Respiratory Equipment and Supplies

CSHCN Services Program Provider Manual

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TEXAS
Health and Human
Services

RESPIRATORY EQUIPMENT AND SUPPLIES

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36.1 Enrollment

Durable medical equipment (DME) providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Out-of-state respiratory equipment providers must meet all of these conditions and be located in the United States, within 50 miles of the Texas state border, and approved by the Department of State Health Services (DSHS).

Important: *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession, as well as those required by the CSHCN Services Program and Texas Medicaid.

Refer to: Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

36.2 Benefits, Limitations, and Authorization Requirements

The CSHCN Services Program may reimburse the rental or purchase of medically necessary and appropriate respiratory equipment. The item must be prescribed by a licensed physician and be a benefit of the CSHCN Services Program.

Equipment may be rented or purchased depending on the cost-effectiveness of the action requested. In general, equipment is purchased if it is needed for more than 6 months. Only new, unused equipment will be rented or purchased for clients. The reimbursement of rented equipment includes all supplies, accessories, adjustments, repairs, and replacement parts needed during the rental period. Supplies needed for use with client owned equipment may be considered for purchase.

Respiratory supplies are a benefit when medically necessary and are available without prior authorization up to the stated quantity limitation unless otherwise stated. Prior authorization is required for quantities exceeding the limitation.

Sterile respiratory supplies are a benefit with prior authorization when medically necessary and documentation shows that the client's medical needs cannot be met with non-sterile (clean) supplies.

Exception: *Ventilators, oxygen concentrators, and cough stimulating devices are rented, not purchased, because of high maintenance costs and the frequency of required repairs.*

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Repairs are considered if the item was purchased by the CSHCN Services Program or is an item on the CSHCN Services Program-approved list that was obtained from another source. The repair must be more cost-effective than the cost of replacement. Repairs may be reimbursed at the list price of parts plus labor time.

The CSHCN Services Program considers requests for coverage of the following types of respiratory equipment:

- Rental or purchase of:
  - Suction equipment
  - Electric percussors for chest physiotherapy
  - High frequency chest wall oscillation systems (HFCWO)
  - Medical grade or "heavy duty" air compressors
  - Continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP) machines (BiPAP machines will only be provided to clients who have documented treatment failure of CPAP)
  - Immersion heaters
  - Nebulizers
  - Pulse oximeters
  - Ventilators and supplies (ventilators may be a benefit for lease only)
  - Controlled dose inhalation drug delivery system
  - Cardiorespiratory (apnea) monitors (only nonrecording apnea monitors will be authorized for ventilator dependent clients)
- Rental of:
  - Stationary gaseous oxygen cylinders or liquid oxygen systems
  - Portable gaseous oxygen system

    Note: *Stands, carts, regulators, oxygen conservers, and carrying cases are included in the rental reimbursement for stationary gaseous oxygen cylinders, liquid oxygen systems, and portable gaseous oxygen systems.*
  - Oxygen concentrators (a back up cylinder of gaseous oxygen is included in the rental reimbursement)
  - Cough stimulating devices (Cofflator)
- Purchase of:
  - Liquid or gaseous oxygen contents or refills for client-owned equipment
  - Oxygen humidification devices (e.g., Cascade device)
  - Ambu bag
  - Tracheostomy tubes and supplies
  - Incentive spirometer
  - Mucus clearance valve

    Note: *Rental of substitute equipment is not covered when a purchased item that is under warranty is being repaired.*

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The CSHCN Services Program will cover only one of the following per client:

- A cough stimulating device
- An HFCWO

The CSHCN Services Program will consider the following two situations with documentation of medical necessity:

- Requests for the rental or purchase of duplicate items that will be used in two different locations. The CSHCN Services Program will not pay for the rental or purchase of items when the provision of the items are the legal responsibility of a school district or the Texas Workforce Commission (TWC).
- Requests to replace items purchased within the last 2 years.

The CSHCN Services Program may cover items under the Family Support Services (FSS) benefit within annual coverage limits. Type of items include, but are not limited to:

- Room air vaporizers or humidifiers
- Air filtering systems
- Specialized vacuum cleaners
- Heaters
- Air conditioners
- Dehumidifiers

Contact the CSHCN Services Program at 1-800-252-8023 for additional information about the FSS benefit.

The following equipment is not a benefit of the CSHCN Services Program:

- Intrapulmonary percussive ventilation (IPV) system
- Vaporizers
- Room air humidifiers

Providers must have the client or the client's representative complete the CSHCN Services Program Documentation of Receipt form when DME is delivered to the client. The date of delivery on the documentation of receipt form is the date of service that should appear on the claim. The provider should retain this form; do not submit it with the claim.

The documentation of receipt form is available in both English and Spanish.

The following table is a list of respiratory equipment and supplies and their limitations.

Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
A4216	As needed	A4481	31 per month	A4483	15 per month
A4556	15 per month	A4557	2 per month	A4605	10 per month
A4606	4 per month	A4606 with modifier U5	1 per 6 months	A4611	1 per 5 years
A4612	1 per 5 years	A4613	1 per 5 years	A4614	1 per 6 months
A4615	2 per month	A4616	4 per year	A4617	2 per month
A4618	4 per month	A4619	2 per month	A4620	2 per month
A4623	1 per month	A4623 with modifier U3	31 per month	A4624	85 per month

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Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
A4627	1 per 6 months	A4628	2 per month	A4629	30 per month
A7000	5 per month	A7002	8 per month	A7003	2 per month
A7004	2 per month	A7005	1 per 6 months	A7006	1 per month
A7007	2 per month	A7009	1 per year	A7010	1 per 2 months
A7012	2 per month	A7013	2 per month	A7014	1 per 3 months
A7015	1 per month	A7016	2 per month	A7017	1 per 3 years
A7018	4 per month	A7025	1 per lifetime	A7026	1 per 6 months
A7027	1 per 3 months	A7028	1 per month	A7029	2 per month
A7030	1 per 3 months	A7031	1 per month	A7032	2 per month
A7033	2 per month	A7034	1 per 3 months	A7035	1 per 6 months
A7036	1 per 6 months	A7037	1 per month	A7038	2 per month
A7039	1 per 6 months	A7520	1 per month	A7520 with U1 modifier	1 per month
A7520 with U2 modifier	1 per month	A7521	1 per month	A7522	4 per year
A7523	1 per 2 years	A7525	4 per month	A7526	20 per month
A9284	1 per 6 months	A9900	As needed	E0424	1 rental per month
E0431	1 rental per month	E0433	1 rental per month	E0434	1 rental per month
E0439	1 rental per month	E0441	1 per month	E0442	1 per month
E0443	1 per month	E0444	1 per month	E0445	1 rental per month
E0445 with modifier U4	1 purchase per 5 years; 1 rental per month	E0457	1 purchase per 5 years; 1 rental per month	E0459	1 purchase per lifetime; 1 rental per month
E0465	1 rental per month	E0466	1 rental per month	E0467	1 rental per month
E0468	1 rental per month	E0470	1 purchase per 5 years; 1 rental per month	E0471	1 rental per month
E0472	1 rental per month	E0480	1 purchase per 5 years; 1 rental per month	E0482	1 purchase per 3 years; 1 rental per month
E0483	1 purchase per lifetime; 1 rental per month	E0500	1 purchase per 5 years; 1 rental per month	E0550	1 purchase per 3 years; 1 rental per month
E0561	1 purchase per 5 years; 1 rental per month	E0562	1 purchase per 5 years; 1 rental per month	E0565	1 purchase per 5 years; 1 rental per month
E0570	1 per 5 years	E0574	1 per 5 years	E0575	1 per 5 years

