PROVIDER POLICIES & PROCEDURES

TRANSANAL IRRIGATION (TAI) SYSTEMS

The primary purpose of this policy is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for a transanal irrigation (TAI) system. 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.

A TAI system, also known as rectal irrigation, is a method for bowel management. It is used to prevent chronic constipation and fecal incontinence. Rectal irrigation can be administered either on one's own or with assistance.

CLINICAL GUIDELINE

Coverage guidelines for a TAI system are made in accordance with the CT Department of Social Services (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:

Initial Authorization Request:

A manual TAI system may be considered medically necessary as part of a bowel management program when the following criteria are met:

1. The system is used for the management of chronic neurogenic bowel dysfunction;
2. The individual is at least 2 years of age;
3. The individual suffers from fecal incontinence, chronic constipation, and/or time-consuming bowel management procedures that significantly impact the individual's quality of life (i.e., inability to participate fully in work or school);
4. Initial management involving diet, bowel habit, laxatives or constipating medications have failed; and
5. The individual has no known contraindications (see below).

Reauthorization Request:

1. The individual is consistently using the TAI system as directed by their physician; and
2. The TAI system has shown to be effective in managing fecal incontinence and/or chronic constipation.

Note: Authorization requests for individuals switching from one type of a TAI system to another, e.g., individual switching from a Peristeen system to a Navina system, will be treated as a new authorization

request and will require the necessary documentation outlined in Procedure for initial authorization requests.

Transanal irrigation is contraindicated in the following scenarios:

- Known anal or colorectal stenosis
- Colorectal cancer
- Radiotherapy to the pelvis
- Recent abdominoperineal surgery
- Active inflammatory bowel disease
- Diverticulitis
- Ischemic colitis
- Chronic and complex diverticular disease
- Abdominal, anal or colorectal surgery within the last 3 months
- Within 4 weeks of endoscopic polypectomy, recent colonic biopsy, recent endoscopic mucosal resection and recent endoscopic sub-mucosal dissection
- Severe autonomic dysreflexia
- Spinal cord shock phase
- In patients who are pregnant and have not used the system before (If the individual is pregnant and has never used anal irrigation before, the individual should not start the irrigation procedure during pregnancy)

Note: since the list of contraindications provided by the manufacturer is not exhaustive, providers should consider individual patient factors when deciding if use of the device is appropriate in a given circumstance.

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 TAI system is required. Requests for coverage will be reviewed in accordance with the processes in place for reviewing requests for medical supplies. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

If determined to be medically necessary:

- The initial authorization and first reauthorization will be given for a period of three months.
  A TAI system will be authorized along with a three-month supply of catheters (HCPCS code A4453 – 6 units [15 catheters per unit].
- Subsequent reauthorizations will be given for a period of one year. A TAI system will be authorized along with a 1-year supply of catheters (HCPCS code A4453 – 24 units [15 catheters per unit]).

Initial Authorization Requests
The following information is needed to review initial authorization requests for a TAI system:

1. Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request

via on-line web portal;
2. A signed prescription, written within the past 6 months, from a licensed physician, APRN, or PA enrolled in the Connecticut Medical Assistance Program (CMAP);
3. Documentation written within the past 6 months from the requesting provider which supports the medical necessity of the requested TAI system including:
    a. Other methods of bowel management that have been tried without success (e.g., oral laxatives, suppositories, enemas etc.);
    b. Any medical complications resulting from chronic fecal incontinence/constipation (e.g., urinary tract infections, hospitalizations, etc.); and
4. Pricing information - Manufacturer's suggested retail price (MSRP) and actual acquisition cost (AAC)* which includes all manufacturer and volume discounts.

*Ref: DSS Pricing Policy for MEDS items available at:
https://www.huskyhealthct.org/providers/provider_postings/policies_procedures/DSS_Pricing_Policy_for_MEDS_Items.pdf

Reauthorization Requests
The following information is needed to review reauthorization requests for a TAI system:

1. Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request via on-line web portal;
2. A signed prescription, from a licensed physician, APRN, or PA enrolled in the Connecticut Medical Assistance Program (CMAP);
    a. For first reauthorization request, prescription must be written within the past 6 months;
    b. For all other subsequent reauthorization requests, prescription must be written within the past 12 months;
3. Documentation from the requesting provider that shows ongoing and consistent use of the TAI system and evidence that the system continues to be effective in managing fecal incontinence and/or chronic constipation;
    a. For first reauthorization request, documentation must be written within the past 6 months;
    b. For all other subsequent reauthorization requests, documentation must be written within the past 12 months; and
4. Pricing information - Manufacturer's suggested retail price (MSRP) and actual acquisition cost (AAC)* which includes all manufacturer and volume discounts.

Note: Authorization requests for individuals switching from one type of a TAI system to another, e.g., individual switching from a Peristeen system to a Navina system, will be treated as a new authorization request and will require the necessary documentation outlined in this section for initial authorization requests.

*Ref: DSS Pricing Policy for MEDS items available at:
https://www.huskyhealthct.org/providers/provider_postings/policies_procedures/DSS_Pricing_Policy_for_MEDS_Items.pdf

EFFECTIVE DATE
This Policy is effective for prior authorization requests for a TAI system for individuals covered under the HUSKY Health Program beginning August 1, 2019.

