MULTI-FUNCTION VENTILATOR (E0467) CHECKLIST

Policies

- NCD 280.1 - Ventilators Covered for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. Includes both positive and negative pressure types. (See §240.5 of the NCD Manual).
- Oxygen and Oxygen Equipment LCD, L33797, Policy Article A52514
- Mechanical In-exsufflation Devices LCD, L33795, Policy Article A52510
- Suction Pump LCD, L33612, Policy Article A52519
- Nebulizer LCD, L33370, Policy Article A52466

Documentation to support medical necessity of ventilator includes:

- Valid physician's order
- Payable Diagnosis
- Documentation of medical necessity in medical record
- Ventilator settings
- Documentation describing the supplier's back-up plan in the event primary multi-function ventilator breaks down
- Proof of Delivery

Documentation to support medical necessity of oxygen, nebulizer, cough stimulator, or suction pump includes:

- Valid physician's order
- CMN (if applicable)
- Payable Diagnosis (if applicable)
- Documentation of medical necessity in medical record specific to additional function's policy
- Proof of Delivery

Additional documentation required:

- Same/similar documentation must be included for all rental and owned equipment
  - When the beneficiary owns any of the same or similar equipment, or has reached the 36-month cap for oxygen equipment, for equipment which has not reached the end of its reasonable useful lifetime, payment for the E0467 will be denied
  - Same/similar equipment includes: oxygen and oxygen equipment, nebulizers and related accessories, aspirator and related accessories, cough stimulator, High Frequency Chest Wall Oscillation, Oscillatory Positive Expiratory Pressure and related accessories, CPAP/RAD and related accessories, oral appliance, ventilators

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- Documentation must meet medical necessity requirements for the vent and at least one of the following- oxygen, cough stimulator, or suction pump, nebulizer.

MEDICAL NECESSITY FOR VENT FUNCTION (REQUIRED FOR EVERY E0467)

Medical records must state:

- ☐ Multi-function ventilator ordered in the chart notes, ***and***
- ☐ Documentation supporting condition and need for ventilator and additional function, ***and***
- ☐ Test results or documentation of severity of disease, ***and***
- ☐ Proof of use of multi-function ventilator to support dependency (printout from machine or physician documentation of actual use)

To qualify for ventilator function, the progress notes document at least one of the following diagnoses (not all-inclusive):

- ☐ ALS
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Other CNS Demyelination
- ☐ Quadriplegia/Quadriparesis
- ☐ Myoneural Disorders
- ☐ Post-polio syndrome
- ☐ Chest wall deformities
- ☐ Kyphoscoliosis
- ☐ Tuberculosis
- ☐ Sarcoidosis
- ☐ Chronic Respiratory Failure consequent to Chronic Obstructive Pulmonary Disease
- ☐ Tracheostomy

MEDICAL NECESSITY WHEN USING OXYGEN FUNCTION:

- ☐ Face to face within 30 days prior to the initial CMN date for oxygen being written supporting a chronic lung condition or hypoxia related symptoms, how it was treated prior with results or treatment(s) considered and ruled out, and that they are in a chronic stable state as an outpatient or within 2 days of discharge to home from the hospital
- ☐ Qualifying test results done within 30 days prior to initial CMN date

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- ☐ Initial CMN supporting diagnosis, testing within the medical records
- ☐ Face to face re-evaluation within 90 days of the recertification date on the CMN supporting continued use and benefit for group I or group II
- ☐ Most recent testing performed between 61st-90th day following the initial certification for group II
- ☐ Recertification CMN (time will vary based on group I (12 months) or group II (3 months))

MEDICAL NECESSITY WHEN USING COUGH STIMULATOR FUNCTION:

To qualify for ventilator function, the progress notes document at least one of the following diagnoses (not all inclusive):

