PROVIDER POLICIES & PROCEDURES

INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEMS & ACCESSORIES 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 that delivers high frequency pulses of air and aerosol to the lungs at frequencies of 200 to 300 cycles per minute at peak pressures from 20 to 40 cm H_2O. The purpose of IPV is to mobilize endobronchial secretions and improve atelectasis. The patient or caregiver controls the inspiratory time, peak pressure, and delivery rates.

Accessories
An IPV system (E0481) includes the compressor, hand-held units, tubing and related accessories. This applies to an IPV system in which the high frequency pulses of air are generated by the compressor and an IPV system in which the pulses are generated by a hand-held percussive nebulizer with a standard high-pressure compressor.

An IPV system may also be used with an additional accessory, an IPV circuit kit, e.g., Phasitron® kit. This is an open flow system that utilizes a sliding venturi mechanism to allow air to flow around obstructions thus facilitating the mobilization and clearance of secretions in the airway.

CLINICAL GUIDELINE

Coverage guidelines for an IPV system and accessories 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 and accessories in a home setting may be considered medically necessary for individuals with a respiratory or neuromuscular disease that impact 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.

IPV Circuit Kits:
An IPV circuit kit may be considered medically necessary when:

A. Criteria for *initial authorization of an IPV system and accessories* are met.

Reauthorization

Continued use of an IPV system and accessories 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.

IPV Circuit Kits:
An IPV circuit kit for continued use of an IPV system may be considered medically necessary when:

A. Criteria for *reauthorization of an IPV system and accessories* are met.

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 and accessories, including IPV circuit kits, 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 and accessories, including IPV circuit kits**:**

1. Fully completed authorization request via on-line web portal; and
2. Signed prescription by a physician, advanced practice registered nurse (APRN), or physician assistant (PA) within the last twelve (12) months of the request; and
3. Documentation from the requesting physician supporting the medical necessity of the IPV system and accessories within the last twelve (12) months; and
4. Documentation from the requesting physician showing standard chest physiotherapy has failed to improve symptoms, is unavailable, or not tolerated within the last twelve (12) months; and
5. For reauthorization requests only, documentation from the requesting physician within the last six (6) months demonstrating symptom improvement or stabilization, and compliance with the device; and
6. For IPV circuit kits(A9900), pricing information as outlined in the *DSS Pricing Policy for MEDS Items.*

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
A9900	IPV circuit kits

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

- 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.
Reviewed	March 2022	Reviewed and approved without changes at the

		March 9, 2022 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 21, 2022. Approved by DSS on March 24, 2022.
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Updated	February 2024	Introduction updated to simplify the description of the IPV device. Policy updated throughout to include accessories and IPV circuit kits. Code section updated to include code for IPV circuit kits. Changes approved at the February 14, 2024 Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on March 18, 2024. Approved by DSS on March 28, 2024.
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