IMPLANTABLE INTRATHECAL AND EPIDURAL 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 implantable intrathecal and epidural 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.

The implantable infusion pump (IIP) is a drug delivery system that provides continuous infusion of a medication at a constant and precise rate.

Intrathecal pumps deliver small doses of medication directly to the spinal fluid. They consist of a small battery-powered, programmable pump that is implanted under the subcutaneous tissue of the abdomen and connected to a small catheter tunneled to the site of spinal entry.

Both programmable and non-programmable infusion pumps are available. Programmable infusion pumps are used when dose titration and regulation vary due to the changing condition of the individual; while non-programmable pumps are used for fixed rate medication delivery when an individual’s dosage is expected to be stable.

Prior to implanting a permanent intrathecal device providers should conduct a temporary trial to determine its benefits. During the trial, the planned drug should be infused through an indwelling catheter that may be placed in the intrathecal or epidural space.

CLINICAL GUIDELINE

Coverage guidelines for the use of implantable intrathecal and epidural infusion pumps are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines only. Coverage determinations are based on an assessment of the individual and his or her 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:

Implantation
The HUSKY Health program considers implantable intrathecal or epidural infusion pumps medically necessary when:

Continuous or regular infusion of a medication is required to treat or manage a specific condition; and

1. Other forms of administration of medications have failed or were inadequate; and
2. Life expectancy is greater than three (3) months; and
3. For intrathecal placement, tumor advancement on the thecal sac has been ruled out by appropriate testing; and
4. No contraindications to implantation exist, such as sepsis or coagulopathy; and
5. A temporary trial of spinal (epidural or intrathecal) medications has been successful as defined by a 50% reduction in pain in the case of spinal analgesics, or by other objective measures appropriate to the use of other medications, prior to permanent implantation.

**Note:** A temporary trial of an intrathecal or epidural infusion pump used for the treatment of malignant pain may be considered medically necessary based on the above criteria.

All other uses of implantable intrathecal and epidural drug infusion pumps are typically considered investigational and therefore not medically necessary; however, other uses may be considered medically necessary based on an assessment of the individual and his or her unique clinical needs.

**Replacement**
The HUSKY Health program considers replacement of implantable infusion pumps (which may also involve upgrading to the most current technology) medically necessary when the device is no longer functioning.

Replacement or upgrades of implantable infusion pumps are typically not considered medically necessary when requested for convenience or to upgrade to newer technology when the current components remain functional; however, a replacement or upgrade may be considered medically necessary based on an assessment of the individual and his or her unique clinical needs.

**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 implantable intrathecal and epidural drug infusion pumps is required. Requests for coverage of implantable intrathecal and epidural drug infusion pumps will be reviewed in accordance with procedures in place for reviewing requests for surgical procedures. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for implantable intrathecal and epidural drug infusion pumps:
1. Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request via on-line web portal; and
2. Documentation from requesting physician which includes diagnosis and clinical information supporting medical necessity; and
3. Documentation of the individual’s response to temporary trial.

**Note:**
Medical records may be requested.
Please note that authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the individual having active coverage, benefits and policies in effect at the time of service.

To determine if a service or procedure requires prior authorization, CMAP Providers may refer to the Benefit and Authorization Grids summaries on www.huskyhealth.com by clicking here. For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.
(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.

**ADDITIONAL RESOURCES AND REFERENCES:**

**Peer Reviewed Publications:**

**Government Agency, Medical Society, and Other Authoritative Publications:**


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### PUBLICATION HISTORY

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<tr>
<td>Original Publication</td>
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<tr>
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