5101:3-10-22 **Volume ventilators, positive and negative pressure ventilators, continuous positive airway pressure (CPAP), alternating positive airway pressure (APAP), and intermittent positive pressure ventilation (IPPV).**

(A) Any provider billing for ventilatory support services (including volume ventilators, positive and negative pressure ventilators, CPAP, APAP and IPPV) shall have on staff or under contract a licensed respiratory care professional (LRCP) available on a twenty-four-hour basis to provide respiratory care, technical support and clinical ventilator services.

(B) Volume ventilator services and APAP or IPPV services used as an alternative to a volume ventilator are covered for recipients residing in a personal residence, a nursing facility (NF), or an intermediate care facility for the mentally retarded (ICF-MR), are reimbursed on a rental only basis and require prior authorization. The monthly rental fee includes reimbursement for the use of a volume ventilator (portable or stationary), APAP, or IPPV, all service and maintenance, related ventilator supplies and equipment listed in paragraph (B)(3)(a) of this rule, and the LRCP services listed in paragraph (B) (3)(b) of this rule. For APAP and IPPV used as an alternative to a volume ventilator, noninvasive applications are covered when a tracheostomy is not medically necessary.

(1) To be considered for prior authorization, patients must have a permanent tracheostomy, unless an APAP or IPPV is prescribed, and require periodic or continuous mechanical ventilatory support as a result of one or more of the following:

(a) Chronic respiratory failure

(b) Spinal cord injury

(c) Neuromuscular diseases

(d) Chronic pulmonary disorders

(e) Other neurological disorders and thoracic restrictive diseases

(2) Ventilator, APAP and IPPV services may be prior authorized for up to six months at a time. All requests for prior authorization of ventilator services must include a "Prior Authorization" form ODHS 3142 and a prescription from a physician who has examined the patient within thirty days prior to the first date of service being requested. The prescription, or an attached certification of medical necessity, must include:

(a) Certification that the only alternative is a volume ventilator when APAP or IPPV is prescribed.

(b) Medical history (not required if request is for continuation of services),

(c) Diagnosis and degree of impairment,

(d) Degree of ventilatory support required (e.g., continuous, nocturnal only),

(e) Ventilator settings/parameters ordered at time of prior authorization request,

(f) List of other respiratory equipment in use,

(g) Documentation that recipient is being weaned (if applicable), and

(h) Documentation (e.g., copy of a recent checksheet) that a LRCP routinely checks or changes ventilator settings in compliance with physician ordered parameters (not applicable to initial prior authorization request).

(3) The monthly rental payment for ventilator services includes reimbursement for the following equipment and supplies and respiratory services:

(a) Equipment and supplies

(i) Mechanical ventilator and accessories, including inlet ventilator filters,

(ii) Humidification unit and accessories

(iii) Humidifier bacteria filters,

(iv) Humidifier tubing (ventilator to humidifier),

(v) Permanent or reusable patient circuits (disposable patient circuits are billable only to NFs and ICFs-MR), and

(vi) Related accessory and supply items including tracheostomy flex

tubes, and peep valves.

(b) Licensed respiratory care professional (LRCP) services

(i) Home evaluation (prior to discharge), and home equipment set-up.

(ii) In-home training of the caregiver(s) (e.g. ventilator operation, tracheostomy care, cleaning/sterilization techniques).

(iii) LRCP visits to include multiple visits in the first week of service and subsequent visits no less frequent than once per month at a frequency determined by the LRCP, in consultation with the patient's physician, to be appropriate to the patient's condition.

(iv) Routine maintenance as specified by manufacturer or company protocol and in compliance with industry standards.

(v) Twenty-four-hour on call respiratory therapist services with two-hour response for emergency visits to include equipment servicing, repair or replacement.

(4) Reimbursement for back-up equipment for a medically necessary mechanical ventilator may be allowed only when the following documentation is provided:

(a) Estimated response time to the recipient's address is provided in writing, signed by the supervisor of the emergency team(s) responsible for serving the recipient's address; and

(b) The emergency medical team estimated response time is more than thirty minutes; and

(c) A statement signed by the recipient's attending physician declares that thirty minutes without a mechanical ventilator would create a life-threatening situation for the recipient.

(5) When ventilators are provided to medicaid eligible residents of a NF or ICF-MR, reimbursement shall not be provided for more than one back-up ventilator per eight primary ventilators.

(C) Positive and negative pressure ventilator services may be provided to recipients

residing in a personal residence, NF, or ICF-MR, are reimbursed on a rental only basis, and require prior authorization. The monthly rental fee includes reimbursement for the use of a positive or negative pressure ventilator (portable or stationary), all service and maintenance, related ventilator supplies and equipment listed in paragraph (B) (3)(a) of this rule, as applicable, and those required LRCP services listed in paragraph (B)(3)(b) of this rule. Positive and negative pressure ventilator services may be prior authorized for up to six months at a time. Prior authorization requests must include the documentation listed in paragraph (B)(2) of this rule.

(D) Service and maintenance on patient-owned ventilators requires prior authorization and may be billed once per month. The prior authorization request and documentation of medical necessity must include a physician prescription for mechanical ventilatory support, patient diagnosis and degree of impairment. Payment will be authorized only when the department determines that the ventilator is medically necessary.

(E) With prior authorization, payment can be made for a continuous positive airway pressure (CPAP) home system. The CPAP system was designed for patients with obstructive sleep apnea. Rental for a six-month period or purchase may be authorized only when a trial period has proven to be beneficial. Documentation will be necessary to substantiate ongoing rental or purchase.

(1) A request for prior authorization must contain all of the following information:

(a) A statement of medical necessity from the patient's attending physician indicating:

(i) Diagnosis of obstructive sleep apnea (OSA). the diagnosis of OSA requires documentation of a combined obstructive apnea and hypopnea index of at least five, with each episode lasting a minimum of ten seconds, during at least three hours of recorded sleep.

(ii) Surgery is a likely alternative.

(b) A hospital summary which includes a sleep study report documenting the combined obstructive and hypopnea index, and 0_2 saturation on room air with saturation level at eighty-eight per cent or below for more than five per cent of total sleep study. A second sleep study of at least three hours duration must show efficacy of CPAP system by decreasing number of airway obstructions per hour. Sleep study must also show an increase in saturation of at least fifteen per cent (e.g., eighty per cent to

ninety-two per cent) and increase the saturation to eighty-nine per cent or greater. The two sleep studies may be performed consecutively during one combined study period. If oxygen is needed in addition to CPAP, documentation of effectiveness must be shown on sleep study.

(c) A statement from the prescribing physician documenting any correctable causes of the patient's sleep apnea which are present, (e.g., alcohol, bedtime sedatives/hypnotics, weight) and whether or not they are being treated or have been abolished. It must be specified if none exist.

(d) A statement from the prescribing physician, indicating whether the patient is symptomatic or asymptomatic and what impairment(s) secondary to sleep apnea is (are) present.

(e) A statement from the prescribing physician certifying that the recipient is using the device regularly as prescribed.

(2) If any of the information in paragraph (E)(1) of this rule is missing or provided by the supplier instead of the prescribing physician, prior authorization will be denied. A new request for authorization can then be resubmitted with the required information.

(F) In extreme and unusual circumstances an alternating positive airway pressure (APAP) system may be prior authorized for obstructive sleep apnea when additional documentation is provided that:

(1) CPAP and other alternatives have been tried and are not effective.

(2) A one-week trial period using a respiratory support system was effective; and

(3) The prescribing physician certifies in writing the effectiveness of the system and that the patient is using the device regularly as prescribed.

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