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Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation	Procedure Code	Maximum Limitation
E0580	1 purchase per 3 years; 1 rental per month	E0600	1 per 5 years	E0601	1 purchase per 5 years; 1 rental per month
E0618	1 purchase per 5 years; 1 rental per month	E0619	1 purchase per 5 years; 1 rental per month	E1353	1 per year
E1355	1 per 3 years	E1372	1 per 3 years	E1390	1 per calendar month
E1399	As needed	K0462	1 per month	K0730	1 per 5 years
K0738	1 per month	K0739	2 hours per day	L8501	1 per 6 months
S8101	1 per 6 months	S8185	1 per 5 years	S8189	As needed
S8999	1 per year				

36.2.1 General Authorization Requirements

Requirements for authorization and prior authorization vary with the type of equipment requested. Refer to the types of equipment listed below for authorization and prior authorization requirements. Authorization and prior authorization request forms must be submitted in writing and must include documentation of medical necessity.

Refer to: Chapter 4, "Prior Authorizations and Authorizations."

CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form.

Note: *Fax transmittal confirmations are not accepted as proof of timely authorization submission.*

36.2.2 Noninvasive Positive Pressure Ventilation (NPPV)

Prior authorization is required for rental or purchase of NPPV devices, including CPAP and respiratory assist devices (RADS) which include Bi-Level PAP with or without a set backup respiratory rate when medically necessary primarily for clients requiring treatment of obstructive sleep apnea, restrictive thoracic disorders, severe chronic obstructive pulmonary disease, central sleep apnea, complex sleep apnea, and hypoventilation syndrome. Prior authorization must be submitted on a completed CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form that has been signed and dated by the prescribing physician.

Note: *Other conditions may be considered with prior authorization of medical necessity.*

RADS with a set backup rate are available for rental only when medically necessary.

For client owned devices, proof of ownership of the NPPV device is required when requesting prior authorization for purchase of the associated supplies. A claims history of the purchase of an NPPV device or the associated supplies will meet this requirement. A statement from the ordering physician providing the make and model of the client-owned device will meet this requirement if claims history is not available.

Humidification devices used with continuous positive airway pressure (CPAP), or respiratory assist devices (RAD) such as a bi-level PAP with or without a set backup respiratory rate require prior authorization. Documentation of medical necessity including the diagnosis and expected outcome must be submitted with the request for prior authorization. Prior authorization for heated humidification must include documentation of a medical reason requiring heated humidification.

Tubing and filters are considered part of the rental and will not be reimbursed separately.

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Headgear, masks, and other client interfaces may be prior authorized separately when requested for the rental of NPPV with documentation of medical necessity.

36.2.2.1 Continuous Positive Airway Pressure (CPAP) System

A CPAP device (procedure code E0601) is used primarily for the treatment of obstructive sleep apnea. Other conditions may be considered based on medical necessity.

The CPAP device may be prior authorized for rental or purchase based on the physician's predicted length of treatment.

The CPAP device may be approved for an initial 3-month rental period based on documentation that supports the medical necessity and appropriateness of the device along with documentation of a sleep study lasting a minimum of 2 hours and when at least one of the following conditions are met for clients who are 18 years of age and older:

- The Sleep Study Respiratory Disturbance Index (RDI) or Apnea/Hypopnea Index (AHI) is greater than or equal to 15 events per hour
- The Sleep Study RDI or AHI is greater than 5 events per hour and at least one of the following is true:
  - Excessive daytime sleepiness (documented by either an Epworth Sleepiness Scale 10 or greater or a Multiple Sleep Latency Test less than six)
  - Documented symptoms of impaired cognition, mood disorders, or insomnia
  - Documented hypertension (systolic blood pressure greater than 140 mm Hg and/or diastolic blood pressure greater than 90 mm Hg)
  - Documented ischemic heart disease or previous myocardial infarction
  - Documented history of stroke
  - Greater than 20 episodes of oxygen desaturation less than 85 percent during a full night sleep study
  - Any one episode of oxygen desaturation less than 70 percent
  - Documented pulmonary hypertension

Polysomnography documentation of AHI greater than one event per hour may be used to establish medical necessity for clients who are 17 years of age and younger.

CPAP may be medically necessary for the treatment of obstructive sleep apnea (OSA) in clients who are younger than 18 years of age when one of the following criteria are met:

- Adenoidectomy or tonsillectomy is contraindicated
- Adenoidectomy or tonsillectomy is delayed
- Adenoidectomy or tonsillectomy has been unsuccessful in relieving symptoms of OSA

Note: *American Academy of Sleep Medicine guidelines indicate that it is clinically appropriate to treat clients who are 18 through 20 years of age using the adult criteria.*

Prior authorization for purchase after a maximum three-month rental period may be granted if the client is continuing to use the equipment at a minimum of four hours in a 24-hour period and symptoms are improved as documented by a physician. This documentation of compliance and effectiveness must be provided with a new completed CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form signed and dated by a physician.

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36.2.2.2 Respiratory Assist Devices (RADs), including BiPAP

A RAD with or without a set backup rate may be considered for prior authorization when the client has one of the following conditions as documented by a sleep study and meets criteria for medical necessity for the specific medical condition:

- OSA
- Restrictive thoracic disorders i.e., neuromuscular diseases or severe thoracic cage abnormalities
- Severe chronic obstructive pulmonary disease (COPD)
- Central sleep apnea (CSA)
- Complex sleep apnea (CompSA)
- Hypoventilation syndrome
- Meets criteria for the specific medical condition noted below

36.2.2.2.1 RAD for Treatment of Obstructive Sleep Apnea (OSA)

A RAD without backup may be considered for an initial three month trial period with prior authorization for treatment of OSA when all of the following criteria are met:

- All of the required documentation listed in the CPAP section is submitted with the prior authorization request
- The client meets the criteria for the initial CPAP three month trial
- Documentation supports that CPAP has been tried with documentation of one of the following:
  - The treating practitioner verifies that a CPAP trial failed to be effective in treating the client's OSA
  - CPAP was found to be ineffective during the initial facility based or sleep laboratory titration trial

If a CPAP device is tried and is not effective during an initial facility based titration or home trial; substitution of a RAD does not require a new face to face clinical evaluation or a new sleep test.

