The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and i

b. Intolerance of CPAP pressures necessary to correct obstructive sleep apnea (OSA) component (ie, difficulty exhaling against fixed airway pressure)
c. Lack of resolution of hypercarbia, nocturnal desaturation, and OSA despite 3 months of CPAP use
d. Titration study demonstrates OSA despite CPAP 15 cm H_2O (1471 Pa) that is responsive to BiPAP

3. Daytime hypercapnia with $PaCO_2$ greater than 45 mm Hg (6.0 kPa) without other etiology (eg, kyphoscoliosis, lung parenchymal disease, myopathy, severe hypothyroidism)
4. Sleep-disordered breathing or hypoventilation on polysomnography, as indicated by **ONE OR MORE** of the following:
   a. Apnea-hypopnea index of 5 or greater
   b. Increase in $PaCO_2$ during sleep by more than 10 mm Hg (1.3 kPa) above value while awake
   c. Significant oxygen desaturation (eg, less than 90%) not explained by obstructive apneas or hypopneas
5. TSH level does not demonstrate hypothyroidism

F. OSA in child or adolescent and **ONE OR MORE** of the following:
1. Mild OSA (ie, apnea-hypopnea index from 1 to 5) and **ONE OR MORE** of the n0000]TJETQ0 following:
   a. achondroplasia
   b. behavioral problems
   c. cardiovascular disease (eg, elevated blood pressure, pulmonary hypertension)
   d. Chiari malformation
   e. craniofacial abnormalities
   f. Down Syndrome
   g. excessive daytime sleepiness
   h. impaired cognition
   i. inattention or hyperactivity
   j. mucopolysaccharidoses
   k. neuromuscular disorders
   l. Prader-Willi syndrome
2. Moderate or severe OSA (ie, apnea-hypopnea index greater than 5)
3. Residual apnea-hypopnea index greater than 5 in pediatric patient after adenotonsillectomy

G. Restrictive disorder of chest wall, as indicated by **ALL** of the following:
1. hyeW*ntlowing:

xcessive daytime sleepiness

2.

3. Inspiratory flows delivered by device not appropriate for patient.
4. Patient does not meet ventilator minimum body weight requirements.
5. Pressure range (eg, expiratory pressure, inspiratory pressure) not appropriate for patient.
6. Tidal volume range delivered by device not appropriate for patient.
7. Ventilator inspiratory trigger delay (ie, airway pressure rise time) not appropriate for patient.
8. Ventilator inspiratory trigger sensitivity not appropriate for patient.

D. The following setting or functionality is required by the member and is not available with simple BiPAP device:
   1. Alarms required by member are not available on the device.
   2. Daytime ventilation using mouthpiece is required.
   3. Pressure range delivered by device is not appropriate for member.
   4. Member requires volume-assured pressure support or volume control mode (eg, obesity hypoventilation syndrome).

E. Ventilated patient requires cough assistance via volume ventilator's breath stacking capability.

F. Ventilation is required 24 hours per day.

V. HMV Continued Use

For HMV continued use beyond the initial 3-month determination, medical necessity must be reestablished every 6 months thereafter. The following is to be provided for continued use:

A. Re-evaluation by the treating medical professional must be completed no earlier than 61 days after initiating therapy.

B. Documentation of the persistence of the disease process for which HMV has been prescribed.

C. Medical records must document that the member is compliant with and benefitting from HMV.

D. At least 30 consecutive days of device data, beginning after 31 days of initiation, demonstrating that the member is utilizing the device an average of 4 hours per 24-hour period. **NOTE:** Failure of the member to consistently use HMV for an average of 4 hours per 24-hour period would demonstrate non-compliant utilization of the device for its intended purpose and expectation of benefit, which would constitute a denial in continued coverage as *not reasonable and necessary*.

E. Additional information as requested.

VI. In accordance with Rule 5160-10-01 for each claim, the provider cannot legitimately receive payment until necessary supporting documents have been obtained and placed in the provider’s files. These documents include the prescription and the following items:

A. A completed CMN form: ODM 01902.

B. Practitioner order and chart notes, which support the determination of medical necessity.

7. Gay PC. Nocturnal ventilatory support in COPD. UpToDate. Updated January 4, 2024. Accessed May 16, 2024. www.uptodate.com
8. Gay PC, Owens RL; ONW*nBT2 792 reW*n:q5(pT( )6(Teqh(;)-O)-4c)-4(i)5(l)Eqxpe4(4)rq0.(i)5(l)5(pT

The MEDICAL Policy Statement detailed above has received due consideration as de