PROVIDER POLICIES & PROCEDURES

INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEMS FOR HOME USE

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 intrapulmonary percussive ventilation (IPV) systems for home use. 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.

Intrapulmonary percussive ventilation is a mechanized form of chest physiotherapy. IPV delivers mini-bursts of respiratory gasses to the lungs via a mouthpiece. The purpose of IPV is to mobilize endobronchial secretions and diffuse patchy atelectasis. The patient or caregiver controls variables such as inspiratory time, peak pressure and delivery rates.

CLINICAL GUIDELINE

Coverage guidelines for an IPV system for home use 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:

Initial Authorization

The use of an IPV system in a home setting may be considered medically necessary for individuals with a respiratory or neuromuscular disease requiring airway clearance (e.g., cystic fibrosis, chronic diffuse bronchiectasis, Duchenne muscular dystrophy) when:

A. Standard chest physiotherapy has failed to improve or stabilize symptoms; or
B. Standard chest physiotherapy is unavailable or not tolerated.

Reauthorization

Continued use of an IPV system in a home setting may be considered medically necessary when:

A. The above criteria under *Initial Authorization* have been met;
B. There is documentation of symptom improvement or stabilization; and
C. There is documentation of compliance with the device.

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 for the home use of an IPV system 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 home use of an IPV system:

1. Fully completed authorization request via on-line web portal;
2. Documentation from the requesting physician supporting the medical necessity of the IPV system; and
3. For reauthorization requests only, documentation from the requesting physician demonstrating symptom improvement and compliance with the device.

EFFECTIVE DATE
This policy for the prior authorization for home use of an IPV system for individuals covered under the HUSKY Health Program is effective August 1, 2017.

LIMITATIONS
Not Applicable

CODE:

Code	Description
E0481	Intrapulmonary percussive ventilation system and related accessories

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. **HUSKY Plus Physical Program (or HUSKY Plus Program):** A supplemental physical health program pursuant to Conn. Gen. Stat. § 17b-294, for medically eligible members of HUSKY B in Income Bands 1 and 2, whose intensive physical health needs cannot be accommodated within the HUSKY Plan, Part B.
8. **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.
9. **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

- Finder, J. D. (2019). Atelectasis in children. Redding, G. (Ed.). UpToDate. Retrieved from https://www.uptodate.com/contents/search.
- Simon, R. H. (2020). Cystic fibrosis: Overview of the treatment of lung disease. Mallory, G. B. (Ed.). UpToDate. Retrieved from https://www.uptodate.com/contents/search.

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	June 2017	Approved by Medical Policy Review Committee on May 10, 2017. Approved by Clinical Quality Subcommittee on June 20, 2017. Approved by DSS on July 14, 2017.
Update	May 2018	Update to reference section. Change approved at the May 25, 2018 Medical Policy Review Committee meeting. Change Approved by the CHNCT Clinical Quality Subcommittee on June 18, 2018. Approved by DSS on June 20, 2018.

Updated	May 2019	Update to reference section. Change approved at the May 8, 2019 Medical Reviewer meeting. Change approved by the CHNCT Clinical Quality Subcommittee on June 19, 2019. Approved by DSS on June 21, 2019.
Updated	June 2020	Change from investigational to medically necessary for respiratory and neuromuscular conditions requiring airway clearance when standard chest physiotherapy has failed to improve symptoms. Change approved at the April 8, 2020 Medical Reviewer meeting. Change approved by the CHNCT Clinical Quality Subcommittee on June 15, 2020. Approved by DSS on June 19, 2020.
Reviewed	March 2021	Reviewed and approved without changes at the March 10, 2021 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 15, 2021. Approved by DSS on March 23, 2021.
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Reviewed	March 2023	Reviewed and approved without changes at the March 8, 2023 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 20, 2023. Approved by DSS on March 27, 2023.