36.2.2.2.2 RAD for Treatment of Restrictive Thoracic Medical Conditions

A RAD without a set backup rate may be considered for treatment of thoracic medical conditions with prior authorization when all of the following are met:

- The client is diagnosed with a neuromuscular disorder, (e.g., Duchenne muscular dystrophy, ALS, spinal cord injuries) or has a diagnosis of a severe thoracic cage abnormality, (e.g., severe chest wall deformities) negatively impacting the client's respiratory effort.
- Medical necessity documentation indicates significant respiratory insufficiency documented by one of the following:
  - An arterial blood gas (ABG) PaCO2 > 45mm Hg, obtained while awake and breathing the client's routinely prescribed FI02
  - Sleep oximetry demonstrates oxygen saturation < 88% for > 5 minutes of continuous nocturnal recording time (minimum recording time of 2 hours), done while the client is breathing their routinely prescribed FIO2

For clients who have been diagnosed with a neuromuscular disorder only, documentation must support one of the following:

- Maximal inspiratory pressure is < 60 cm H2
- Forced vital capacity is < 50% of predicted

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A RAD with a set back-up rate requires prior authorization and may be considered for the treatment of thoracic medical conditions when all of the following are met:

- The client meets the criteria for use of the RAD without a back-up rate for treatment of a thoracic medical condition
- The ordering physician verifies the following:
  - Client has tried a RAD without a backup rate for at least 60 Days
  - Client was compliant in use of the device using on average 4 or more hours in a 24-hour day
  - The desired therapeutic respiratory response was not achieved with the RAD without a set back up rate

36.2.2.2.3 RAD for Treatment of Severe COPD

A RAD without a set backup rate may be considered for the treatment of severe COPD with prior authorization when all of the following criteria are met:

- The client's arterial blood gas PaCO2 is less than 52 mm Hg, obtained while awake and when the client is using their routinely prescribed FIO2 or 2LPM of oxygen. The blood gas should be obtained while the client is using whichever concentration of oxygen is the higher of the two.
- Sleep oximetry demonstrates oxygen saturation < 88% for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2LPM or the client's prescribed FIO2 (whichever is higher).
- Prior to initiating therapy, documentation of sleep apnea and that treatment with a CPAP has been considered with an explanation of why it has been ruled out.

To rule out the use of a CPAP, formal sleep testing is not required if there is sufficient information in the client's medical record submitted with the request that demonstrates the client does not have some form of OSA, CSA, or CompSA as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation.

A RAD with a backup feature will be considered with prior authorization for severe COPD when all of the following criteria are met:

- The client meets the criteria for use of the RAD without a backup rate for COPD
- The ordering practitioner verifies that:
  - The client has tried the RAD without a backup rate for at least 60 days.
  - The client was compliant in the use of the device using on average 4 or more hours in a 24 hour day.
  - The desired therapeutic respiratory response was not achieved with the RAD without a set backup rate.

36.2.2.2.4 RAD for Treatment of Central sleep Apnea (CSA) or Complex Sleep apnea (CompSA)

A RAD without a set backup rate will be considered with prior authorization for the treatment of CSA or CompSA when a facility based polysomnogram indicates all of the following:

- The client has a diagnosis of CSA or CompSA
- The sleep study documents one of the following:
  - The sum total of central hypopneas plus central apneas is greater than 50% of the total apneas and hypopneas rate

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- A central hypopnea/apnea rate index greater than 5 events per hour and significant improvement of the sleep associated hypoventilation while breathing the client's prescribed FiO2
- Documentation ruling out CPAP as effective therapy if either OSA or CSA is a component of the initially observed sleep associated hypoventilation

A RAD with a backup rate will be considered with prior authorization for the treatment of CSA or CompSA when all of the following are met:

- The client meets the criteria for use of the RAD without a backup rate for the treatment of CSA or CompSA
- The ordering practitioner verifies that all of the following are met:
  - Client has tried a RAD without a backup rate for at least 60 days
  - Client was compliant in the use of the device using on average 4 or more hours in a 24 hour day
  - The desired therapeutic response was not achieved with the RAD without a set backup rate

36.2.2.2.5 RAD for Treatment of Hypoventilation Syndrome

A RAD without a set backup rate may be considered for treatment of hypoventilation syndrome with prior authorization when all of the following criteria are met:

- An initial arterial blood gas PaCO2 is > 45 mm Hg while awake breathing routinely prescribed FIO2
- A spirometry shows a forced expired volume in 1 sec (FEV1) or the forced vital capacity (FVC) is > 70%.
- A facility based polysomnogram demonstrates an oxygen saturation < 88% for 5 minutes or longer of continuous nocturnal recording time (minimum recording time of 2 hours) not caused by obstructive upper airway events

A RAD with a set backup respiratory rate may be considered with prior authorization for the treatment of hypoventilation syndrome when one of the following are met:

- The client has hypoventilation syndrome as determined by a facility based polysomnogram that demonstrates the desired respiratory therapeutic effects were not achieved with a RAD without a backup rate
- The client meets the criteria for RAD without a backup rate for hypoventilation syndrome and the physician documents the desired respiratory therapeutic effects were not achieved with the RAD without a backup rate

36.2.2.2.6 Extension Request for RAD With or Without a Set Backup Rate

Prior authorization is required for an extension of a RAD with or without a set backup rate.

Purchase of a RAD without a set backup rate or continued rental of a RAD with or without a set backup rate (after the initial rental) may be considered with prior authorization and all of the following:

- The client has completed an initial three month rental period
- Submission of a new CSHCN Services Program Prior Authorization Request for Continuous Positive Airway Pressure (CPAP) or Respiratory Assist Device (RAD) Form that has been signed and dated by the ordering practitioner
- Submission of medical necessity documentation that the client is continuing to use the equipment a minimum of four hours in a 24-hour period
- Medical necessity documentation indicates that client symptoms are improved

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When requesting an extension for a RAD with or without a set backup rate documentation of a capillary blood gas (CBG) demonstrating a PaCO2 greater than or equal to 45 mm Hg, obtained while awake and breathing the client's routinely prescribed FI02 may be submitted in lieu of an ABG.

36.2.3 Controlled Dose Inhalation Drug Delivery System

Prior authorization is required for purchase of a controlled dose inhalation drug delivery system (procedure code K0730) and requires documentation of medical necessity for the following conditions:

Conditions
Pulmonary artery hypertension
Chronic pulmonary heart disease
Other chronic pulmonary heart diseases

Other conditions may be considered with prior authorization and documentation of medical necessity.

Note: *The pulmonary hypertension may not be secondary to pulmonary venous hypertension or disorders of the respiratory system.*

36.2.4 Secretion and Mucus Clearance Devices

Secretion and mucus clearing devices are a benefit when medically necessary and are typically needed by clients diagnosed with cystic fibrosis (CF), chronic bronchitis, bronchiectasis, ciliary dyskinesia syndromes, some forms of asthma, neuromuscular degenerative disorders, post-operative atelectasis, or thoracic wall defects.

Secretion and mucus clearing devices may be considered when documentation clearly shows the client has one of the following indications for this form of therapy as described by the American Association for Respiratory Care (AARC) in the Clinical Practices Guidelines for Postural Drainage Therapy (I) (199-1):

- Evidence retained secretions
- Evidence that the client is having difficulty with the secretion clearance
- Presence of atelectasis caused by mucus plugging

The following therapies and devices do not require prior authorization when requested within the benefit limitations:

- Incentive spirometers
- Manual percussion
- Mucus clearance valved chamber (Oscillating Positive Expiratory Pressure (PEP) - Flutter Valve)
- Moisture exchangers (procedure code A4483) for use only when used for mechanically ventilated clients who own their own equipment

These following therapies and devices require prior authorization:

- Insufflation-exsufflation devices, (e.g., Cough Assist, Cofflator)
- Electrical percussors
- High frequency chest wall oscillation (HFCWO) system
- Percussion cup
- Intermittent positive pressure breathing (IPPB) devices

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Prior authorization requests for rental or purchase of secretion and mucus clearance devices must be submitted on the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form signed and dated by a physician.

