PROVIDER POLICIES & PROCEDURES

ROBOTIC ASSISTIVE FEEDING DEVICE (e.g., OBI®)

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 robotic assistive feeding device, e.g., Obi® (DESIN LLC, Jacksonville, FL). 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.

The Obi is an adaptive feeding device intended for individuals with upper extremity strength and mobility limitations. The Obi is intended to allow users to select between four compartments of food and decide when the food is captured and delivered to the mouth. The device requires a caregiver to prepare the food, place the food in the device, and position the user and device for optimal use. The manufacturer states that the Obi allows the user to control the device with any part of the body that can activate a switch. If that is not possible for the user, the caregiver will need to power on the device. A caregiver will need to clean the device.

CLINICAL GUIDELINE

Coverage guidelines for a robotic assistive feeding device 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:

The use of a robotic assistive feeding device is considered **investigational and therefore not medically necessary** for all indications.

There is insufficient published scientific evidence in the peer-reviewed medical literature to support the clinical utility of robotic assistive feeding devices, including the Obi for individuals with neuromuscular disease. HUSKY Health will periodically evaluate any new published evidence, clinical guidelines, and other relevant factors on an ongoing basis that may become available to determine if any revisions to these guidelines are appropriate in the future.

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 a robotic assistive feeding device 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.

EFFECTIVE DATE
This policy for the prior authorization for a robotic assistive feeding device for individuals covered under the HUSKY Health Program is effective May 01, 2024.

LIMITATIONS
Not Applicable

CODE:
N/A

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

- Centers for Medicare and Medicaid Services (CMS). National Coverage Determination for Durable Medical Equipment (DME) Reference List. NCD 280.1. Effective May 5, 2005. Available at: https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?&&NCDId=190&ncdver=1&NCDSect=280.1&bc=BEAAAAAAAQAAAA%3D%3D Accessed on 12/12/2023
- Mandy A, Sims T, Stew G, Onions D. Manual Feeding Device Experiences of People with a Neurodisability. Am J Occup Ther. 2018;72(3):7203345010p1-7203345010p5. doi:10.5014/ajot.2018.025353

PUBLICATION HISTORY

Status	Date	Action Taken
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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.