Geisinger

Geisinger Health Plan Policies and Procedure Manual

Policy: MP362

Section: Medical Policy

Subject: Non-invasive Home Ventilator

Applicable Lines of Business

Commercial	**X**	**CHIP**	**X**
Medicare	**X**	**ACA**	**X**
Medicaid	**X**		

I. Policy: Non-invasive Home Ventilator

II. Purpose/Objective:

To provide a policy of coverage regarding Non-invasive Home Ventilator

III. Responsibility:

A. Medical Directors
B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

DESCRIPTION:
A non-invasive home ventilator is a device capable of providing pressurized air with or without supplemental oxygen, and an array of features including pressure support; rate support; volume support; or various combinations of those features. The device delivers the air via a tightly sealed non-invasive nasal interface or mask.

REQURES PRIOR AUTHORIZATION by a Plan Medical Director or Designee

CRITERIA FOR COVERAGE: A non-invasive home ventilator is considered to be medically necessary when all of the following criteria are met:

- The member is alert and oriented; **and**
- The member is able to clear secretions either by coughing or by using an assist device; **and**
- Documentation of characteristic sleep-associated hypoventilation symptoms (e.g., daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, or dyspnea); **and**
- The member meets one of the following conditions:

1. **Progressive neuromuscular disease** (e.g., myasthenia gravis, amyotrophic lateral sclerosis (ALS), muscular dystrophy, etc) resulting in respiratory insufficiency
   - Chronic obstructive pulmonary disease (COPD) does not contribute significantly to the pulmonary limitation
   - Documentation of ONE of the following:
   - An arterial blood gas PaCO2 greater than or equal to 45 mm Hg, done while awake and breathing the prescribed FIO2
   - Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for a minimum of 5 minutes while breathing the prescribed recommended FIO2
   - Documentation of ONE of the following:
     - Maximal inspiratory pressure is less than 60 cm H20
     - Forced vital capacity is less than 50% predicted

2. **Severe thoracic cage abnormality** (e.g., post-thoracoplasty for TB, Fibrothorax, Asphyxiating thoracic dystrophy) resulting in respiratory insufficiency with ALL of the following:
   - Chronic obstructive pulmonary disease does not contribute significantly to pulmonary limitation
   - Documentation of ANY ONE of the following:
     - An arterial blood gas PaCO2 greater than or equal to 45 mm Hg, done while awake and breathing the prescribed FIO2
     - Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for a minimum of 5 minutes while breathing the prescribed recommended FIO2

3. **Hypoventilation Syndrome** resulting in respiratory insufficiency with ALL of the following:

   - An arterial blood gas PaCO2 greater than or equal to 45 mm Hg, done while awake and breathing the prescribed FIO2
   - Spirometry shows a forced expired volume in 1 second (FEV1) or forced vital capacity (FVC) greater than or equal to 70%
   - Documentation of ANY ONE of the following:
     - An arterial blood gas PaCO2, done during sleep or immediately upon awakening, and breathing the prescribed FIO2, shows the PaCO2 worsened by 7 mm HG or more compared to the initial arterial blood gas
     - A facility-based polysomnogram or portable home sleep testing demonstrates oxygen saturation less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time (minimum recording time of 2 hours) that is not caused by obstructive upper airway events, AHI apnea-hypopnea index less than 5

4. **Severe Chronic Obstructive Pulmonary Disease (COPD**) resulting in respiratory insufficiency with ALL of the following:

- Obstructive Sleep Apnea (OSA) has been ruled out as a predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation (Note: Formal sleep testing is not required if there is sufficient information in the medical record to demonstrate that the individual does not suffer from some form of sleep apnea such as Central Sleep Apnea and/or Complex Sleep Apnea desaturation)
- Compliance with a continuous positive airway pressure device (CPAP) use and CPAP has failed to relieve symptoms, improve awake hypercapnia and/or nocturnal arterial oxygen desaturation
- Documentation of an arterial blood gas PaCO2, done while awake and breathing the prescribed FIO2, is greater than or equal to 52 mm Hg
- Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for greater than or equal to a cumulative 5 minutes of nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2 LPM or the prescribed FIO2 (whichever is higher)

Continued home use of a non-invasive positive pressure ventilator after the initial three (3) months if ALL of the following are documented:

- A signed and dated statement completed by the treating physician no sooner than 61 days after initiating use of the device stating ALL of the following:
- Evaluation has been completed
- Member is compliant using the device (i.e. average of 4 hours per 24 hour period)
- Member is benefiting from its use

EXCLUSIONS:
Any application of non-invasive home ventilator not meeting the criteria established under the Indication section of this policy will be denied as being not medically necessary.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

Medicaid Business Segment:
Any requests for services that do not meet criteria set in the PARP may be evaluated on a case by case basis.

CODING ASSOCIATED WITH: Non-invasive Home Ventilator
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov ***or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

E0466 Home ventilator, any type, used with non-invasive interface (e.g., mask, chest shell)

E0467 Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions [when specified as used with a non-invasive interface]

LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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This policy will be revised as necessary and reviewed no less than annually**.**

Devised: 10/22

Revised:

Reviewed: 10/23