PROVIDER POLICIES & PROCEDURES

NON-WEARABLE AUTOMATED EXTERNAL DEFIBRILLATORS FOR HOME USE (HCPCS CODE E0617)

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 a non-wearable automated external defibrillator (AED) 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.

Automatic defibrillators are devices that are capable of monitoring cardiac rhythms, detecting dysrhythmias, and delivering a defibrillation shock to the heart when appropriate without any user decision-making. There are both wearable (a vest-like garment) and non-wearable (a portable unit for use in the home) defibrillator devices. This policy refers to a non-wearable automatic external defibrillator. Requests for wearable defibrillator devices (HCPCS code K0606) are reviewed using Change Healthcare's InterQual (IQ) criteria.

CLINICAL GUIDELINE

Coverage guidelines for a non-wearable AED 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:

A non-wearable AED for home use may be considered medically necessary when the following criteria and the standard indications* are met:

A. The individual has a documented standard indication for either an implantable or wearable defibrillator and implantation/use of the appropriate device is contraindicated;

OR

B. The individual has a documented standard indication for an implantable defibrillator and implantation of the device is delayed due to comorbid conditions, systemic infection, recovery from surgery, or lack of vascular access and a contraindication for a wearable defibrillator is documented;

OR

C. A previously implanted defibrillator requires explantation, and a contraindication for a wearable defibrillator is documented;

AND

D. There is documentation that a family member/caregiver that resides with the individual has been trained in proper use of the device.

*Standard Indications

A. Any of the following indications (1-10) apply:
   1. Individuals with a prior myocardial infarction (MI) and left ventricular ejection fraction (LVEF) ≤ 30 percent.
   2. Individuals with a prior MI, nonsustained ventricular tachycardia (VT), and LVEF ≤ 40 percent who have ventricular fibrillation (VF) or sustained VT-induced during electrophysiology study.
   3. Individuals with cardiomyopathy, New York Heart Association (NYHA) functional class II to III and LVEF ≤ 35 percent and on guideline-directed medical therapy (GDMT).
   4. Individuals with nonischemic cardiomyopathy, with any of the following:
      - clinical documentation of a LVEF ≤ 35
      - newly diagnosed nonischemic cardiomyopathy with severely reduced left ventricular (LV) systolic function (LVEF ≤ 35) that is potentially reversible
   5. Individuals with reduced LV systolic function (LVEF ≤ 35) who also had any of the following:
      - a MI within the past 40 days
      - coronary revascularization with coronary artery bypass graft (CABG) in the past three months
   6. Individuals with congenital long QT syndrome who have recurrent symptoms and/or torsades de pointes despite therapy with beta blockers or other high-risk patients.
   7. High-risk individuals with hypertrophic cardiomyopathy, arrhythmogenic right ventricular (RV) cardiomyopathy, cardiac sarcoidosis, or possibly giant cell myocarditis.
   8. High-risk individuals with Brugada syndrome, catecholaminergic polymorphic VT, and other channelopathies.
   9. Individuals with a prior episode of resuscitated VT/VF or sustained hemodynamically unstable VT in whom a completely reversible cause cannot be identified. This includes individuals with any of the following:
      - a variety of underlying heart diseases
      - idiopathic VT/VF and congenital long QT syndrome
      - unexplained syncope and a high suspicion of VT/VF as the etiology
   10. Individuals with severe heart failure who are awaiting heart transplantation.

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 a non-wearable AED for home use 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.

Note: If all medical necessity criteria, as outlined in the *Clinical Guideline* section of this policy are met, an initial authorization for rental of the device will be granted for 12 months. After the initial 12-month

period, if all criteria as outlined in the *Clinical Guideline* section of this policy continue to be met, an authorization for rental of the device will be given at 12-month intervals.

The following information is needed to review requests for a non-wearable AED for home use:

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 a non-wearable AED for home use.

EFFECTIVE DATE

This policy for the prior authorization for an AED for home use for individuals covered under the HUSKY Health Program is effective November 01, 2024.

LIMITATIONS

N/A

CODES:

Reviewed Using Policy

Code	Description
E0617	External defibrillator with integrated electrocardiogram analysis
A9999	Miscellaneous DME supply or accessory, not otherwise specified (used in this instance for replacement supplies and accessories)

Reviewed Using InterQual Criteria

Code	Description
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type

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

- Center for Medicare and Medicaid Services (CMS). Local Coverage Determination (LCD) L33690 – Automatic External Defibrillators. Revision effective date 1/1/2020. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33690. Accessed on January 26, 2024.
- Centers for Medicare and Medicaid Services (CMS). Policy Article A52458 – Automatic External Defibrillators. Revision effective date 10/1/2023. Available at: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52458&ver=34. Accessed on January 26, 2024.
- DSS PB 2022-38 Documentation Requirements: Prior Authorization of Medical Equipment, Devices, and Supplies (MEDS). May 2022. Available at: https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb22_38.pdf&URI=Bulletins/pb22_38.pdf. Accessed on January 29, 2024.
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- Sharieff W, Kaulback K. Assessing automated external defibrillators in preventing deaths from sudden cardiac arrest: An economic evaluation. Int J Technol Assess Health Care. 2007;23(3):362367.
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PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	September 2024	Approved at the CHNCT Medical Reviewer meeting on September 11, 2024. Approved at the September 17, 2024 CHNCT Clinical Quality Subcommittee meeting. Approved by DSS on September 27, 2024.

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.