PROVIDER POLICIES & PROCEDURES

RESUSCITATION KIT

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 resuscitation kits. 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. Resuscitation kits may include an oxygen cylinder, flow regulator, bag valve mask (ambu bag), other assorted masks, tubing, and a carrying case.

CLINICAL GUIDELINE

Coverage guidelines for resuscitation kits 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:

Rental of a resuscitation kit may be considered medically necessary when the individual's treating physician, advanced practice registered nurse (APRN), or physician assistant (PA) has documented a medical need for a resuscitation kit and the kit includes, at a minimum, emergency oxygen, tubing, and a bag valve mask.

Resuscitation kits are typically useful for individuals:

A. On mechanical ventilation in a home setting;
B. With a chronic medical condition (e.g., pulmonary, cardiac, or neuromuscular condition) requiring continuous, long-term oxygen therapy; or
C. Who require intermittent assistance to maintain an oxygen saturation (Sp02) above 92%.

Other clinical scenarios will be reviewed on a case-by-case basis.

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 resuscitation kits is required. Requests for coverage are reviewed in accordance with procedures in place for reviewing requests for medical supplies and durable medical equipment.

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.

Coverage determinations are based upon a review of requested and/or submitted case-specific information.

Note: DSS has published a monthly maximum allowed amount for rental of resuscitation kits (reference DSS Provider Bulletins 2011-04 and 2012-09).

The following information is needed to review requests for resuscitation kits:

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 resuscitation kit.

EFFECTIVE DATE

This policy for the prior authorization for resuscitation kits for individuals covered under the HUSKY Health Program is effective May 1, 2024.

LIMITATIONS

Coverage is limited to the rental of a resuscitation kit.

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.

REFERENCES

- DSS Provider Bulletin 2011-04: Updated MEDS Fee Schedule and Reimbursement, dated March 2011.
- DSS Provider Bulletin 2012-09: Updated MEDS Fee Schedule and Reimbursement, dated March 2012.
- National Heart, Lung, and Blood Institute. Going Home on a Ventilator. Last updated March 24, 2022. Available at: https://www.nhlbi.nih.gov/health/ventilator/home-care#:~:text=Equipment%20for%20home%20ventilation,-The%20type%20of&text=Some%20ventilators%20are%20portable%20and,of%20oxygen%20therapy%20for%20emergencies Accessed on January 18, 2024.
- UptoDate. Portable oxygen delivery and oxygen conserving devices. Last updated February 13, 2025.

PUBLICATION HISTORY

Status	Date	Action Taken
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Reviewed	March 2025	Reviewed and approved without changes at the March 12, 2025 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 17, 2025. Approved by DSS on April 3, 2025.