PROVIDER POLICIES & PROCEDURES

AMBULATORY INFUSION PUMPS

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for ambulatory infusion pumps. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

External infusion pumps are devices used to provide continuous ambulatory drug infusion therapy over an extended period. Routes of drug administration using external infusion pumps include intravenous, intra-arterial, subcutaneous, and intra-peritoneal. The external infusion pump is electric, or battery powered, and drug reservoir refilling is non-invasive.

Prior Authorization Requirements

- Prior authorization is required for the rental and purchase of mechanical ambulatory infusion pumps (HCPCS codes E0779 and E0780)
- Prior authorization is required for the rental of an electric/battery-operated ambulatory infusion pump (HCPCS code E0781) beyond 3 months

Reference: DSS MEDS-DME Fee Schedule Instructions

Note: HUSKY Health uses Change Healthcare's InterQual® Criteria when reviewing prior authorization requests for ambulatory infusion pumps for insulin delivery (HCPCS code E0784). HUSKY Health will use this policy to review requests for other ambulatory infusion pumps for which InterQual criteria are not currently available.

CLINICAL GUIDELINE

Coverage guidelines for ambulatory infusion pumps are made in accordance with the DSS definition of Medical Necessity. The following criteria are guidelines *only*. Coverage determinations are based on an assessment of the individual and their unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

An ambulatory infusion pump may be considered medically necessary for one of the following indications:

A. Administration of deferoxamine for the treatment of acute iron poisoning or chronic iron overload; OR
B. Administration of chemotherapy for the treatment of cancer; OR
C. Administration of morphine and other parenteral analgesics when used in the treatment of intractable pain caused by cancer; OR

D. Administration of other drugs if criteria 1, 2, and 3 are met:
   1. Parenteral administration of the drug in the home is reasonable and necessary; AND
   2. An infusion pump is necessary to safely administer the drug; AND
   3. Either one of the following:
      a. The drug is administered by a prolonged infusion of at least 8 hours because of proven improved clinical efficacy and the therapeutic regimen is proven or generally accepted to have significant advantages over intermittent bolus administration regimens or infusions lasting less than 8 hours; OR

      b. The drug is administered by intermittent infusion (lasting less than 8 hours) which does not require the individual to return to the practitioner's office prior to the beginning of each infusion and the systemic toxicity or adverse effects of the drug are unavoidable without infusing it at a strictly controlled rate.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Prior authorization of ambulatory infusion pumps is required. Requests for coverage are reviewed in accordance with procedures in place for reviewing requests for durable medical equipment. Coverage determinations are based upon a review of requested and/or submitted case-specific information.
The following information is needed to review requests for an ambulatory infusion pump:
1. Fully completed authorization request via on-line web portal;
2. A signed prescription, written within the past 12 months, from the treating physician, advanced practice registered nurse (APRN), or physician assistant (PA) enrolled in the Connecticut Medical Assistance Program (CMAP); and
3. Clinical documentation supporting medical necessity, dated within the past 12 months, as outlined in the *Clinical Guideline* section of this policy.

EFFECTIVE DATE
This policy for the prior authorization for ambulatory infusion pumps for individuals covered under the HUSKY Health Program is effective February 01, 2024.

LIMITATIONS
Not Applicable

CODES:

Code	Description

E0779	Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater
E0780	Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours
E0781	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient

DEFINITIONS

1. **HUSKY A**: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. **HUSKY B**: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. **HUSKY C**: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. **HUSKY D**: Connecticut residents who are ages 19-64 without dependent children and who: (1) do not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).
5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.
6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.
7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.
8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

REFERENCES

- Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) for Infusion Pumps (280.14). Effective date 12/17/2004. Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=223&ncdver=2 Accessed on December 11, 2023.

- Noridian Healthcare Solutions LLC. Local Coverage Determination: External Infusion Pumps (L33794). Revised 7/1/2023. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33794&ver=142&bc=0 Accessed on December 11, 2023.

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	December 2023	Approved by Medical Policy Review Committee on December 13, 2023. Approved at the December 18, 2023. CHNCT Clinical Quality Subcommittee meeting. Approved by DSS on January 03, 2024.
Updated	December 2024	Authorization requirements added for rental and purchase of ambulatory infusion pumps. Procedure updated to include the need for a signed prescription within 12 months. Changes approved at the December 11, 2024 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 16, 2024. Approved by DSS on December 27, 2024.