PROVIDER POLICIES & PROCEDURES

ALLERGEN REDUCING PRODUCTS: HYPOALLERGENIC COVERS, AIR PURIFIERS, DEHUMIDIFIERS

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 allergen reducing products. 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.

Hypersensitivity to inhaled allergens is common among individuals with asthma and allergic rhinitis. Sensitization to one or more indoor allergens (e.g., dust mite, cat, dog, cockroach, mold), combined with accumulation of these allergens in the home, has been found to be one of the strongest risk factors for asthma in numerous studies.

The use of mite-proof/hypoallergenic mattress covers, pillow covers or blankets, as part of an allergy-control program, has been found to reduce the level of exposure to mite allergens. Hypoallergenic covers are made of alternative or finely woven fabrics that allow airflow without passage of dust mites and pet allergens. However, while these covers can reduce exposure, the use of bedding covers as an isolated intervention is unlikely to reduce allergic rhinitis or asthma symptoms to a clinically meaningful degree. Instead, bedding covers should be a component of a comprehensive plan to reduce exposure to dust mite, as well as any other allergens relevant to the individual.

Studies have shown that air purifiers can reduce the amount of particulate matter in the air in a home, which can also help reduce asthma symptoms. They can serve as an important component of a comprehensive plan to reduce asthma and allergy triggers in the home.

Mold spores can trigger symptoms of allergic rhinitis and asthma in sensitized individuals. Mold thrives in humid conditions. Dehumidifiers can be effective in reducing the humidity that encourages growth of mold in the environment. They can serve as an important component of a comprehensive plan to reduce asthma and allergy triggers in the home.

CLINICAL GUIDELINE

Coverage guidelines for allergen reducing products 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:

Hypoallergenic bedding covers (i.e., pillow, mattress, blanket), air purifiers, and dehumidifiers may be considered medically necessary when:

1. The individual has been diagnosed with asthma or allergic rhinitis (exacerbated by indoor allergens); and
2. The diagnosis is supported by one of the following:
    a. Allergen testing confirms the individual has indoor allergies; or
    b. Recent documentation (within one year) from the treating physician, APRN, or PA supports the diagnosis.

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 allergen reducing products is required. Requests for coverage are reviewed in accordance with procedures in place for reviewing requests for medical supplies and 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 allergen reducing products:
1. Fully completed authorization request via on-line web portal; and
2. A signed prescription, written within the past 12 months, from the treating physician, advanced practice registered nurse (APRN), or physician assistant (PA) enrolled in the Connecticut Medical Assistance Program (CMAP); and
3. Documentation from the treating provider, written within the past 12 months, as outlined in the *Clinical Guideline* section of this policy, supporting the medical need for the allergen reducing product; and
4. Pricing information as outlined in the *DSS Pricing Policy for MEDS Items*.

EFFECTIVE DATE
This policy for the prior authorization for allergen reducing products for individuals covered under the HUSKY Health Program is effective May 01, 2024.

LIMITATIONS
Not Applicable

CODE:

Code	Description
E1399	Durable medical equipment, miscellaneous

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.

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PUBLICATION HISTORY

Status	Date	Action Taken
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Updated	August 2024	Update to Clinical Guideline section to simplify language surrounding criteria. Changes approved at the August 28, 2024 CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on September 16, 2024. Approved by DSS on September 27, 2024.
Updated	February 2025	Update to Clinical Guideline section to clarify clinical criteria. Changes approved at the February 12, 2025 CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on March 17, 2025. Approved by DSS on April 3, 2025.