PROVIDER POLICIES & PROCEDURES

IMPLANTABLE NEUROSTIMULATORS AND ASSOCIATED DEVICES

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 neurostimulators and their associated devices. 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.

Implantable neurostimulators are micro-electronic devices that deliver stimulation to the nervous system and offer various therapeutic treatment options including, but not limited to, deep brain stimulation, gastric electrical stimulation, spinal cord stimulation, and vagus nerve stimulation.

Please refer to the DSS MEDS fee schedule for orthotics and prosthetics for a list of implantable neurostimulators and their associated devices requiring prior authorization.

CLINICAL GUIDELINE

Coverage guidelines for implantable neurostimulators and their associated devices 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:

CHNCT uses Change Healthcare's InterQual (IQ) criteria for most implantable neurostimulators and associated devices. CHNCT will use this policy for replacement of items associated with implantable neurostimulators for which there are no IQ criteria. Please see the *Codes* section of this policy for a list of items reviewed using IQ criteria.

Replacement of the items listed below is considered medically necessary when there is a documented need for continued use of the device and one of the following criteria is met:

A. The individual's existing item is malfunctioning, cannot be repaired, and is no longer under warranty; or
B. The individual's condition has changed such that the item is inadequate or no longer meets the individual's functional needs.

Items covered by above criteria:

- External patient programmer for use with implantable neurostimulator.
- Radiofrequency transmitter for use with implantable neurostimulator.
- External recharging system for a battery used with an implantable neurostimulator.

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 implantable neurostimulators and associated devices is required. Requests for coverage are reviewed in accordance with procedures in place for reviewing requests for orthotics and prosthetics. Coverage determinations are based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for implantable neurostimulators and associated devices:

1. Fully completed authorization request via on-line web portal;
2. Prescription from the treating physician, advanced practice registered nurse (APRN), or physician assistant (PA), signed and dated within the past 12 months; and
3. Documentation from the treating provider, written within the past 12 months supporting the medical need for an implantable neurostimulator and associated devices:
    a. Initial requests for neurostimulators and associated devices (reviewed using IQ criteria):
        i. Condition requiring device;
        ii. Recent physical exam;
        iii. Results of trial with temporary device including duration, patient response and patient understanding of device;
        iv. Prior therapies/treatments tried, failed, or contraindicated including dates and reason for discontinuation; and
        v. Physician plan of care
    b. Revision or removal (reviewed using IQ criteria):
        i. Details of complication; and
        ii. Physician plan of care;
    c. Replacement of associated devices (reviewed using this policy):
        i. Clinical indication;
        ii. Duration of use;
        iii. Reason for replacement (for replacements only); and
        iv. Date of warranty expiration (for replacements only, if applicable).

EFFECTIVE DATE

This policy for the prior authorization for implantable neurostimulators and associated devices for individuals covered under the HUSKY Health Program is effective August 01, 2024.

LIMITATIONS

N/A

CODES:

Reviewed Using Policy

Code	Description
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only
L8684	Radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement
L8689	External recharging system for battery (internal) for use with implantable neurostimulator, replacement only

Reviewed Using InterQual Criteria

Code	Description
L8679	Implantable neurostimulator, pulse generator, any type
L8680	Implantable neurostimulator electrode, each
L8682	Implantable neurostimulator radiofrequency receiver
L8683	Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
L8685	Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
L8686	Implantable neurostimulator pulse generator, single array, nonrechargeable, includes extension
L8687	Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
L8688	Implantable neurostimulator pulse generator, dual array, nonrechargeable, includes extension

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

N/A

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	June 2024	Approved at the June 12, 2024 CHNCT Medical Reviewer meeting. Approved at the June 17, 2024 CHNCT Clinical Quality Subcommittee meeting. Approved by DSS on June 26, 2024.