Note: *Clients requiring more than one secretion and mucus clearance device must have a pulmonologist as the prescribing physician who submits a signed and dated letter of medical necessity for the need of two devices.*

36.2.4.1 Cough Augmentation Device (Insufflation Devices or Cough Assist Machine)

A cough augmentation device may be considered for prior authorization for rental only for those clients who have chronic pulmonary disease or neuromuscular disorders (including spinal cord injury) that affect the respiratory musculature, causing a weak, ineffectual or absent cough.

Prior authorization for a cough augmentation device may be considered for an initial three-month rental period with all of the following documentation completed, signed, and dated by the client's treating physician:

- Diagnosis and background history including recent illnesses, complications, medications used, history of recent hospitalizations, results of pulmonary function studies (if applicable); due to diagnosis- related complications.
- History of school, work, or extracurricular activity or absences or other clinical evidence supporting deterioration to the level of requiring the use of a cough augmentation device to clear the airways, such as a weak, ineffective cough as demonstrated by pulmonary function studies (PFTs).
- Medical reasons why the client, parent, guardian, or caregiver cannot do chest physiotherapy, or why such therapies were previously ineffective.

Requests for prior authorization recertification must include documentation by the client's treating physician that the client is compliant with the use of the equipment and that the treatment is effective.

36.2.4.2 Electrical Percussors

An electrical percussor may be considered for rental or purchase with documentation of medical necessity on the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form including a description of all previous courses of therapy (such as manual percussion and postural drainage (P&PD) and valved devices) and why they did not adequately assist the client in airway mucus clearance.

Note: *Rental period may be considered for a maximum of nine months.*

36.2.4.3 High Frequency Chest Wall Oscillation (HFCWO) System

Prior authorization of a HFCWO system may be considered for clients with one of the following conditions:

- Bronchiectasis when it is confirmed by CT scan and characterized by either a continuous daily productive cough for 6 months or frequent exacerbations of pulmonary infections (i.e., more than 2 times per year) requiring antibiotic therapy
- Cystic Fibrosis or other documented chronic supperative endobronchitis
- Chronic neuromuscular disorder affecting the ability to cough or clear respiratory secretions

A HFCWO system may be considered for prior authorization with documentation of all the following:

- Medical necessity including submission of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form
- Other mechanical devices or chest physiotherapy modalities used by a client, parent, guardian, or caregiver
- Reason why other modalities have not been effective

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- If previously used, the device use has not resulted in aspiration, exacerbation of any gastrointestinal or pulmonary issues, nor caused an exacerbations of seizure activity

An initial three-month rental may be prior authorized for the HFCWO system. If the HFCWO system is documented to be effective, at the end of the initial three-month rental, purchase of the system may be prior authorized. If at the end of the initial three-month rental, a determination of purchase cannot be made, an additional three-month rental may be given.

Prior authorization for the initial three-month rental of an HFCWO system generator and vest may be considered with all of the following information:

- Documentation that the client has one of the medical conditions listed above and has used a cough augmentation device for a minimum of three months prior to the request and that this therapy has been ineffective
- Client has a chronic respiratory illness or with exacerbation or change in baseline respiratory condition in the past 6 months (provide additional information in narrative section)
- Client or family unable to do chest physiotherapy or chest physiotherapy is contraindicated (provide medical reasons in narrative section)
- Client has tried other appropriate (age, ability, skill) modes of chest physiotherapy, such as the use of electrical percussor therapy or oscillating positive expiratory pressure valve for a minimum of four months prior to the request and why the therapy has been ineffective (provide information on other therapies and why they are ineffective in narrative section)

Prior authorization for an additional three-month rental may be considered with the above documentation and documentation of compliance with the ordered therapy.

Prior authorization for the purchase of an HFCWO system may be considered based on the outcome of the rental period(s) and the following required documentation:

- Documentation of vest tolerance and positive outcomes or results of therapy, including physician's statement of a trial of the HFCWO in a clinic, hospital, or the home setting documenting the effectiveness and tolerance of the system
- Physician's description and assessment of the effectiveness including:
  - Decreased medication use
  - Shorter hospital length of stay
  - Decreased hospitalizations
  - Fewer school, work, or extracurricular activity absences due to diagnosis- related complications
  - The frequency and compliance graphs from the device for the 6-month period showing use of the system at least 50 percent or 3 months of the maximum time prescribed by the physician for each day
- Diagnosis and background history including:
  - Complications
  - Medications used
  - IV antibiotic therapy with dosage, frequency and duration
  - Recent hospitalizations
  - School, work, and extracurricular activity absences due to diagnosis-related complications
- Evidence of clinical improvement other than pulmonary function tests, including improved work or school attendance or ability to participate in extracurricular activities

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- Documentation that the previous use of the HFCWO device has not resulted in aspiration, exacerbation of a gastrointestinal or pulmonary issue, or exacerbation of seizure activity

A HFCWO system purchase will be reimbursed only once per lifetime, due to the lifetime warranty provided by the manufacturer.

Note: *Requests for a vest replacement due to growth or is no longer functional will be considered for prior authorization with appropriate documentation and submission of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form.*

36.2.4.4 Percussion Cup

Requests for purchase of a percussion cup for chest physiotherapy requires submission of the CSHCN Services Program Prior Authorization Request for Secretion and Mucus Clearance Devices Form and documentation of medical necessity. Requests for percussion cups should be requested with the miscellaneous DME procedure code E1399.

36.2.4.5 Intermittent Positive Pressure Breathing (IPPB) Devices

Prior authorization is required for rental or purchase of an IPPB (procedure code E0500) with documentation of ineffective response with use of other modalities (e.g. treatment with a cough assist device) and there is a need to improve lung expansion due to:

- The presence of clinically significant pulmonary atelectasis when other forms of therapy have been unsuccessful or the client is unable to cooperate with the treatment
- Inability to clear secretions due to pathology that severely limits the client's ability to ventilate or cough effectively and failure to respond to other modes of treatment including but not limited to:
  - Neuromuscular disorders or kyphoscoliosis with decreases in lung volume
  - Presence of acute severe bronchospasm or exacerbated COPD that fails to respond to other therapy
  - The need to deliver aerosol medication
- The need to deliver aerosol medications when other methods of delivery have been unsuccessful including but not limited to:
  - Clients with fatigue as a result of ventilatory muscle weakness such as neuromuscular disease, kyphoscoliosis or spinal cord injury
  - Clients with severe hyperinflation where IPPB may decrease dyspnea and discomfort during nebulized therapy

Rental of the IPPB device includes all supplies (e.g. humidification and tubing).

36.2.5 Nebulizers

A nebulizer may be rented or purchased for clients when:

- The equipment is prescribed by a physician for an approved diagnosis.
- The documentation submitted with the claim, the authorization, or prior authorization request supports medical necessity and appropriateness.

The purchase of nebulizers may be reimbursed with the anticipation that the equipment will last a minimum of 2 years with continuous use and up to 5 years with intermittent use.

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The following procedure codes may be reimbursed for nebulizers and supplies:

Procedure Codes				
Small Volume Nebulizer and Supplies				
A7003	A7004	A7005	A7006	E0565
Large Volume Nebulizer and Supplies				
A7007	A7008	E0585		
Filtered Volume Nebulizer and Supplies				
A7006	E0565			
Ultrasonic Volume Nebulizer and Supplies				
E0574	E0575			

Note: *Prescribed medications for use with aerosol delivery by SVN may be considered under the Vendor Drug Program.*

36.2.5.1 Medications Small Volume Nebulizer

Prior authorization is not required for purchase of a medication small volume nebulizer (SVN) and related supplies for the conditions listed below.

