Sentara® Health Plans

Commercial

Second Ventilator

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Effective Date	06/2000
Next Review Date	08/2024
Coverage Policy	DME 51
Version	5

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Purpose:

This policy addresses a Second Ventilator.

Description & Definitions:

A ventilator is an apparatus used to move breath in and out of an individual's lungs that cannot do so unassisted.

Criteria:

A second ventilator in the home setting is considered medically necessary with **1 of the following**:

- An individual requires one type of ventilator (e.g., a negative pressure ventilator with a chest shell) for part of the day and needs a different type of ventilator (e.g., positive pressure ventilator with a nasal mask) during the rest of the day.
- An individual is confined to a wheelchair and requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without both pieces of equipment, the individual may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.
- The individual is on a ventilator 12 hours or more continuously per day
- The individual lives in an area where a replacement ventilator cannot be provided within two (2) hours
- For individuals who require mechanical ventilation during mobility, as prescribed in their plan of care.

Coding:

Medically necessary with criteria:

Coding	Description
E0465	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466	Home ventilator, any type, used with noninvasive interface, (e.g., mask, chest shell)
E0467	Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions

Considered Not Medically Necessary:

Coding	Description
	None

Document History:

Revised Dates:

- 2019: November
- 2018: November
- 2015: July
- 2014: June, October
- 2013: June, August
- 2012: March, June
- 2011: September, October
- 2010: June, September
- 2008: June
- 2005: February, May
- 2004: November
- 2003: March, September

Reviewed Dates:

- 2023: August
- 2022: August
- 2021: November
- 2020: October
- 2019: October
- 2018: September
- 2017: November
- 2016: July
- 2015: June
- 2011: June
- 2009: June
- 2007: December
- 2004: September, October
- 2003: January, August
- 2002: April, October
- 2001: June

Effective Date:

- June 2000

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

MUST SEE MEMBER BENEFIT FOR DETERMINATION.
We only cover DME that is Medically Necessary and prescribed by an appropriate Provider. We also cover colostomy, ileostomy, and tracheostomy supplies, and suction and urinary catheters. We do not cover DME used primarily for the comfort and wellbeing of a Member. We will not cover DME if We deem it useful, but not absolutely necessary for Your care. We will not cover DME if there are similar items available at a lower cost that will provide essentially the same results as the more expensive items.

Pre-Authorization is Required for All Rental Items.

Pre-Authorization is Required for All Repair and Replacement.

Keywords:

SHP Second Ventilator, SHP Durable Medical Equipment 51, negative pressure ventilator, positive pressure ventilator