

OHCA Guideline

Medical Procedure Class:	Cough Assist Device
Initial Implementation Date:	3/28/2017
Last Review Date:	2/12/2021
Effective Date:	3/1/2021
Next Review/Revision Date:	March 2024
* This document is not a contract, and these guidelines do not reflect or represent every conceivable 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.	
<input type="checkbox"/> New Criteria <input checked="" type="checkbox"/> Revision of Existing Criteria	
Summary	
Purpose:	To provide guidelines to assure medical necessity and consistency in the prior authorization process.
Definitions	
<p>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.</p> <p>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.</p>	
Description	
<p>Cough Assist Device – Device that assists in clearing secretions by gradually applying a positive pressure to the airway and then shifting to a negative pressure therefore producing a high outward flow of air which stimulates a natural cough. This therapy can be effective for people who have an ineffective ability to cough. This therapy may be used in conjunction with high frequency chest wall oscillation.</p>	
HCPCS Codes Covered Requiring Prior Authorization (PA)	
E0482 – See HCPCS manual for code description	
Approval Criteria	
<u>Initial Coverage:</u>	
<p>A cough assist device is considered medically necessary when <u>ALL</u> of the following criteria are met:</p> <ol style="list-style-type: none"> 1. The member has <u>ONE</u> of the following: <ol style="list-style-type: none"> a. A documented diagnosis of cystic fibrosis; <u>OR</u> b. A diagnosis of bronchiectasis confirmed by a high resolution or spiral CT scan, or ciliary dyskinesia <u>AND</u> is characterized by <u>ONE</u> of the following: <ol style="list-style-type: none"> 1) Daily productive cough of 6 month continuous duration; <u>OR</u> 	

- 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 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 the inability to manage thick mucus;
 - 11) Cranial devastation, e.g., tumor, CVA, etc., that results in flaccid or spastic body functions; **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 pulmonary 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.

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, 3/20/2020.
- 3. Wellmark BCBS, Medical policy 01.01.01, Airway Clearance Devices, January 2021.