Conditions
Bronchiectasis - any type
Cystic Fibrosis with pulmonary manifestations
Pneumonia - any type
Influenza
Bronchitis - any type
Emphysema - any type
Asthma - any type
COPD - any type
Pneumoconiosis - any type
Acute, Sub-acute or Chronic respiratory conditions
Respiratory conditions due to radiation, smoke, unspecified and specified external agents
Abnormal sputum
Other diseases of the trachea and bronchus
Tracheostomy Status
Attention to tracheostomy
HIV with pulmonary manifestations
Pneumocystis
Complications of a specified or unspecified transplanted organ, bone marrow, or stem cells
Primary Pulmonary Hypertension
Other Chronic Pulmonary Heart Disease

Note: *Prescribed medications for use with aerosol delivery by SVN may be considered under the Vendor Drug Program.*

SVNs for conditions not listed above require prior authorization with documentation of medical necessity.

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Sterile water, saline, and dextrose, diluent/flush 10 ml does not require prior authorization when requested within the limitations within this chapter.

Documentation for prior authorization must include frequency and duration of need for the nebulizer treatments ordered.

36.2.5.2 Large Volume Nebulizer

Prior authorization is not required for large volume nebulizers (procedure codes A7007 and A7017) used with compressors in humidification systems and may be considered for purchase when medically necessary. Prior authorization with documentation of medical necessity is required for large volume nebulizers that exceed the limitations in this chapter.

If heat is required, a heating element, such as an immersion element, may be added.

The autoclave nebulizer (procedure code E0580) for use with a regulator or flow meter may be considered with prior authorization and documentation of medical necessity.

36.2.5.3 Compressors and other DME used with Large Volume Nebulizers

Prior authorization is required for rental or purchase of compressors (procedure code E0565), nebulizer compressors and heaters (procedure code E0585), or large volume ultrasonic nebulizers (procedure code E0575) when the following criteria is met:

- The client has thick, tenacious secretions
- The client has one of the following medical conditions:
  - Cystic fibrosis
  - Bronchitis
  - A tracheostomy
  - A tracheobronchial stent

Equipment used with a large volume nebulizer to create a humidification system may be considered with prior authorization and documentation of medical necessity.

Procedure code E0565 may be considered when all of the following criteria are met:

- The compressor is needed for the administration of pentamidine using a filtered nebulizer
- The client has one of the following medical conditions:
  - HIV with pulmonary complications
  - Pneumocystosis
  - Complications of organ transplants

36.2.5.4 Filtered Nebulizer

Prior authorization is required for the administration set with small volume filtered pneumatic nebulizers (procedure code A7006) and must include documentation of medical necessity of one of the following conditions:

- HIV
- Complications of organ transplants, unspecified site

The administration set may be considered for other immunodeficiency conditions with prior authorization and documentation of medical necessity.

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36.2.5.5 Ultrasonic Nebulizers

Prior authorization with documentation of medical necessity is required for purchase of ultrasonic nebulizers (procedure code E0574) used for the administration of bronchodilators and other select medication for clients who meet the criteria for a standard nebulizer.

Note: *Speed, convenience, or ease of use is not considered medically necessary.*

The prior authorization request must provide documentation that:

- The client did not have clinical improvement with treatment using a medication small volume nebulizer
- The client was compliant with other nebulizer treatment and medication therapy
- Use of a standard nebulizer has failed to control the client's disease process resulting in emergency room use or hospitalizations

36.2.6 Oxygen Therapy

All oxygen therapy supplies and related equipment requires prior authorization.

Devices used for in-home oxygen therapy including stationary oxygen concentrators, portable compressed gas cylinders, or liquid oxygen reservoir oxygen systems are a benefit when medically necessary and require prior authorization.

Prior authorization may be considered for monthly rental only and must be requested on a completed CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form signed and dated by the client's ordering practitioner. Medical necessity documentation must be submitted with the request.

Oxygen system rental includes, but is not be limited to:

- Oxygen concentrator or oxygen tanks
- Regulator
- Flow meter
- Humidifier
- Cannula or mask
- Tubing

Devices used for in-home oxygen therapy may be considered for the treatment of chronic hypoxemia which may be the result of, but not limited to:

- Bronchopulmonary dysplasia or other respiratory diagnoses due to prematurity.
- Respiratory failure or insufficiency; musculoskeletal weakness, such as that caused by Duchenne's muscular dystrophy or spinal muscle atrophy.
- Diagnosis of cluster headaches.
- Severe lung disease, such as chronic obstructive pulmonary disease (COPD), diffuses interstitial lung disease, cystic fibrosis, bronchiectasis, or widespread pulmonary neoplasm.

Stationary oxygen concentrators are the preferred oxygen therapy home delivery system. If other types of oxygen therapy home delivery systems are required, documentation of medical necessity to support an exception must be provided. The other types of delivery systems include:

- Compressed gas cylinder systems (nonportable tanks).
- Liquid oxygen reservoir systems.

Multiple oxygen types (e.g., liquid and gas) will not be prior authorized concurrently.

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Extensive supplemental humidification systems (procedure code E0550) may be prior authorized separately for monthly rental of oxygen equipment with documentation of medical necessity. The documentation must include all of the following:

- The client has a tracheostomy or tracheobronchial stent
- The client has thick tenacious secretions not responsive to normal levels of humidification provided with routine humidifiers used with regulators or flow meters.
- The client is not currently renting a ventilator
- The client is not currently renting a compressor for the delivery of humidification

All other humidification systems are included in the oxygen monthly rental and will not be prior authorized separately.

Supplies and refills (procedure codes E0441, E0442, E0443, E0444, and E0447) may be prior authorized for those clients who own their own oxygen systems.

Prior authorization of home oxygen therapy for an initial three-month rental period may be considered when a CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form is submitted along with medical necessity documentation that meets one of the oxygen coverage categories below:

- Evidence from the client's treating physician of a determination that the client has severe lung disease or hypoxia-related symptoms that are expected to improve with oxygen therapy.
    - The client's medical diagnosis requiring oxygen therapy
    - The oxygen flow rate
    - An estimate of the frequency, duration of use (e.g., 2 liters per minute, 15 minutes per hour, 12 hours per day) and duration of need (e.g., 3 months)
- A qualifying blood gas assessment may be supported by the results of either pulse oximetry or an arterial blood gas and includes all of the following:
    - Date of testing
    - Results of testing
    - If the blood gas assessment occurred during the client's inpatient hospital stay, a blood gas performed no more than two days before discharge is acceptable
    - If a blood gas is obtained while the client is at home, the assessment must be performed while the client is in a stable chronic state (i.e., not during a period of acute illness or an exacerbation of their underlying disease) within the 30-day period prior to the request for service

Oxygen therapy is available for clients with an eligible condition as outlined below.

