OHCA Guideline

Medical Procedure Class:	**ABI Vest/High Frequency Chest Wall Oscillation Device**
Initial Implementation Date:	4/10/2017
Last Review Date:	5/25/2022
Effective Date:	6/1/2022
Next Review/Revision Date:	May 2025

Reviewed By

* This document is not a contract, and these guidelines do not reflect or represent every conceived situation. Although all items contained in these guidelines may be met, this does not reflect, or imply, any responsibility of this agency or department to change the plan provision to include the stated service as an eligible benefit.

☐ New Criteria ☒ Revision of Existing Criteria

Summary

Purpose:	To provide guidelines to assure medical necessity and consistency in the prior authorization process.

Definitions

Cystic Fibrosis (CF) - an inherited disease characterized by the buildup of thick, sticky mucus that can damage many of the body's organs. The disorder's most common signs and symptoms include progressive damage to the respiratory system and chronic digestive system problems. The feature of the disorder and their severity varies among affected individuals.

Bronchiectasis – a form of chronic obstructive pulmonary disease (COPD) in which the large airways of the lungs (bronchi) become damaged and widened. Mucous can collect in these dilated airways, allowing bacteria to grow and cause recurrent lung infections. The disease may be localized to one area of a lung, or generalized throughout both lungs, e.g., central or diffuse disease.

Description

High Frequency Chest Wall Oscillation Device – a product designed to assist in the mobilization of retained pulmonary secretions. It operates on the principle of chest percussion, but allows the individual to self-administer the required treatment. It consists of an inflatable vest, worn by the member, that is connected by tubes to an air pulse generator. The high, intense, percussive action of the vest dislodges and facilitates mucus movement. This therapy may be used in conjunction with a cough assist device.

HCPCS Codes Covered Requiring Prior Authorization (PA)

E0480, E0481, and E0483– See HCPCS manual for code description

Approval Criteria

Initial Coverage:

A **high frequency chest wall oscillation device** is considered medically necessary when **ALL** of the following criteria are met:

1. The member has **ONE** of the following:
   a. A documented diagnosis of cystic fibrosis; **OR**
   b. A diagnosis of bronchiectasis confirmed by a high resolution or spiral CT scan or ciliary dyskinesia **AND** is characterized by **ONE** of the following:

1) Daily productive cough of 6 month continuous duration; **OR**
2) Frequent (>2 per year) pulmonary exacerbation episodes that require IV antibiotic and/or steroid therapy; **OR**

c. Is within the first 6 months post lung transplant and unable to tolerate standard chest physiotherapy; **OR**
d. A documented diagnosis of one of the following neuromuscular disease processes resulting in inability to clear retained pulmonary secretions:
   1) Post-Poliomyelitis
   2) Acid Maltase Deficiency
   3) Anterior Horn Cell disease
   4) Multiple Sclerosis
   5) Quadriplegia
   6) Hereditary Muscular Dystrophy
   7) Myotonic Disorder
   8) Other Myopathies
   9) Paralysis of the diaphragm
   10) Severe developmental disability resulting in retained, thick mucus secretions
   11) Cranial devastation, e.g., tumor, CVA, etc., that results in flaccid or spastic body function; **AND**

2. Documentation of alternative therapy (e.g., daily percussion and postural drainage, autologous drainage, positive end expiratory pressure, and/or flutter link device) as ineffective, not tolerated, or contraindicated and/or caregiver is unable to provide effective chest percussion and postural drainage; **AND**
3. Submission of written treating provider orders specifying the frequency and duration of the chest treatments; **AND**
4. When indicated, submit hospital admit notes and/or orders of IV antibiotic therapy prescribed as a direct result of ineffective airway clearance.

Continued Rental Coverage:

For continued rental coverage, up to 13 months total, documentation must be submitted that confirms the device is still medically indicated, continues to be used by the member as prescribed by the treating provider, and continues to be effective at improving the lung function of the member.

Note: Multi-function respiratory therapy systems, e.g., Volara™ System are not covered. Services considered experimental or investigational are not covered.

References

1. Oklahoma Health Care Authority Policy OAC 317:30-3-1; 30-5-Part 17 Medical Suppliers
2. Aetna, Clinical Policy Bulletin No. 0067, Chest Physiotherapy and Airway Clearance Devices, 03/15/2022.
3. Wellmark BCBS, Medical policy 01.01.01, Airway Clearance Devices, January 2022.
4. CMS LCD 33785 High Frequency Chest Wall Oscillation Devices, revised 1/1/2020
5. Florida BCBS Coverage Guideline, Subject: Oscillatory Devices Used in the Home for the Treatment of Cystic Fibrosis and Other Respiratory Disorders, revised 4/15/2022.