J3358, J3380, J3385, J3397, J7183, J9312, J9332, Q5103, Q5104, Q5106, Q5115, Q5119, Q5121, Q5123, Q5133, Q5134, Q5135, Q5138, Q5151, Q5152, Q9997, Q9998, Q9999 [Deleted 4/2025: J1300]

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

References

1. MCG™ Care Guidelines, 26th edition, 2022, Home Infusion Management, CCG: C-1030(CCG).
2. MCG™ Care Guidelines, 26th edition, 2022, Caregiver Resources Evaluation, CCG: C-1056(CCG).
3. Polinski JM, Kowal MK, Gagnon M, et al. Home infusion: safe clinically effective, patient preferred, and cost saving. Healthcare. March 2017; 5(1-2):68-80. PMID 28668202

Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <<https://www.cms.hhs.gov>>.

Policy History/Revision	
Date	Description of Change
07/01/2025	Document updated. The following changes were made to Coverage table: 1) Changed code for Soliris from J1300 to J1299; 2) Added the following codes with associated products – 90283, 90284, J1552, J1599, J1562, J1576, J2351, Q5133, Q5134, Q5135, Q5138, Q5151, Q5152, Q9997, Q9998, and Q9999.
02/01/2025	Document updated. The following change was made to Coverage: Added EXCEPTION language regarding drug shortages/recalls. No new references added.
10/01/2024	Document updated. The following change was made to Coverage: Removed J0585 Onabotulinumtoxin A (Botox®), J0586 Abobotulinumtoxin A (Dysport®), J0587 rimabotulinumtoxin B (Myobloc®), and J0588 Incobotulinumtoxin A (Xeomin®) from Medications and Codes table.
06/01/2024	New medical document originating from medical policy RX501.096. Coverage unchanged.