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

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.ct.gov/husky by clicking on “For Providers” followed by “Benefit Grids”. For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.
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.ct.gov/husky by clicking on “For Providers” followed by “Benefit Grids”. For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.
EFFECTIVE DATE
This Policy is effective for prior authorization requests for implantable intrathecal and epidural infusion pumps for individuals covered under the HUSKY Health Program effective October 1, 2013.

LIMITATIONS
Not Applicable

CODES:

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>62360</td>
<td>Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir</td>
</tr>
<tr>
<td>62361</td>
<td>Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump</td>
</tr>
<tr>
<td>62362</td>
<td>Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump with or without programming</td>
</tr>
</tbody>
</table>

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)
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.

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:**


**PUBLICATION HISTORY**

<table>
<thead>
<tr>
<th>Status</th>
<th>Date</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original Publication</td>
<td>September 2013</td>
<td></td>
</tr>
<tr>
<td>Reviewed</td>
<td>September 2014</td>
<td>Clinical Quality Subcommittee review. Reference updated. Added CPT code 62360. Update to criteria. Added &quot;or epidural&quot; to statement on page 1 “The HUSKY Health program typically considers implantable intrathecal (or epidural) infusion pumps clinically appropriate for the treatment of…” These changes approved at the September 15, 2014 Clinical Quality Subcommittee meeting.</td>
</tr>
<tr>
<td>Updated</td>
<td>August 2015</td>
<td>Updated definitions for HUSKY A, B, C and D programs at request of DSS.</td>
</tr>
<tr>
<td>Reviewed</td>
<td>September 2015</td>
<td>Clinical Quality Subcommittee review. Reference updated. This change approved at the September 21, 2015 Clinical Quality Subcommittee meeting.</td>
</tr>
<tr>
<td>Updated</td>
<td>March 2016</td>
<td>Updates to language in introductory paragraph pertaining to purpose of policy. Updates to Clinical Guideline section. Updates throughout policy to reflect importance of person-centeredness when reviewing requests for these procedures. Changes approved at the March 21, 2016 Clinical Quality Subcommittee meeting. Changes approved by DSS on May 16, 2016.</td>
</tr>
<tr>
<td>Updated</td>
<td>April 2018</td>
<td>Medical Policy Committee review. Reference update. Approved by Medical Policy Review Committee on</td>
</tr>
</tbody>
</table>

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.ct.gov/husky by clicking on “For Providers” followed by “Benefit Grids”. For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.
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.ct.gov/husky by clicking on “For Providers” followed by “Benefit Grids”. For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.