> ***Note:*** *Oxygen ordered for "as needed" or "PRN" use does not provide a basis to determine if intermittent oxygen is reasonable and medically necessary for the client. Documentation must support the need for intermittent use of oxygen.*

Prior authorization may be considered for clients of any age with significant hypoxemia with documentation of any of the following:

- An arterial pO2 (partial pressure of oxygen) equal to or less than 55 mm Hg or an arterial oxygen saturation equal to or less than 88 percent, taken at rest, breathing room air
- An arterial pO2 equal to or less than 55 mm Hg or arterial oxygen saturation at or below 88 percent, taken during sleep and lasting for at least 5 continuous minutes for clients who have a pO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake

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- A decrease in arterial pO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation of more than 5 percent, for at least 5 continuous minutes taken during sleep with symptoms or signs reasonably attributable to hypoxemia (e.g., impairment of cognitive processes and nocturnal restlessness or insomnia)
- An arterial pO2 equal to or less than 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a member who demonstrates a pO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, supplemental oxygen may be provided for use during exercise if there is evidence the use of oxygen improves the hypoxemia that was demonstrated during exercise when the client was breathing room air

Prior authorization may be considered for clients who are 20 years of age and younger when evidenced by any of the above or the following documentation:

- A neonate, and premature infant of any age who have not reached their 40th week of gestational maturity with an arterial pO2 of less than 60 mmHg or an arterial oxygen saturation level is less than 92 percent
- An infant with chronic neonatal lung disease with an arterial oxygen saturation equal to or less than 92 percent
- Other medical conditions that may be considered on a case by case basis with supporting documentation from the treating physician supporting the need for oxygen therapy. These requests will be reviewed by the CSHCN Services Program Medical Director or designee. Examples include, but are not limited to:
- Infants with bronchopulmonary dysplasia
- Infants with apnea of prematurity or recurrent cyanotic apneic episodes
- Children with severe pulmonary hypotension
- Children who have sickle cell anemia with respiratory conditions
- Infants or children who have idiopathic pulmonary hypertension with sleep associated desaturations or a documented need for an emergent use of oxygen

Coverage for clients of any age whose arterial pO2 is 56-59 Hg or whose arterial blood oxygen saturation is 89 percent with documentation of any of the following:

- Dependent edema suggesting congestive heart failure (CHF)
- Cor Pulmonale (pulmonary hypertension)
- Erythrocythemia with a hematocrit greater than 56 percent

Coverage for clients with a diagnosis of cluster headaches with documentation of all of the following:

- Neurological evaluation with diagnosis of cluster headache
- Documentation of failed medical therapy

For clients whose only diagnosis is Obstructive Sleep Apnea (OSA), documentation must support that the client's oxygen sleep desaturation was not corrected by CPAP or RADs.

For clients not meeting the above blood gas assessment criteria, a request for oxygen therapy may be submitted with the required documentation along with evidenced based documentation supporting the benefits of oxygen therapy for the client's condition, and a letter of medical necessity from the treating practitioner. Submission of the request and the required documentation does not guarantee approval. These requests will be reviewed by the CSHCN Services Program Medical Director or designee.

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Prior authorization of oxygen therapy after an initial three-month rental period may be considered for periods of six months a time with the submission of all of the following documentation:

- A new CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form
- Documentation of a continued need for oxygen therapy
- Documentation of the client's compliance with the oxygen therapy by the ordering practitioner

Documentation (date of test and results) of a new blood gas assessment using pulse oximetry or arterial blood gas documentation that the client meets the criteria of any of the above defined oxygen category requirements.

For clients not meeting the above criteria, a request for oxygen therapy renewal may be submitted with all of the required medical necessity documentation along with evidenced based documentation demonstrating the benefit of oxygen therapy for the client's condition. These requests will be reviewed on a case by case basis by the CSHCN Services Program Medical Director or designee.

Note: *The initial CSHCN Services Program Prior Authorization Request for Oxygen Therapy Form cannot be used to request oxygen therapy renewal or extension. A new prior authorization form must be submitted for each request.*

36.2.6.1 Stationary Oxygen Systems

Rental of a stationary oxygen system includes, but is not limited to, the nasal cannula or mask, tubing, and a basic bubble humidification system. These supplies will not be prior authorized separately.

The types of covered stationary oxygen delivery systems include:

- Oxygen concentrators
- Compressed oxygen gas cylinder systems
- Liquid oxygen cylinder systems

36.2.6.2 Portable Oxygen Systems

Portable oxygen therapy may be considered for prior authorization when medical necessity documentation indicates that the client requires the use of oxygen in the home and would benefit from the use of a portable oxygen system when traveling outside of the home environment.

Portable oxygen systems will not be considered for prior authorization for travel outside of the home environment for clients who qualify for oxygen usage based solely on oxygen saturation levels during sleep.

The types of covered portable oxygen and portable oxygen related delivery systems include:

- Portable tanks for compressed oxygen gas cylinder systems
- Portable tanks for liquid oxygen cylinder systems
- Home compressor attachment used on an oxygen compressor to fill oxygen tanks
- Portable gaseous oxygen system home compressor
- Portable concentrator systems

36.2.7 Pulse Oximeters

Pulse oximeters may be considered for short or long term rental or purchase with prior authorization when medically necessary for continuous overnight monitoring. A completed CSHCN Services Program Prior Authorization Request for Pulse Oximeter Form must be submitted with documentation of medical necessity.

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A pulse oximeter (procedure code E0445 without modifier U4) required for short-term use, defined as equipment rented up to one per six calendar months, may be a benefit when medically necessary and does not require prior authorization for clients with one of the following conditions:

- When the client is stable and is able to wean from home oxygen or ventilator
- When a change in the client's condition requires an adjustment in the liter flow of their home oxygen treatment
- To determine the client's appropriate home oxygen liter flow for ambulation, exercise, or sleep
- To determine the client's appropriate home oxygen liter flow for those who have neuromuscular disease involving the respiratory muscles, with chronic lung disease, or with severe cardiopulmonary disease

Pulse oximetry for use as a continuous client vital signs monitor or for routine spot checks is not a benefit.

Short-term pulse oximetry that is medically necessary more frequently than once every six months requires prior authorization and documentation of all medical necessity will be considered on a case by case basis. Requests must be submitted on the CSHCN Services Program Prior Authorization Request for Pulse Oximeter Form and include documentation why earlier weaning attempts were unsuccessful and changes in the client's condition since the failed weaning attempt.

A pulse oximeter required for long-term use (procedure code E0445 with modifier U4), defined as periods longer than one calendar month in a six month period, may be a benefit for rental or purchase with documentation of medical necessity. The request must be submitted on a completed CSHCN Services Program Prior Authorization Request for Pulse Oximeter Form.

A long-term pulse oximeter may be prior authorized for monthly rental up to a maximum of six months. Recertification for an additional three-month period may be considered for a maximum of nine months.

Documentation of medical of necessity must include a caregiver or health care provider present who has been trained in use of the oximeter and how to respond to readings in a medically safe and appropriate manner, and the client meets one of the following criteria:

- Client is oxygen or ventilator dependent, is not stable, and therefore has frequent need for changes in oxygen or ventilator settings
- Client frequently experiences respiratory complications and requires equipment that has oxygen saturation monitoring capabilities

Pulse oximeter related supplies are included in the pulse oximeter rental, do not require prior authorization within the defined limits for client-owned equipment, and are limited as follows:

- Disposable pulse oximeter probes (procedure code A4606) are limited to four per month
- Reusable pulse oximeter sensor probes (procedure code A4606 with modifier U5) are limited to one every six months

Pulse oximeter probes (procedure codes A4606 and A4606 with modifier U5) are included in the pulse oximeter equipment rental. Pulse oximeter probes will be denied if billed with pulse oximeter equipment (procedure codes E0445 and E0445 with modifier U4) in the same month of service by any provider.

Prior authorization for purchase of the pulse oximeter at the end of the nine months of rental may be considered, if the continuation of pulse oximeter use is documented to be medically necessary by a physician.