- ☐ B91 Sequelae of poliomyelitis
- ☐ E74.02 Pompe disease
- ☐ G12.0 Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
- ☐ G12.1 Other inherited spinal muscular atrophy
- ☐ G12.20 Motor neuron disease, unspecified
- ☐ G12.21 Amyotrophic lateral sclerosis
- ☐ G12.22 Progressive bulbar palsy
- ☐ G12.23 Primary lateral sclerosis
- ☐ G12.24 Familial motor neuron disease
- ☐ G12.25 Progressive spinal muscle atrophy
- ☐ G12.29 Other motor neuron disease
- ☐ G12.8 Other spinal muscular atrophies and related syndromes
- ☐ G12.9 Spinal muscular atrophy, unspecified
- ☐ G14 Postpolio syndrome
- ☐ G35 Multiple sclerosis
- ☐ G70.01 Myasthenia gravis with (acute) exacerbation
- ☐ G71.00 Muscular dystrophy, unspecified
- ☐ G71.01 Duchenne or Becker muscular dystrophy
- ☐ G71.02 Facioscapulohumeral muscular dystrophy
- ☐ G71.09 Other specified muscular dystrophies
- ☐ G71.11 Myotonic muscular dystrophy
- ☐ G71.2 Congenital myopathies
- ☐ G72.41 Inclusion body myositis [IBM]
- ☐ G82.50 Quadriplegia, unspecified
- ☐ G82.51 Quadriplegia, C1-C4 complete

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- ☐ G82.52 Quadriplegia, C1-C4 incomplete
- ☐ G82.53 Quadriplegia, C5-C7 complete
- ☐ G82.54 Quadriplegia, C5-C7 incomplete

Additional requirements:

- ☐ This condition is causing a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions.

MEDICAL NECESSITY WHEN USING SUCTION PUMP FUNCTION:

To qualify for the suction pump function, the beneficiary must have difficulty raising and clearing secretions secondary to one of the following:

- ☐ Cancer or surgery of the throat or mouth
- ☐ Dysfunction of the swallowing muscles
- ☐ Unconsciousness or obtunded state
- ☐ Tracheostomy

MEDICAL NECESSITY WHEN USING NEBULIZER FUNCTION:

- Coverage is driven by diagnosis code and drug
- Must meet requirements based on nebulizer/drug required

Small volume nebulizer requirements:

- ☐ It is reasonable and necessary to administer albuterol (J7611, J7613), arformoterol (J7605), budesonide (J7626), cromolyn (J7631), formoterol (J7606), ipratropium (J7644), levalbuterol (J7612, J7614), or metaproterenol (J7669) for the management of obstructive pulmonary disease; or
- ☐ It is reasonable and necessary to administer dornase alpha (J7639) to a beneficiary with cystic fibrosis; or
- ☐ It is reasonable and necessary to administer tobramycin (J7682) to a beneficiary with cystic fibrosis or bronchiectasis; or
- ☐ It is reasonable and necessary to administer pentamidine (J2545) to a beneficiary with HIV, pneumocystosis, or complications of organ transplants; or
- ☐ It is reasonable and necessary to administer acetylcysteine (J7608) for persistent thick or tenacious pulmonary Secretions.

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Large volume nebulizer requirements:

- ☐ It is reasonable and necessary to deliver humidity to a beneficiary with thick, tenacious secretions, who has cystic fibrosis, bronchiectasis, a tracheostomy, or a tracheobronchial stent

Filtered nebulizer requirements:

- ☐ It is reasonable and necessary to administer pentamidine to beneficiaries with HIV, pneumocystosis, or complications of organ transplants

Controlled dose inhalation drug delivery system requirements:

- ☐ It is reasonable and necessary to deliver iloprost (Q4074) to beneficiaries with pulmonary hypertension only

If using Treprostinil inhalation solution (J7686) and iloprost (Q4074) all of the following criteria must be met:

- ☐ The beneficiary has a diagnosis of pulmonary artery hypertension
- ☐ The pulmonary hypertension is not secondary to pulmonary venous hypertension (e.g., left sided atrial or ventricular disease, left sided valvular heart disease, etc.) or disorders of the respiratory system (e.g., chronic obstructive pulmonary disease, interstitial lung disease, obstructive sleep apnea or other sleep disordered breathing, alveolar hypoventilation disorders, etc.)
- ☐ The beneficiary has primary pulmonary hypertension or pulmonary hypertension which is secondary to one of the following conditions: connective tissue disease, thromboembolic disease of the pulmonary arteries, human immunodeficiency virus (HIV) infection, cirrhosis, anorexigens or congenital left to right shunts. If these conditions are present, the following criteria must be met:
    - The pulmonary hypertension has progressed despite maximal medical and/or surgical treatment of the identified condition; and
    - The mean pulmonary artery pressure is > 25 mm Hg at rest or > 30 mm Hg with exertion; and The beneficiary has significant symptoms from the pulmonary hypertension (i.e., severe dyspnea on exertion, and either fatigability, angina, or syncope); and
    - Treatment with oral calcium channel blocking agents has been tried and failed, or has been considered and ruled out.

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GENERAL DOCUMENTION REQUIREMENTS:

BENEFICIARY AUTHORIZATION ☐ YES ☐ NO

DISPENSING ORDER (PIM 5.2.2)

- ☐ Beneficiary's name
- ☐ Multi-function vent ordered
- ☐ Prescribing practitioner's name
- ☐ Prescribing practitioner's signature (written order) or supplier signature (verbal order)
- ☐ Date of the order

DETAILED WRITTEN ORDERS PRIOR TO CLAIM SUBMISSION (PIM 5.2.3)

- ☐ Beneficiary's name
- ☐ Prescribing practitioner's name (printed or typed)
- ☐ Date of order
- ☐ Multi-function ventilator with description/brand/model including hcpcs;
- ☐ Practitioner signature
- ☐ Practitioner signature date, if applicable
- ☐ Length of need – recommended but not required

PROOF OF DELIVERY (PIM 5.8)

- ☐ Beneficiary's name
- ☐ Delivery address
- ☐ Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, model, serial number)
- ☐ Quantity delivered
- ☐ Date delivered
- ☐ Beneficiary (or designee) signature
- ☐ Relationship to beneficiary if not signed by beneficiary

CONTINUED USE (EVERY 12 MONTHS)

- ☐ Contact the beneficiary regularly to verify they are at home and continuing to use the multi-function ventilator since it is billed monthly with conversation documented, ***or***

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- ☐ Progress note of visit or machine printout documenting multi-function ventilator use

CONTINUED MEDICAL NEED (EVERY 12 MONTHS)

- ☐ A recent order by the treating practitioner, ***or***
- ☐ A recent change in prescription, ***or***
- ☐ Timely documentation in the medical record.

RECOMMENDED BEST PRACTICES

- ☐ Add settings/mode and frequency of use on order
- ☐ The medical record should support the ventilator mode/settings/frequency of use matching the order
- ☐ Have a back-up plan in place which should be provided in the event of an audit request
- ☐ If the ventilator is not ordered to be used continuously there should be good documentation to support need for hours ordered
- ☐ If not using during the office visit when ordered continuously, there should be documentation of why they were able to attend the visit without ventilator support or if it was taken off during the physical examination to support continued need
- ☐ Verify the primary diagnosis billed corresponds to the medical records and qualifying diagnoses. Even though the patient may have OSA, that is not the reason NIV is needed therefore shouldn't be billed as the primary diagnosis
- ☐ Review the medical records to verify the practitioner isn't using BiPAP and ventilator terminology interchangeably
- ☐ Obtain as much information from as many sources as possible supporting need including respiratory therapy notes
- ☐ If BiPAP is mentioned in the medical records, there should be good documentation to support why it will not meet their current respiratory needs
- ☐ BiPAP considered and ruled out with an explanation or proof that BiPAP failed (provides evidence that other therapies were insufficient)