PROVIDER POLICIES & PROCEDURES

PERSONAL AUTOMATED MEDICATION DISPENSERS

The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP Providers) with the information needed to support a medical necessity determination for automated medication dispensing systems. 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.

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. Use of a personal automated medication dispenser can offer individuals the opportunity to more fully participate in his or her own self-care.

CLINICAL GUIDELINE

Coverage guidelines for the use of personal automated medication dispensers are made in accordance with the DSS ddefinition 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:

Individuals for whom a personal automated medication dispenser may be considered medically necessary include those:

- With no more than a 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 may be considered medically necessary based on an assessment of the individual and his or her unique clinical needs.

The use of an automated medication dispenser is **contraindicated:**

- when an individual has the potential for hoarding or selling medications; or
- when an individual is receiving opioid treatment for chronic pain.

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 personal automated medication dispensers is required. Requests for coverage of personal automated medication dispensers are reviewed in accordance with procedures in place for reviewing requests for home health services. 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 personal automated medication dispensers:

1. Fully completed authorization request via on-line web portal;
2. Documentation from the requesting provider supporting the medical necessity of the device. This may include the following:
    - Assessment of the individual'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:
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 should 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 individuals covered under the HUSKY Health Program is effective November 1, 2013.

LIMITATIONS
Not Applicable

CODE:

Code	Description
S5185	Medication reminder service, non-face-to-face; per month

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

- DSS Policy Transmittal 2013-32: Administration of Automated Medication Dispensers for the Purpose of Dispensing Medication, dated November 2013

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	October 2013	
Reviewed	September 2014	Clinical Quality Subcommittee review. References updated. These changes approved at the September 15th, 2014 Clinical Quality Subcommittee meeting.
Updated	August 2015	Updated definitions for HUSKY A, B, C and D programs at request of DSS.
Reviewed	September 2015	Clinical Quality Subcommittee review. Reference Updated. This change approved at the September 21, 2015 Clinical Quality Subcommittee meeting.
Updated	March 2016	Updates to language in introductory paragraph pertaining to purpose of policy. Updates to Clinical Guideline section pertaining to definition of Medical Necessity. Updates throughout policy to reflect importance of person-centeredness when reviewing requests for this service. Changes approved at the March 21, 2016 Clinical Quality Subcommittee meeting. At request of DSS added

		contraindication related to opioid treatment for chronic pain. Changes approved by DSS on April 25, 2016.
Updated	January 2017	Medical Policy Committee review. Reference updated. Approved by Medical Policy Committee on January 11, 2017. Approved by Clinical Quality Subcommittee on March 20, 2017. Approved by DSS on March 27, 2017.
Updated	April 2018	Medical Policy Committee review. Reference updated. Approved by CHNCT Medical Policy Review Committee on February 14, 2018. Approved by CHNCT Clinical Quality Subcommittee on March 19, 2018. Approved by DSS on April 5, 2018.
Updated	February 2019	Reference update. Reviewed and approved at the February 27, 2019 Medial Reviewer Meeting. Change approved by the CHNCT Clinical Quality Subcommittee on March 18, 2019. Approved by DSS on March 27, 2019.
Updated	April 2020	Reference update. Reviewed and approved at the February 12, 2020 Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 16, 2020. Approved by DSS on April 16, 2020.
Reviewed	March 2021	Reviewed and approved without changes at the January 13, 2021 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 15, 2021. Approved by DSS on

		March 22, 2021.
Reviewed	March 2022	Reviewed and approved without changes at the March 9, 2022 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 21, 2022. Approved by DSS on March 24, 2022.
Reviewed	March 2023	Reviewed and approved without changes at the February 8, 2022, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 20, 2023. Approved by DSS on March 27, 2023.
Reviewed	January 2024	Reviewed and approved without changes at the January 10, 2024, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 18, 2024. Approved by DSS on March 28, 2024.
Reviewed	January 2025	Reviewed and approved without changes at the January 8, 2025 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 17, 2025. Approved by DSS on April 3, 2025.