LIMITATIONS
N/A

CODES

Code	Description
A4453	Rectal catheter with or without balloon, for use with any type of transanal irrigation system, each
A4459	Manual transanal irrigation system, includes water reservoir, pump, tubing, and accessories, without catheter, any 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.

ADDITIONAL RESOURCES AND REFERENCES:

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- Baaleman DF, Wegh CAM, Hoogveld MTA, Benninga MA, Koppen IJN. Transanal Irrigation in Children: Treatment Success, Quality of Life, Adherence, Patient Experience, and Independence. *J Pediatr Gastroenterol Nutr*. 2022;75(2):166-172. doi:10.1097/MPG.0000000000003515
- Bowman RM. Myelomeningocele (spina bifida): Management and outcome. In: *UpToDate*, Duryea TK, Dashe JF (Eds.). Wolters Kluwer. Updated August 15, 2025. Accessed on October 22, 2025.
- Centers for Medicare and Medicaid Services. Bowel Management Devices – Policy Article (A54516). Effective date 10/01/2015. Revision date 04/01/205. Available at: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=54516&ver=45&keyword=stimulat&keywordType=starts&areaId=s27&docType=NCA,CAL,NCD,MEDCAC,TA,MCD,6,3,5,1,F,P&contractOption=all&sortBy=relevance&bc=1.
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- FDA 510(k) Premarket Notification database searched using the term "Peristeen". U.S. Food and Drug Administration website: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm
- FDA MAUDE – Manufacturer and User Facility Device Experience database searched using "Peristeen" for all years. U.S. Food and Drug Administration website: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfMAUDE/textSearch.cfm
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- Midrio P, Mosiello G, Ausili E, et al. Peristeen® transanal irrigation in paediatric patients with anorectal malformations and spinal cord lesions: a multicentre Italian study. Colorectal Dis. 2016;18(1):86-93.
- National Institute for Health and Care Excellence (NICE). Peristeen Plus transanal irrigation system for managing bowel dysfunction. MTG36. Published: 23 February 2018. Last updated: 06 June 2022. Available at: https://www.nice.org.uk/guidance/mtg36/chapter/1-Recommendations
- Pacilli M, Pallot D, Andrews A, et al. Use of Peristeen® transanal colonic irrigation for bowel management in children: A single-center experience. J Pediatr Surg. 2014;49(2):269-272; discussion 272.
- Urology & Continence Care Today. Latest developments in transanal irrigation therapy. October 2025. Available at: https://www.ucc-today.com/journals/issue/launch-edition/article/latest-developments-in-transanal-irrigation-therapy-ucct

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	May 2019	Reviewed and approved at the May 22, 2019 Medical Reviewer

		meeting. Reviewed and approved by the CHNCT Clinical Quality Subcommittee on June 19, 2019. Approved by DSS on June 24, 2019.
Update	June 2020	Added statement addressing contraindications for treatment. Change approved at the April 8, 2020 Medical Reviewer meeting. Changed approved by the CHNCT Clinical Quality Subcommittee on June 15, 2020. Approved by DSS on June 19, 2020.
Review	March 2021	Reviewed and approved without changes at the March 10, 2021 CHNCT Medical Reviewer meeting. Approved by CHNCT Clinical Quality Subcommittee on March 15, 2021. Approved by DSS on March 22, 2021.
Update	March 2022	Updated HCPCS coding. Added HCPCS code A4453. Deleted HCPCS code A9999. Change approved at the March 9, 2022 CHNCT Medical Reviewer meeting. Change approved by the CHNCT Clinical Quality Subcommittee on March 21, 2022. Approved by DSS on March 24, 2022.
Review	March 2023	Reviewed and approved without changes at the February 8, 2023, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 20, 2023. Approved by DSS on March 27, 2023.
Update	December 2023	Policy updated throughout to address all anal irrigation systems policy is no longer specific to Peristeen (PAI) system. Clinical Guidelines updated to address authorization process for an individual switching from one system to another. Procedure updated to include the need for a prescription from a licensed physician, APRN, or PA enrolled in CMAP. Change approved at the December 13, 2023, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 18, 2023. Approved by DSS on January 3, 2024.
Updated	November 2024	Clinical Guideline section updated to clarify policy refers to manual pump anal irrigation systems and reasons for contraindications listed out individually. Procedure section updated to include prescription needs to be signed and dated within 12 months for initial and reauthorizations. Changes approved at the November 13, 2024, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 16, 2024. Approved by DSS on December 27, 2024.
Updated	November 2025	Title and content of policy updated to reflect “Transanal Irrigation (TAI) Systems” based on current research, clinical guidelines, and updates to the code descriptions for this system. Clinical Guideline updated to clarify minimum age of the individual. Procedure updated to reflect the requirement of a prescription and clinical documentation dated within 6 months of the request versus 12 months for initial requests. First reauthorization prescription and documentation requirements

		updated to 6 months to match the timeframe for an initial request and then all subsequent reauthorization requests reflect 12 months to match the auth time span for all other subsequent requests. Codes section updated to include the revised code descriptions for A4453 and A4459, effective 04/01/2025. References updated to reflect current research and resources. Format of references also updated to be consistent with other policies. Changes reviewed and approved at the December 10, 2025, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on December 15, 2025. Approved by DSS on December 29, 2025.