Policy

The Medical Management Department reviews referral requests for authorization of airway clearance devices including high frequency chest wall compression vests and mechanical insufflation-exsufflation devices (e.g., cough assist devices).

This Medical Policy does not constitute medical advice. When deciding coverage, the enrollee’s specific plan document must be referenced. The terms of an enrollee’s plan document (Certificate of Coverage (COC) or Summary Plan Description (SPD)) may differ from this Medical Policy. In the event of a conflict, the enrollee’s specific benefit plan document supersedes this Medical Policy. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements, and the plan benefit coverage prior to use of this Medical Policy. Other Policies and Coverage Determination Guidelines may apply. Quartz reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Procedure

A. Documentation Required:
   In order to facilitate the authorization process referral requests must include ALL of the following:
   1. Order from a Pulmonologist or Transplant Surgeon;
   2. Confirmation of diagnosis:
      a. Cystic fibrosis; OR
      b. Lung transplantation within the previous six months; OR
      c. Bronchiectasis confirmed by high-resolution CT scan; OR
      d. Neuromuscular disease meeting criteria in B.1.c below.
   3. Documentation of failed response to standard therapy(s).

B. Medical Necessity Criteria for Rental of a High Frequency Chest Wall Compression System:
   1. Up to 6 months rental of a high-frequency chest compression system is considered medically necessary in lieu of chest physiotherapy for ANY of the following indications, where there is a well documented failure of standard treatments to adequately mobilize retained secretions:
      a. Bronchiectasis, confirmed by CT scan, characterized by daily productive cough for at least 6 continuous months or by frequent (i.e., more than 2 times/year) exacerbations requiring antibiotic therapy; OR
      b. Lung transplant recipients within the first six months post-transplant if they are physically unable to tolerate standard manual CPT; OR
      c. Cystic fibrosis or immotile cilia syndrome; OR
      d. The member has a neuromuscular disease diagnosis that is causing impaired ability to cough due to respiratory muscle weakness or pulmonary restriction (see examples below):
         i. Acid maltase deficiency;
         ii. Anterior horn cell diseases, including amyotrophic lateral sclerosis;
         iii. Hereditary muscular dystrophy;
iv. Multiple sclerosis;
v. Myotonic disorders;
vi. Other myopathies;
vii. Paralysis of the diaphragm;
viii. Post-polio;
ix. Quadriplegia regardless of underlying etiology;
x. Spinal Muscular Atrophy (SMA)

C. Medical Necessity Criteria for Rental of a Mechanical Insufflation-Exsufflation Device
Up to 6 months trial rental of a mechanical insufflation-exsufflation device is considered medically necessary for mobilizing respiratory tract secretions when BOTH of the following criteria are met:

1. neuromuscular disease that is causing impaired ability to cough due to respiratory muscle weakness or pulmonary restriction (see examples below):
   i. Acid maltase deficiency;
   ii. Anterior horn cell diseases, including amyotrophic lateral sclerosis;
   iii. Hereditary muscular dystrophy;
   iv. Multiple sclerosis;
   v. Myotonic disorders;
   vi. Other myopathies;
   vii. Paralysis of the diaphragm;
   viii. Post-polio;
   ix. Quadriplegia regardless of underlying etiology;
   x. Spinal Muscular Atrophy (SMA); AND

2. Well documented failure of standard treatments to adequately mobilize retained secretions

D. Purchase of a High Frequency Chest Wall Compression Vest or Mechanical Insufflation-Exsufflation Device is medically necessary when BOTH of the following criteria are met
1. Documentation of compliance with use of the device; AND
2. Well documented improvement in respiratory symptoms.

E. Indications Considered Experimental, Investigational or not Medically Necessary:
1. Diagnosis of chronic obstructive pulmonary disease (COPD)
2. High-frequency oscillation therapy for treatment of secretion induced atelectasis (E&I)

HCPCS Codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>E0482</td>
<td>Cough stimulating device, alternating positive and negative airway pressure</td>
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<tr>
<td>E0483</td>
<td>High frequency chest wall oscillation air-pulse generator system (includes hoses and vest) each</td>
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References:


Warnock L, Gates A. Chest Physiotherapy compared to no chest physiotherapy for cystic fibrosis. Cochrane Database of Systemic Reviews. 21 December 2015, Accessed August 20, 2019
