PROVIDER POLICIES & PROCEDURES

IMPLANTATION OF POLYETHYLENE-GLYCOL (PEG) SPACING HYDROGEL (I.E. SPACEOAR SYSTEM)

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 implantation of polyethylene-glycol hydrogel (SpaceOAR 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.

Polyethylene glycol (PEG) hydrogel temporarily positions the anterior rectal wall away from the prostate during radiotherapy for prostate cancer with the intent to reduce the radiation dose delivered to the anterior rectum. The absorbable spacer maintains space for the entire course of prostate radiotherapy treatment and is completely absorbed by the patient's body over time.

CLINICAL GUIDELINE

Coverage guidelines for implantation of PEG hydrogel 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:

PEG hydrogel is considered medically necessary for reducing rectal toxicity in men undergoing radiotherapy for prostate cancer.

PEG hydrogel is considered experimental and investigational for all other indications.

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 PEG hydrogel is required. Requests for coverage are reviewed in accordance with procedures in place for reviewing requests for surgical procedures.Coverage determinations are based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for PEG hydrogel:

1. Fully completed authorization request via the on-line web portal; and
2. Documentation from the requesting physician supporting the medical necessity of the requested service.

EFFECTIVE DATE

This policy for the prior authorization for PEG hydrogel for individuals covered under the HUSKY Health Program is effective May, 1, 2022.

LIMITATIONS

Not Applicable

CODE:

Code	Description
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed

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. **HUSKY Plus Physical Program (or HUSKY Plus Program):** A supplemental physical health program pursuant to Conn. Gen. Stat. § 17b-294, for medically eligible members of HUSKY B in Income Bands 1 and 2, whose intensive physical health needs cannot be accommodated within the HUSKY Plan, Part B.
8. **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.

9. **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.

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PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	March 2022	Approved at the February 9, 2022, CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 21, 2022. Approved by DSS on March 24, 2022
Update	March 2023	Updated Clinical Guideline section. PEG hydrogel is medically necessary for reducing rectal toxicity in men undergoing radiotherapy for prostate cancer. Change approved at the February 8, 2023, CHNCT Medical Reviewer meeting. Change approved by the CHNCT Clinical Quality Subcommittee on March 20, 2023. Approved by DSS on March 27, 2023.
Review	December 2023	Reviewed and approved without changes 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 03, 2024.