

**Policy: MP362**

**Section: Medical Policy**

**Subject: Non-invasive Home Ventilator**

**Applicable line of business:**

<b>Commercial</b>	<b>x</b>	<b>Medicaid</b>	<b>x</b>
<b>Medicare</b>	<b>x</b>	<b>ACA</b>	<b>x</b>
<b>CHIP</b>	<b>x</b>		

**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.

**Commercial**

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

**Medicare**

Geisinger Gold Medicare Advantage HMO, PPO, and HMO D-SNP plans are offered by Geisinger Health Plan/Geisinger Indemnity Insurance Company, health plans with a Medicare contract. Continued enrollment in Geisinger Gold depends on contract renewal. Geisinger Health Plan/Geisinger Indemnity Insurance Company are part of Geisinger, an integrated health care delivery and coverage organization.

**CHIP**

Geisinger Health Plan Kids (GHP Kids) is a Children’s Health Insurance Program (CHIP) offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

**Medicaid**

Geisinger Health Plan Family (GHP Family) is a Medical Assistance (Medicaid) insurance program offered by Geisinger Health Plan in conjunction with the Pennsylvania Department of Human Services (DHS). Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

## 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.

## REQUIRES 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 PaCO<sub>2</sub> greater than or equal to 45 mm Hg, done while awake and breathing the prescribed FIO<sub>2</sub>
      - Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for a minimum of 5 minutes while breathing the prescribed recommended FIO<sub>2</sub>
      - Documentation of ONE of the following:
        - Maximal inspiratory pressure is less than 60 cm H<sub>2</sub>O
        - 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 PaCO<sub>2</sub> greater than or equal to 45 mm Hg, done while awake and breathing the prescribed FIO<sub>2</sub>

- Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for a minimum of 5 minutes while breathing the prescribed recommended FIO<sub>2</sub>

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

- An arterial blood gas PaCO<sub>2</sub> greater than or equal to 45 mm Hg, done while awake and breathing the prescribed FIO<sub>2</sub>
- 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 PaCO<sub>2</sub>, done during sleep or immediately upon awakening, and breathing the prescribed FIO<sub>2</sub>, shows the PaCO<sub>2</sub> 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 PaCO<sub>2</sub>, done while awake and breathing the prescribed FIO<sub>2</sub>, 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 FIO<sub>2</sub> (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](http://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]

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**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.**

**REFERENCES:**

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

**Devised:** 10/22

**Revised:**

**Reviewed:** 10/23, 10/24

**CMS UM Oversight Committee Approval:** 12/23

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Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.