WAC 182-552-0500 Respiratory care—Covered—Bi-level respiratory assist devices and supplies. (1) The medicaid agency covers, without prior authorization, one bi-level respiratory assist device (RAD), with or without a back-up rate feature, per client every five years. The client must have a clinical disorder characterized as one of the following and meet the clinical criteria for the specific condition as listed in subsections (2) through (5) of this section.

(a) Restrictive thoracic disorders (e.g., neuromuscular diseases or severe thoracic cage abnormalities); or

(b) Severe chronic obstructive pulmonary disease (COPD); or

(c) Central sleep apnea or complex sleep apnea; or

(d) Hypoventilation syndrome.

(2) Restrictive thoracic disorders - The medicaid agency pays for, without prior authorization, a bi-level RAD either with or without the back-up rate feature, when all of the following clinical criteria are met:

(a) The client has been diagnosed with a neuromuscular disease (e.g., amyotrophic lateral sclerosis (ALS)) or a severe thoracic cage abnormality (e.g., post-thoracoplasty for tuberculosis); and

(b) Chronic obstructive pulmonary disease (COPD) does not contribute significantly to the individual's pulmonary limitation; and

(c) One or more of the following criteria are met:

(i) An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2 (fractionated inspired oxygen concentration) is greater than or equal to forty-five mm Hg; or

(ii) Sleep oximetry demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five minutes of nocturnal recording time (minimum record time of two hours), done while breathing the client's prescribed recommended FIO_2; or

(iii) For a neuromuscular disease (only), either of the following:

(A) Maximal inspiratory pressure is less than sixty cm H_2O; or

(B) Forced vital capacity is less than or equal to fifty percent predicted.

(3) Severe chronic obstructive pulmonary disease (COPD).

(a) The medicaid agency pays, without prior authorization, for a bi-level RAD, without the back-up rate feature, when all of the following clinical criteria are met:

(i) An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, is greater than or equal to fifty-two mm Hg; and

(ii) Sleep oximetry demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five minutes of nocturnal recording time (minimum recording time of two hours), done while breathing oxygen at two LPM or the client's prescribed FIO_2, whichever is higher; and

(iii) Prior to initiating therapy, obstructive sleep apnea and treatment with CPAP has been considered and ruled out.

(b) The medicaid agency pays, without prior authorization, for a bi-level RAD, with the back-up rate feature, for clients with COPD who qualified for a bi-level RAD under (3)(a) of this section when:

(i) Started any time after a period of initial use of the bi-level RAD without the back-up rate feature when both of the following clinical criteria are met:

(A) An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, shows that the client's $PaCO_2$ worsens greater than or equal to seven mm Hg compared to the original result from criterion in subsection (3)(a)(i) of this section; and

(B) A facility-based PSG demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five minutes of nocturnal recording time (minimum recording time of two hours) while using a bi-level RAD without the back-up rate feature that is not caused by obstructive upper airway events, i.e., AHI less than five; or

(ii) Started at a time no sooner than sixty-one days after initial issue of the bi-level RAD without the back-up rate feature, when both of the following clinical criteria are met:

(A) An arterial blood gas $PaCO_2$ is done while awake and breathing the client's prescribed FIO_2, still remains greater than or equal to fifty-two mm Hg; and

(B) Sleep oximetry while breathing with the bi-level RAD without back-up rate feature, demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five minutes of nocturnal recording time (minimum recording time of two hours), done while breathing oxygen at two LPM or the client's prescribed FIO_2, whichever is higher.

(4) Central sleep apnea or complex sleep apnea (i.e., not due to airway obstruction). The medicaid agency pays for, without prior authorization, a bi-level RAD with or without the back-up rate feature, when the client's polysomnogram test reveal all of the following:

(a) The diagnosis of central sleep apnea (CSA) or complex sleep apnea (CompSA);

(b) Significant improvement of the sleep-associated hypoventilation with the use of a bi-level RAD with or without the back-up rate feature on the settings that will be prescribed for initial use at home, while breathing the client's prescribed FIO_2.

(5) Hypoventilation syndrome.

(a) The medicaid agency pays for, without prior authorization, a bi-level RAD without the back-up rate feature, when the clinical criteria in (a)(i) and (ii) of this subsection, or either (a)(iii) or (iv) of this subsection are met:

(i) An initial arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, is greater than or equal to forty-five mm Hg; and

(ii) Spirometry shows an FEV1/FVC greater or equal to seventy percent and an FEV1 greater than or equal to fifty percent of predicted; or

(iii) An arterial blood gas $PaCO_2$, done during sleep or immediately upon awakening, and breathing the client's prescribed FIO_2, shows the client's $PaCO_2$ worsened greater than or equal to seven mm Hg compared to the original result in (a) of this subsection; or

(iv) A facility-based PSG demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five continuous minutes of nocturnal recording time (minimum recording time of two hours) that is not caused by obstructive upper airway events, i.e., AHI less than five.

(b) The medicaid agency pays for, without prior authorization, a bi-level RAD with the back-up rate feature, when the clinical criteria

in (b)(i) and (ii) of this subsection, and either (b)(iii) or (iv) of this subsection are met:

(i) A covered bi-level RAD without the back-up rate feature is being used; and

(ii) Spirometry shows an FEV1/FVC greater than or equal to seventy percent and an FEV1 greater than or equal to fifty percent of predicted; and

(iii) An arterial blood gas $PaCO_2$, done while awake and breathing the client's prescribed FIO_2, shows that the client's $PaCO_2$ worsens greater than or equal to seven mm Hg compared to the ABG result performed to qualify the client for the bi-level RAD without the back-up rate feature; or

(iv) A facility-based PSG demonstrates oxygen saturation less than or equal to eighty-eight percent for greater than or equal to five continuous minutes of nocturnal recording time (minimum recording time of two hours) that is not caused by obstructive upper airway events, i.e., AHI less than five while using a bi-level RAD without the back-up rate feature.

(6) For a bi-level RAD without the back-up rate feature, the medicaid agency pays as follows:

(a) An initial three-month rental period. In accordance with medicare's guidelines, the medicaid agency requires a face-to-face clinical reevaluation of the client by the treating authorized prescriber, between day thirty-one and day ninety-one of the rental period, which documents the following in the client's file to continue rental:

(i) The progress of the client's relevant symptoms; and

(ii) The client's compliance with using the device.

(b) Purchases after the requirements of (a) of this subsection are met.

(7) For a bi-level RAD with the back-up rate feature used with:

(a) An invasive interface, the medicaid agency pays for the rental only.

(b) A noninvasive interface, the medicaid agency pays as follows:

(i) An initial three-month rental period. In accordance with medicare's guidelines, the medicaid agency requires a face-to-face clinical reevaluation of the client by the treating authorized prescriber, between day thirty-one and day ninety-one of the rental period, which documents the following in the client's file to continue rental:

(ii) The progress of the client's relevant symptoms; and

(iii) The client's compliance with using the device.

(iv) Purchase after a total of thirteen months of rental.

(8) Prior authorization is required if the client does not meet the clinical criteria in this section or if the medicaid agency has purchased a CPAP device or other respiratory assist device for the client within the last five years.

(9) Replacement of bi-level RAD. The medicaid agency's policy for replacement of a bi-level RAD is the same as for a CPAP device. See WAC 182-552-0400(6).

[Statutory Authority: RCW 41.05.021. WSR 12-14-022, § 182-552-0500, filed 6/25/12, effective 8/1/12.]