

## High Frequency Chest Wall Oscillation Devices

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<b>Approved By:</b>	Highmark Health Options – Market Leadership
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<b>Products:</b>	Medicaid
<b>Application:</b>	All participating hospitals and providers
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### Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

### POLICY STATEMENT

Highmark Health Options may provide coverage under medical surgical benefits of the Company's Medicaid products for medically necessary high frequency chest wall oscillation devices.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

### DEFINITIONS

**Highmark Health Options (HHO)** – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children's Program (DHCP) and Diamond State Health Plan Plus LTSS (DSHP Plus LTSS) members.

**High frequency chest wall oscillation (HFCWO) Device (e.g., ABI Vest Airway Clearance System, Therapy Vest)** – An airway clearance device consisting of an inflatable vest connected by tubes to a small air-pulse generator.

### PROCEDURES

A prior authorization is required.

High frequency chest wall oscillation devices (HFCWO) may be considered medically necessary for individuals: when ANY of the following criteria are met:

- Diagnosis of cystic fibrosis; or
- Diagnosis of bronchiectasis, which has been confirmed by CT scan which is characterized by:
  - Daily productive cough for at least six (6) continuous months; or
  - Frequent (i.e., more than two (2)/year) exacerbations requiring antibiotic therapy. (Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion); or
- The individual has one of the following neuromuscular disease diagnoses:
  - Acid maltase deficiency (Pompe Disease); or
  - Anterior horn cell diseases; or
  - Multiple sclerosis; or
  - Quadriplegia; or
  - Hereditary muscular dystrophy; or
  - Myotonic disorders; or
  - Other myopathies; or
  - Paralysis of the diaphragm; and
- There must be well-documented failure of standard treatments to adequately mobilize retained secretions or valid reasons why standard chest physiotherapy cannot be performed (such as inability of caregiver to perform), is unavailable or not tolerated.

HFCWO devices not meeting the criteria as indicated in this policy are considered not medically necessary. Replacement supplies used with individual owned equipment may be considered medically necessary if the individual meets the criteria listed above for the base device.

**NONCOVERED**

Volara system with in-line ventilator adaptor (OPTIMUS Handset 2) and Volara patient circuit kit (OPTIMUS OLE AC Patient Circuit Kit) device is not covered.

**POST-PAYMENT AUDIT STATEMENT**

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

**PLACE OF SERVICE: OUTPATIENT**

The use of a High Frequency Chest Wall Oscillation Device is typically an outpatient procedure which is only eligible for coverage as an inpatient procedure in special circumstances, including, but not limited to, the presence of a comorbid condition that would require monitoring in a more controlled environment such as the inpatient setting.

**CODING REQUIREMENTS**

**COVERED CODES**

CPT code	Description
A7020	Interface for cough stimulating device, includes all components, replacement only.
A7025	High frequency chest wall oscillation system, vest, replacement for use with patient owned equipment, each.
A7026	High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each.

<b>E0482</b>	Cough stimulating device, alternating positive and negative airway pressure.
<b>E0483</b>	High frequency chest wall oscillation system, includes all accessories and supplies, each.

**COVERED DIAGNOSIS CODES**

Codes						
A15.0	B91	D81.810	D84.1	E84.0	E84.9	G12.0
G12.1	G12.8	G12.9	G12.20	G12.21	G12.22	G12.29
G14	G35	G71.0	G71.00	G71.01	G71.02	G71.09
G71.20	G71.21	G71.220	G71.228	G71.29	G71.3	G71.8
G71.11	G71.12	G71.13	G71.14	G71.19	G72.0	G72.1
G72.2	G72.89	G73.7	G82.50	G82.51	G82.52	G82.53
G82.54	J47.0	J47.1	J47.9	J98.6	M33.02	M33.12
M33.22	M33.92	M34.82	M35.03	Q33.4		

**REIMBURSEMENT**

Participating facilities will be reimbursed per their Highmark Health Options contract.

**Reference**

Lechtzin, N. The Impact of High-Frequency Chest Wall Oscillation on Healthcare Use in Patients with Neuromuscular Diseases. *AnnalsATS*. 2016;13(6): 904-909.

Huang, W. High-frequency chest wall oscillation in prolonged mechanical ventilation patients: a randomized controlled trial. *The Clin Resp J*. 2016: 272-284.

Hayes, Inc. High Frequency Chest Wall Compression for Diseases Other than Cystic Fibrosis. Publication date: August 11, 2016. Annual Review March 5, 2018.

Hayes, Inc. High-Frequency Chest Wall Compression for Cystic Fibrosis. Publication date: December 22, 2016. Annual Review March 13, 2019. Accessed April 7, 2020.

Mikesell C, Kempainen R, Laguna T, et. al. Objective Measurement of Adherence to Out-Patient Airway Clearance Therapy by High-Frequency Chest Wall Compression in Cystic Fibrosis. *Respir Care*. 2017 Jul;62(7):920–927.

Seifer FD, Hansen G, Weycker D. Health care utilization and expenditures among patients with comorbid bronchiectasis and chronic obstructive pulmonary disease in US clinical practice. *Chron Resp Dis*. 2019; 16:1-8.

Sancho J, Bures E, Ferrer S, et al. Mechanical insufflation-exsufflation with oscillations in amyotrophic lateral sclerosis with home ventilation via tracheostomy. *Resp Care*. 2021; 66(3):378-382.

United States Food and Drug Administration. 2022. Baxter Healthcare Corporation Recalls Volara System for Risk of Respiratory Distress in Ventilated Patients During Home Use. Retrieved from [Baxter Healthcare](#)

[Corporation Recalls Volara System For Risk Of Respiratory Distress In Ventilated Patients During Home Use | FDA](#)

**POLICY UPDATE HISTORY**

10/27/2021	Approved in Medical Policy Committee
12/2021	Approved in QI/UM
10/26/2022	Annual review; approved in medical policy committee
11/2022	Approved in QI/UM