PERSONAL AUTOMATED MEDICATION DISPENSERS

The purpose of this policy is meant to provide guidance to providers enrolled in the Connecticut Medical Assistance Program (CMAP Providers) on the requirements for the prior authorization of automated medication dispensing systems. This includes both the applicable medical necessity criteria for approval of coverage for HUSKY Health Program members and the applicable procedures and guidelines for the prior authorization process.

Personal automated medication dispensers are programmable, locked medication storage devices that automatically dispense a dose of medication at predetermined times. These devices can also act as reminder systems, notifying individuals when it is time to take their medication with audible alarms, lights, texts and voice messages. Some of these devices also have monitoring capabilities which can track dispensing activity as well as contact caregivers or monitoring services when medications are not dispensed at the scheduled time.

POLICY

Coverage guidelines for the use of personal automated medication dispensers will be made in accordance with the DSS Definition of Medical Necessity. The following criteria are guidelines only. Coverage determinations are based on an individual assessment of the member and his or her clinical needs.

The HUSKY Health Program considers personal automated medication dispensers clinically appropriate for individuals:

- With mild cognitive impairment who require prompting to adhere to a medication regimen.
- With visual impairments significant enough to impair the ability to distinguish between different medications and/or limit the ability to read the days and times on a traditional medication box or “pill box”.
- With previous hospitalizations or emergency department visits related to incorrectly taking medications.
- Who have been unable to adhere to a medication regimen (despite the use of a traditional medication box) for reasons which can be remedied by the use of an electronic medication box.

Requests for the management of conditions or situations other than those listed above will be reviewed in accordance with the Department of Social Services’ (DSS) Definition of Medical Necessity.

The use of an automated medication dispenser is contraindicated when an individual has the potential for hoarding or selling medications.

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 member 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.
NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnostic, 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 personal automated medication dispensers is required. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

Information Required for Review:
1. Fully completed State of Connecticut, Department of Social Services Outpatient Prior Authorization Request Form;
2. Documentation from the requesting physician supporting the medical necessity of the device. This may include the following:
   • Assessment of client’s cognition;
   • Description of existing functional and/or sensory impairments;
   • History of medication compliance;
   • History of hospital or emergency department admissions associated with incorrect medication dosing; and
3. Documentation from a home visit where direct observation of medication self administration took place.

Note:
Medical records may be requested.

Requesting Authorization:
Requests for coverage of personal automated medication dispensers will be reviewed in accordance with procedures in place for reviewing requests for home health services.

The initial authorization period will be granted for 30 days in order to assess the effectiveness of the automated medication dispenser in maintaining and/or improving medication compliance.

Subsequent requests for authorization must include clinical documentation that supports maintenance/improvement in compliance with the individual’s medication regimen.

Note:
If the item is determined to be medically necessary, a request for authorization of at least one skilled nursing visit should also be submitted.

The skilled nursing visit(s) should occur during the first one to two weeks after the individual receives the device to ensure the proper use of the device as well as to reinforce medication education including self-
management skills.

The home health agency will provide and oversee the use of the automated medication dispenser.

EFFECTIVE DATE
This policy for the prior authorization of personal automated medication dispensers for HUSKY Health Program members is effective November 1, 2013.

LIMITATIONS
Not Applicable

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<td>S5185</td>
<td>MEDICATION REMINDER SERVICE, NON-FACE-TO-FACE; PER MONTH</td>
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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
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 member 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.

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

PUBLICATION HISTORY

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<th>Status</th>
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<tr>
<td>Original Publication</td>
<td>October 2013</td>
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<tr>
<td>Reviewed</td>
<td>September 2014</td>
<td>Clinical Quality Subcommittee review. References updated. These changes approved at the September 15th, 2014 Clinical Quality Subcommittee meeting.</td>
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<tr>
<td>Updated</td>
<td>August 2015</td>
<td>Updated definitions for HUSKY A, B, C and D programs at request of DSS.</td>
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