A pulse oximeter may be prior authorized for purchase when a purchase is determined to be more cost effective than leasing the device with supplies.

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Pulse oximetry equipment that has been purchased is anticipated to last a minimum of five years. Replacement of equipment may also be considered for prior authorization when loss or irreparable damage has occurred outside the warranty terms, conditions, and limitations. A copy of the police or fire report, when appropriate, and the measures to be taken to prevent reoccurrence must be submitted with the prior authorization request.

36.2.8 Tracheostomy Tubes and Related Supplies

Tracheostomy tubes and related supplies may be a benefit when medically necessary for clients with a tracheostomy.

Tracheostomy supplies, including inner cannulas, are available for purchase when medically necessary without prior authorization within the benefit limits.

A tracheostomy speaking valve (procedure code L8501) is considered a medically necessary accessory that enhances the function of the tracheostomy and is available for purchase without prior authorization when requested within the benefit limits.

Tracheostomy tubes (procedure codes A7520, A7521, and A7522) are medically necessary for clients with a tracheostomy and are available for purchase with prior authorization.

For the initial tracheostomy tube request, two tubes may be considered for prior authorization in the first month of service (two the same size and one smaller for emergencies).

For the remainder of the initial prior authorization period and for subsequent requests, one tracheostomy tube will be prior authorized per month.

More than one tracheostomy tube per month may be considered on a case-by-case basis with medical documentation supporting why the tracheostomy tube must be changed more frequently in order to meet the client's medical needs.

When requesting prior authorization for non-customized or non-specialized tracheostomy tubes without specialized functions, providers must submit the most appropriate procedure code, no modifier is required.

When requesting prior authorization for specialized, but non-customized tracheostomy tubes with specialized functions, providers submit the request with modifier U1.

When requesting prior authorization for customized tracheostomy tubes, providers must submit the request with modifier U2.

With the use of either modifier U1 or U2, the following documentation is required:

- The manufacturer's retail or invoice pricing information
- A physician statement of the reason the client cannot use a standard tracheostomy tube
- The manufacturer's information on the specialized functions of the tracheostomy tube or the order form describing the customization of the tracheostomy tube

A non-in-line humidification system is acceptable for clients using a tracheostomy collar.

Suction machines, suction canisters, suction tubing, tracheal suction tubes, and oropharyngeal suction catheters are a benefit with documentation of medical necessity to have oral, nasopharyngeal, or tracheal suctioning performed.

36.2.8.1 Tracheostomy Tube Inner Cannula

Clients with a tracheostomy tube with a reusable inner cannula (procedure code A4623) are allowed one reusable inner cannula per month without prior authorization.

Reusable inner cannulas are included in the prior authorization for any custom tracheostomy tube that is approved.

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Requests for more than one reusable inner cannula per month require prior authorization and medical documentation from the client's physician to support the need for more than one reusable inner cannula per month.

Clients with a tracheostomy tube with a disposable inner cannula (procedure code A4623 with modifier U3) are allowed 31 disposable inner cannulas per month without prior authorization.

If more than 31 disposable inner cannulas per month are needed, prior authorization is required and documentation from the client's ordering practitioner must support the medical need.

A tracheostomy speaking valve (procedure code L8501) is considered a medically necessary accessory that enhances the function of the tracheostomy and is limited to one per six months without prior authorization.

36.2.9 Cardiorespiratory Monitor (CRM)

A cardiorespiratory monitor (CRM) is a benefit when medically necessary and may be considered for clients who require moment to moment cardiac and respiratory monitoring due to the potential for sudden unexpected deterioration. Rental of equipment includes all necessary accessories, supplies, adjustments, repairs, and replacement parts.

A CRM with recording feature (procedure code E0619) may be considered for rental without prior authorization for clients who are four months of age and younger for a maximum of two months with documentation of one of the following conditions:

- Central apnea (respiratory control disorders)
- Cardiac rhythm issues

If a two-month rental has expired for clients who are four months of age and younger, continuation may be considered with prior authorization which must include all of the following:

- The client has on-going, documented cardiorespiratory episodes (e.g., apnea or dysrhythmia)
- A physician interpretation, signed and dated by the physician, of the most recent two month's
- CRM data recorded downloads
- A completed CSHCN Services Program Authorization and Prior Authorization Request for Cardio-respiratory Monitor (CRM) Form must be submitted with documentation of medical necessity

A CRM with or without recording feature (procedure codes E0618 or E0619) may be considered for prior authorization for rental or purchase for clients who are five months of age and older with one of the following conditions:

- An episode of apparent life-threatening event (ALTE) in an infant birth through 12 months of age
- Symptomatic central apnea
- Technology dependence such as:
    - Mechanical ventilation
    - Tracheostomy with a critical airway obstruction
    - Assisted ventilation dependence
    - Cardiac dysrhythmia with significant risk of morbidity or mortality

A CRM may be prior authorized initially for monthly rental up to a maximum of six months. Extension for an additional three month rental may be considered for a maximum total of nine months.

Prior authorization for purchase of the CRM at the end of the nine month rental may be considered if the continued use of the pulse oximeter is documented to be medically necessary by a physician.

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Procedure codes A4556 and A4557 for the CRM may be reimbursed for clients with a purchased monitor, procedure code E0618 or E0619, within the last 5 years.

Leads and electrodes for use with a CRM owned by the client must be prior authorized. A physician statement must be submitted with the claim confirming that the client owns the monitor.

36.2.10 Mechanical Ventilation

Positive and negative pressure ventilators (procedure codes E0465, E0466, E0467, and E0468) and related equipment may be considered for rental only with prior authorization and documentation of medical necessity. All requests must include the ventilator settings. Requests for prior authorization must be completed by the ordering practitioner and submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form with documentation of medical necessity.

All ventilators (pressure support with or without invasive interface), related equipment and supplies require prior authorization.

Documentation must support why heated or non-heated humidification (when requested) is medically necessary for use with the mechanical ventilation including the expected outcome.

Mechanical ventilation may be considered for treatment of, but not limited to the following:

- Neuromuscular and/or musculoskeletal diseases and conditions affecting the respiratory muscles
- Thoracic restrictive disease
- Chronic respiratory failure

For rented or client owned ventilators, when heated or non-heated humidification is requested, documentation submitted must support why it is medically necessary for the use with the ventilation.

36.2.11 Negative Pressure Ventilators

Mechanical ventilation may be considered for the treatment of, but not limited to:

- Neuromuscular or musculoskeletal diseases and conditions affecting the respiratory muscles
- Thoracic restrictive diseases
- Chronic respiratory failure

The following table lists covered mechanical ventilation services and benefit limitations for clients who require assisted mechanical ventilation. All items must be requested by the client's treating physician and require prior authorization for rental only:

Service	Rental Limitation
Chest Shell [cuirass or "clam shell" (procedure code E0457)]	1 per month
Chest wrap (procedure code E0459)	1 per month
Dual function respiratory device (procedure code E0468)	1 per month
Invasive home ventilator for clients with a trache-ostomy (procedure code E0465)	1 per month
Multi-function respiratory device (procedure code E0468)	1 per month
Noninvasive positive pressure or volume control ventilator- for clients without a tracheostomy (procedure code E0466)	1 per month

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Rental of a chest shell and chest wrap is limited to once per month for a total of up to six months. Consideration for each additional six months requires prior authorization with documentation of continued medical necessity, client compliance, and maintenance of the client's respiratory status.

