MEDICAL REVIEW GUIDELINE
Dual-Function Home Ventilator (E0468)

Adopted by Medical Care Management Committee on 8/28/2025
MCMC Approval Date: 10/15/2026

COMMUNITY HEALTH CHOICE
COMMUNITY CARES

Dual-Function Home Ventilator (E0468)

This Medical Review Guideline (Guideline) is provided for informational purposes only and does not constitute medical advice. It is intended solely for the use of Community Health Choice, Inc. (Community) clinical staff as a guideline for use in determining medical necessity of requested procedures and therapy. This Guideline does not specifically address eligibility or benefit coverage. Other Policies and Coverage Determination Guidelines may apply. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Review Guideline. If there is a discrepancy between this Guideline and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern. Community reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

APPLIES TO

☐ STAR
☐ CHIP/CHIP-P
☒ Health Insurance Marketplace
☐ Medicare Advantage (i.e. D-SNP)
☐ STAR+PLUS

PURPOSE

The overall purpose of this guideline is to facilitate the utilization management process by providing an overview of how Community appropriately determines medical necessity of a home dual-function ventilator for the Marketplace Population. This policy was written because there is no InterQual review criteria subset for HCPCS code E0468.

For Medicaid, see Texas Medicaid Provider Procedures Manual (TMPPM) for criteria.
For Medicare, see National Coverage Determination (NCD) and Local Coverage Determination (LCD)

This Guideline is intended to facilitate the utilization management process by providing an overview of how Community appropriately determines medical necessity. The goal of Community in adopting this guideline is not to disrupt the physician-patient relationship nor to diminish physician autonomy. Instead, it is to promote patient safety and improved clinical outcomes through the adherence to evidence-based practices. Community has developed this Guideline via an ongoing process that includes a review of the most current evidence-based literature and input from clinical and program staff, and often from external clinical experts. Deeming a particular service or supply medically necessary, does not guarantee that the service or supply is covered and will be paid by Community for a particular member.

HCPCS Code	Description
E0468	Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions.

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GUIDELINE

The use of a dual-function ventilator is for life-threatening conditions requiring sustained mechanical support, not intermittent respiratory assistance.

A dual-function ventilator is considered medically necessary for an individual who meets the medical necessity coverage criteria for a home ventilator **AND** has a requirement for cough assist device.

A dual-function ventilator is not intended for use as a CPAP or RAD. However, a home ventilator may be considered when documentation of medical necessity explaining why CPAP or RAD is not medically appropriate for the member.
This guideline does not address other ventilators E0465, E0466, E0467. See InterQual criteria.

This guideline does not address the use of respiratory assist devices including BiPAP or CPAP. Positive pressure ventilators can be set up to function in a bi-level mode. An invasive ventilator should not be provided when a bi-level device with and without back up meets the members' needs.

PROCESS FOR REVIEW

MEDICAL NECESSITY

1. This ventilator (E0468) is a rental only DME and requires on-going rental period authorizations.
2. For other ventilators (E0465-E0467), see InterQual criteria.
3. Qualifying conditions: These conditions affect the respiratory musculature, causing a weak, ineffectual, or absent cough. Ventilators are covered for conditions such as:
    - ***Neuromuscular diseases*** affecting the muscles of respiration. Examples include muscular dystrophies, multiple sclerosis, spinal cord injuries, spinal muscular atrophy, diaphragmatic paralysis, myasthenia gravis, and amyotrophic lateral sclerosis.
    - ***Thoracic restrictive diseases*** such as a group of conditions that limit the lungs' ability to expand, impacting breathing and oxygen intake. These disorders can stem from issues within the lungs (intrinsic) such as sarcoidosis, radiation therapy and pulmonary fibrosis or conditions affecting the chest wall, e.g., severe kyphoscoliosis, asphyxiating thoracic dystrophy, pectus excavatum, Parkinson's disease
    - ***Lung disease such as*** chronic obstructive pulmonary disease (COPD) or cystic fibrosis
    - ***Other chronic respiratory or neuromuscular conditions*** that are severe enough that failure of respiratory support would be life-threatening.

