Clinical Policy: Non-Invasive Home Ventilators

Description
This policy will provide general guidelines as to when non-invasive home ventilators are or are not medically necessary.

Policy/Criteria
I. It is the policy of health plans affiliated with Centene Corporation® that non-invasive home ventilators are medically necessary for the following indications:
   A. Initial request for the first three months of non-invasive home ventilator use for restrictive thoracic disorders, all of the following:
      1. Documentation of a neuromuscular disease (ex. amyotrophic lateral sclerosis) or a severe thoracic cage abnormality (ex. post-thoracoplasty for tuberculosis or Severe Kyphoscoliosis) and both of the following:
         a. One of the following:
            i. An arterial blood gas partial pressure of carbon dioxide (PaCO2) was measured while awake and breathing room air or on prescribed oxygen with a measurement of: PaCO2 $\geq 45$ mm Hg;
            ii. Sleep Oximetry demonstrates O2 saturation $\leq 88\%$ for at least 5 mins while breathing prescribed O2;
         b. If member has a neuromuscular disease, maximal inspiratory pressure is $< -60$ cm H2O, or forced vital capacity is $< 50\%$ predicted;
      2. Respiratory failure has failed to improve with an adequate trial of bilevel positive airway pressure (Bi-PAP), as evidenced by one of the following: (Note: PaCO2 levels may not normalize even with adequate response to Bi-PAP therapy. Failure to normalize PaCO2 levels alone is not considered a therapeutic failure of Bi-PAP)
         a. Intolerance to Bi-PAP, as indicated by the member’s request to discontinue nocturnal assisted ventilation;
         b. Worsening dyspnea, hemodynamic instability, or unresponsive hypoxemia;
         c. Signs of respiratory failure, including tachypnea (respiratory rate $> 24$/min) and respiratory acidosis (e.g., pH $< 7.35$);
      3. Chronic obstructive pulmonary disease (COPD) does not contribute significantly to the member’s pulmonary limitation;
      4. None of the following contraindications:
         a. FIO2 requirement $> 0.40$;
         b. Positive-end expiratory pressure (PEEP) $> 10$ cm H2O;
         c. Need for continuous invasive monitoring in adult patients.
   B. Initial request for the first three months of non-invasive home ventilator use for severe COPD, all of the following:
1. Member has had an arterial blood gas PaCO2 measurement, done while awake and breathing at their baseline and prescribed FIO2, which is greater than or equal to 52 mm Hg;

2. Prior to initiating therapy, sleep apnea and treatment with a continuous positive airway pressure device (CPAP) has been considered and ruled out. (Note: Formal sleep testing is not required if the medical record demonstrates that sleep apnea (Obstructive Sleep Apnea (OSA), CSA and/or CompSA) is not the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation;

3. Respiratory failure has failed to improve with an adequate trial of Bi-PAP, as evidenced by one of the following: (Note: PaCO2 levels may not normalize even with adequate response to Bi-PAP therapy. Failure to normalize PaCO2 levels alone is not considered a therapeutic failure of Bi-PAP);
   a. Intolerance to Bi-PAP, as indicated by the member’s request to discontinue nocturnal assisted ventilation;
   b. Worsening dyspnea, hemodynamic instability, or unresponsive hypoxemia;
   c. Signs of respiratory failure: include tachypnea (respiratory rate >24/min) and respiratory acidosis (e.g., pH <7.35);

4. None of the following contraindications:
   a. FIO2 requirement > 0.40;
   b. PEEP > 10 cm H2O;
   c. Need for continuous invasive monitoring.