A chest shell may be prior authorized for purchase following the initial three-month rental period of the non-invasive negative pressure ventilator depending on the physician's predicted length of treatment and the client's compliance.

A ventilator may be considered for an initial three-month rental period. Following the initial three-month rental period, if the ventilator was effective, it may be considered for ongoing six-month rental periods. A new prior authorization form must be submitted with each request.

The DME provider is responsible for ensuring that there is a contingency plan to manage interruptions in the use of equipment such as emergency situations and mechanical failures that would be life threatening for the client. The contingency plan should include input from the client's physician that takes into account the severity of the client's condition and time restraints in providing emergency support. Back-up ventilators are not paid separately from the primary ventilator in use and are considered to be a part of the primary ventilator DME rental agreement.

36.2.12 Home Ventilators (Any Type) With or Without Invasive Interface

A home ventilator using an invasive interface (procedure code E0465), a non-invasive interface (procedure code E0466), a multi-function respiratory device (procedure code E0467), or a dual function respiratory device (procedure code E0468) may be prior authorized for a rental of an initial period of three months for clients who require assisted mechanical ventilation.

An invasive home ventilator (procedure code E0465) may be prior authorized for rental for those clients who have a tracheostomy and require mechanical ventilation.

A noninvasive positive pressure or volume control ventilator (procedure code E0466) may be prior authorized for rental only for those clients who do not have a tracheostomy and require mechanical ventilation.

A multi-function respiratory device home ventilator (procedure code E0467) may be prior authorized for rental for those clients who require mechanical ventilation with documentation of medical necessity for the multi-function device.

A dual-function respiratory device home ventilator (procedure code E0468) may be prior authorized for rental for those clients who require mechanical ventilation with documentation that also meets the medical necessity criteria for a cough augmentation device.

Requests must be submitted on the CSHCN Services Program Prior Authorization and Authorization Request for Durable Medical Equipment (DME) Form and must be completed by the ordering practitioner and submitted with documentation of medical necessity.

Following the initial rental period of three months, additional requests may be considered for six month intervals at a time with prior authorization, documentation of medical necessity, and documentation of client compliance and effectiveness. A new prior authorization form must be submitted for each request.

The monthly ventilator rental includes all ventilator equipment and related supplies regardless of the client's duration of use, whether 24 hours per day or less including but not limited to:

- Internal filters
- External filters
- Ventilator circuits with an exhalation valve
- High and low pressure alarms
- Humidification systems including supplies and solutions, (e.g., sterile or distilled water)

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- Compressors and supplies
- Tracheostomy tube filters and humidification devices, such as heat moisture exchangers (HME)
- Humidification device
- Resuscitation bag
- Back up ventilator

Note: *Oxygen rental is not considered a ventilator supply and may be considered for separate prior authorization.*

The DME provider is responsible for ensuring that there is a contingency plan to manage interruptions in the use of equipment such as emergency situations and mechanical failures that would be life threatening for the client. The contingency plan should include input from the client's physician that takes into account the severity of the client's condition and time restraints in providing emergency support. Back-up ventilators are not paid separately from the primary ventilator in use and are considered to be a part of the primary ventilator DME rental agreement.

36.2.13 Repair to Client -Owned Equipment

Repairs to client-owned equipment may be prior authorized as needed with documentation of medical necessity.

Note: *Technician fees are considered part of the cost of the repair.*

The CSHCN Services Program or its designee reserves the right to request additional documentation about the need for repairs when there is evidence of abuse or neglect to equipment by the client, client's family, or caregiver. When there is documented proof of abuse or neglect, requests for repairs will not be authorized.

Providers are responsible for maintaining documentation in the client's medical record specifying the repairs and supporting medical necessity.

Documentation must include all the following:

- The date of purchase
- The serial number of the current equipment (as applicable)
- The cause of the damage or need for repairs
- What steps the client or caregiver will take to prevent further damage if repairs are due to an accident
- The cost of purchasing new equipment as opposed to repairing current equipment

Temporary replacement of client owned equipment during the repair may be considered for prior authorization for one month using procedure code K0462.

Labor for repair of client owned equipment may be considered for prior authorization using procedure code K0739 up to a maximum of two hours per day (maximum quantity of 8 units).

Note: *Routine maintenance of rental equipment is the provider's responsibility.*

36.2.14 Aerosol Treatments

Outpatient nebulized aerosol treatments may be a benefit when medically necessary for worsening of an acute or chronic respiratory condition and evidence that the client's breathing is compromised when billed with revenue code B-412 with one following procedure codes in addition to the code for the primary procedure:

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Procedure Codes		
94640	94644	94645

Documentation must be maintained in the client's medical record that supports the need for outpatient aerosol treatment for worsening of the client's respiratory condition and is subject to retrospective review and recoupment.

36.2.15 Diagnostic Testing

Nitric oxide expired gas determination (FeNO) measurement (procedure code 95012) may be a benefit when medically necessary to diagnose or assess asthma and/or to evaluate the client's response to anti-inflammatory therapy. Procedure code 95012 is limited to once per day and must be billed with procedure codes 94010 or 94060.

Revenue code B-419 is a benefit for the hospital when billed with procedure code 95012.

Exhaled NO measurement may be reimbursed when it is utilized to determine responsiveness to anti-inflammatory steroid treatment for clients with chronic respiratory symptoms possibly due to eosinophilic airway inflammation as follows:

- To assist is assessing the etiology of respiratory symptoms
- To help identify the eosinophilic asthma phenotype
- To assess potential response or failure to respond to anti-inflammatory agents, particularly inhaled corticosteroids (ICS)
- To establish a baseline FeNO during non-exacerbations for subsequent monitoring of chronic persistent asthma
- To guide changes in dosing of anti-inflammatory medications: step down dosing, step-up dosing, or discontinuation of anti-inflammatory medications
- To assist in evaluation of compliance with use of anti-inflammatory medications
- To assess whether airway inflammation is contributing to respiratory symptoms

If expired NO determination is measure during an office visit and additional evaluation and management (E&M) components are billed, a separate E&M procedure code may be reimbursed using modifier 25.

> ***Note:*** *Procedure code 95012 is reimbursed as a global service and cannot be separated into technical and professional components because the instrument produces an exhaled NO value requiring little interpretation.*

36.2.16 Other Equipment

All other respiratory equipment must be authorized. Documentation of medical necessity for the item must accompany the claim.

36.3 Claims Information

DME services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Modifier RR must be used for DME rental equipment, and modifier NU must be used for the purchase of new DME equipment.

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Home health DME providers must use benefit code DM3 on all claims and authorization requests. All other providers must use benefit code CSN on all claims and authorization requests.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

Refer to: Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information about electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims filing.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing and may be left blank.

36.4 Reimbursement

Respiratory equipment may be reimbursed the lower of either the billed amount or the amount allowed by Texas Medicaid.

Reimbursement of rented equipment includes all of the supplies, accessories, adjustments, repairs, and replacement parts needed during the rental period.

Respiratory equipment that has been purchase is anticipated to last a minimum of five years and may be considered for replacement when five years have passed or the equipment is no longer repairable.

Replacement of equipment may also be considered when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and measures to be taken to prevent reoccurrence must be submitted with the request.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website atwww.tmhp.com/resources/rate-and-code-updates/rate-changes.

Note: *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

36.5 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.

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