A. Initial Authorization

1. Initial rental authorization of the device is for 90 days (i.e. 3 months).
2. Related accessories are included in the monthly rental payment and cannot be billed separately

3. Documentation includes all of the following:
   - Ordered by a physician, physician assistant or nurse practitioner
   - The member must meet the medical necessity criteria for both a mechanical ventilator and the integrated cough augmentation device. Documentation from the treating provider is required to establish this medical necessity (see qualifying conditions above).
   - The member's medical record must provide documentation that less intensive therapies (such as BiPaP) has failed or is insufficient for the member's condition.

B. Subsequent Authorization(s)

1. Repeat (ongoing) rental authorization can be up to 6 months.
2. The dual-function ventilator is considered medically necessary for continued use when the following criteria are met:
   - The pretreatment clinical condition met initial criteria
   - There is documentation of compliant usage

NOT MEDICALLY NECESSARY

A home ventilator device (HCPCS E0468) is considered NOT medically necessary for any of the following:

- A non-life-threatening condition
- Treatment for obstructive sleep apnea. The clinical outcomes have not been shown to be superior to other standard treatments (e.g., CPAP, BPAP)
- When the sole purpose of the home ventilator is to function as a respiratory assistance device (RAD) including continuous positive airway pressure (CPAP), auto-titrating PAP (APAP), bilevel positive airway pressure (BPAP, BiPAP), etc.

ACCESSORIES/RELATED SUPPLIES		
E0468 is defined as including "all accessories, components, and supplies for all functions". This means that related supplies needed for the device's function, like tubing and masks, are included in the coverage for the primary code. The following HCPCS codes are considered bundled (i.e. included) in the monthly rental of a dual-function home ventilator.		
A4216	A4217	A4481
A4483	A4604	A4611
A4613	A4618	A7020
A7027	A7028	A7029
A7030	A7031	A7032
A7033	A7034	A7035
A7036	A7037	A7038
A7039	A7046	E0465

E0466	E0470	E0471
E0472	E0482	E0561
E0562	E0562	

REFERENCES

1. National Coverage Determination (NCD): Noninvasive Positive Pressure Ventilation (NIPPV) in the Home for the Treatment of Chronic Respiratory Failure (CRF) Consequent to Chronic Obstructive Pulmonary Disease (COPD). 240.9

2. Agency for Healthcare Research and Quality (AHRQ). Evidence-based Practice Centers (EPC) Reports. Technology Assessment Program. Noninvasive Positive Pressure Ventilation in the Home. Project ID: PULT0717. Final report 2/04/2020. Accessed August 28, 2025.

3. National Coverage Determination (NCD) National Durable Medical Equipment (280.1) Revision effective date: 06/09/2025. Accessed October 9, 2026.

4. Local Coverage Determination (LCD) Respiratory Assist Devices (L33800) Revision date: 06/09/2025. Accessed October 9, 2026.

6. CGS Administrators, LLC. Correct Billing and Coding of Ventilators; Accessed October 9, 2026.

7. UptoDate: Respiratory muscle weakness due to neuromuscular disorder: Management, updated September 29, 2026. Accessed October 9, 2026.

8. Respiratory Management of Patients With Neuromuscular Weakness: An American College of Chest Physicians Clinical Practice Guideline and Expert Panel Report. Chest. 2023. Khan A, Frazer-Green L, Amin R, et al. Accessed October 9, 2026.

This Guideline is reviewed annually and is approved by the Medical Care Management Committee.

Policy History (reviews and revisions)	Date	Approval Date
Policy developed	08/28/2025	09/18/2025
Reviewed. No changes in policy content. References reviewed and updated.	10/09/2026	10/15/2026