C. Initial request for the first three months of non-invasive home ventilator use for obesity hypoventilation syndrome (also known as the Pickwickian Syndrome), all of the following:

1. Member has a BMI greater than 30;

2. Member has had an initial arterial blood gas PaCO2, done while awake and breathing the beneficiary’s prescribed FIO2, is greater than or equal to 45 mm Hg;

3. Respiratory failure has failed to improve with an adequate trial of Bi-PAP as evidenced by one of the following: (Note: PaCO2 levels may not normalize even with adequate response to Bi-PAP therapy. Failure to normalize PaCO2 levels alone is not considered a therapeutic failure of Bi-PAP);
   a. Intolerance to Bi-PAP, as indicated by the member’s request to discontinue nocturnal assisted ventilation;
   b. Worsening dyspnea, hemodynamic instability, or unresponsive hypoxemia;
   c. Signs of respiratory failure: include tachypnea (respiratory rate >24/min) and respiratory acidosis (e.g., pH <7.35).
   d. An arterial blood gas PaCO2, done during sleep or immediately upon awakening, and breathing the beneficiary’s prescribed FIO2, shows the beneficiary's PaCO2 worsened greater than or equal to 7 mm HG compared to the original result (see C.2);

4. None of the following contraindications:
   a. FIO2 requirement > 0.40;
   b. PEEP > 10 cm H2O;
   c. Need for continuous invasive monitoring.
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D. Initial request for the first three months of non-invasive home ventilator use for members who have experienced treatment failure with Bi-PAP, both of the following:

1. Treatment failure, one of the following:
   a. Intolerance to Bi-PAP, as indicated by member request to discontinue nocturnal assisted ventilation;
   b. Worsening dyspnea, hemodynamic instability, or unresponsive hypoxemia;
   c. Signs of respiratory failure. Criteria for respiratory failure include tachypnea (respiratory rate >24/min) and respiratory acidosis (e.g., pH <7.35) (PaCO2 levels may not normalize even with adequate response to Bi-PAP therapy. Failure to normalize PaCO2 levels alone is not considered a therapeutic failure of Bi-PAP);

2. None of the following contraindications:
   a. FIO2 requirement > 0.40;
   b. PEEP > 10 cm H2O;
   c. Need for continuous invasive monitoring.

II. It is the policy of Health Plans affiliated with Centene Corporation that continued use of non-invasive home ventilators after the initial three month certification period is **medically necessary** when meeting the following:

A. Medical records document improvement in relevant signs or symptoms due to the device;
B. The member uses the device for at least an average of 4 hours per 24-hour period;
C. None of the following contraindications:
   1. FIO2 requirement > 0.40;
   2. PEEP > 10 cm H2O;
   3. Need for continuous invasive monitoring.

III. It is the policy of Health Plans affiliated with Centene Corporation that a second or back up non-invasive ventilator is considered medically necessary for the following indications:

A. A second ventilator to serve a different purpose from the first ventilator, based on the member’s medical needs. For example, two different types of ventilators are needed for each day, e.g., negative pressure ventilator with chest shell for one indication and a positive pressure ventilator with nasal mask the rest of the day;

B. A back-up ventilator for one of the following:
   1. Member is confined to a wheelchair and requires a wheel-chair mounted ventilator during the day and another ventilator of the same type for use while in bed (unable to position the wheel-chair-mounted ventilator close enough to the bed for use while sleeping). Without both pieces of equipment, member may be prone to medical complications, unable to achieve appropriate medical outcomes, or may not be able to use the equipment effectively;
   2. Residence in remote areas with poor emergency access.

IV. It is the policy of Health Plans affiliated with Centene Corporation that non-invasive home ventilators for overlap syndromes (presence of more than one condition, such as COPD and sleep apnea) require **secondary review** by a medical director.
Background
Noninvasive ventilation (NIV) refers to the administration of ventilatory support without using an invasive artificial airway (endotracheal tube or tracheostomy tube). The use of noninvasive ventilation has markedly increased over the past two decades, and noninvasive ventilation has now become an integral tool in the management of both acute and chronic respiratory failure, in both the home setting and in the critical care unit. Noninvasive ventilation has been used as a replacement for invasive ventilation, and its flexibility also allows it to be a valuable complement in patient management. Its use in acute respiratory failure is well accepted and widespread.1

Ventilatory support can be achieved through a variety of interfaces (mouth piece or nasal, face, or helmet mask), using a variety of ventilatory modes (e.g., volume ventilation, pressure support, bi-level positive airway pressure [BiPAP], proportional-assist ventilation [PAV], continuous positive airway pressure [CPAP]) with either ventilators dedicated to noninvasive ventilation (NIV) or those capable of providing support via an endotracheal tube or mask.1

Respiratory failure is not a disease, but a consequence of the problems that interfere with the ability to breathe. The term refers to the inability to perform adequately the fundamental functions of respiration: to deliver oxygen to the blood and to eliminate carbon dioxide from it. Respiratory failure has many causes and can come on abruptly (acute respiratory failure)—when the underlying cause progresses rapidly—or slowly (chronic respiratory failure)—when it is associated over months or even years with a progressive underlying process. Typically, respiratory failure initially affects the ability either to take up oxygen (referred to as oxygenation failure) or to eliminate carbon dioxide (referred to as ventilatory failure). People may live functional lives at home for many years with chronic respiratory failure. Noninvasive ventilation has also been an important advance for patients with chronic respiratory failure.2

Home mechanical ventilation represents a valuable therapeutic option to improve alveolar ventilation in patients with chronic respiratory failure. The primary goal of home mechanical ventilation is a reduction of symptoms, improvement of quality of life, reduce readmission risk and in many cases, reduction of mortality.3

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

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<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
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<tr>
<td>E0466</td>
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### ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

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<thead>
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<tr>
<td>E86.1</td>
<td>Hypovolemia</td>
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<tr>
<td>E87.70</td>
<td>Fluid overload unspecified</td>
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<tr>
<td>G35</td>
<td>Multiple sclerosis</td>
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<tr>
<td>G47.33</td>
<td>Obstructive sleep apnea</td>
</tr>
<tr>
<td>G47.8</td>
<td>Other sleep disorders</td>
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<tr>
<td>G71.09</td>
<td>Other specified muscular dystrophies</td>
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<tr>
<td>J96.00</td>
<td>Acute respiratory failure, unspecified whether with hypoxia or hypercapnia</td>
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<tr>
<td>J98.4</td>
<td>Other disorders of lung</td>
</tr>
<tr>
<td>J98.9</td>
<td>Respiratory disorder unspecified</td>
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<tr>
<td>M19.90</td>
<td>Unspecified osteoarthritis, unspecified site</td>
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<td>M51.27</td>
<td>Other intervertebral disc displacement, lumbosacral region</td>
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<td>N17.9</td>
<td>Acute kidney failure unspecified</td>
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<td>Q99.9</td>
<td>Chromosomal abnormality</td>
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<td>R06.00</td>
<td>Dyspnea unspecified</td>
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<tr>
<td>R53.1</td>
<td>Weakness</td>
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<tr>
<td>Z48.3</td>
<td>Aftercare following surgery for neoplasm</td>
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<tr>
<td>Z85.841</td>
<td>Personal history of malignant neoplasm of brain</td>
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### Reviews, Revisions, and Approvals

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<tr>
<th>Description</th>
<th>Date</th>
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<tbody>
<tr>
<td>Original approval date (WellCare)</td>
<td>5/19</td>
<td>5/19</td>
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<td>Annual review. Converted to new template. Clarified initial request is for 3 months. Applied contraindications to each indication. Removed verbiage about pediatric indications being addressed by state requirements. Removed requirements in the obesity hypoventilation syndrome indication for PSG or home sleep test demonstrating ≤88% O2 saturation. Reworded statement about medical director review of overlap syndromes. Removed coding instructions related to billing of secondary codes, Medicare billing, and excluded codes. Updated background.</td>
<td>4/20</td>
<td>4/20</td>
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<td>Added criteria for second/back up noninvasive ventilator from CP.MP.107 DME.</td>
<td>5/20</td>
<td>05/20</td>
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### References

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Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members**, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at [http://www.cms.gov](http://www.cms.gov) for additional information.

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