High Frequency Chest Wall Oscillation Devices

For any item to be covered by The Health Plan, it must:

1. Be eligible for a defined Medicare or The Health Plan benefit category
2. Be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
3. Meet all other applicable Medicare and/or The Health Plan statutory and regulatory requirements

For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity. *Please refer to individual product lines certificates of coverage for possible exclusions of benefit.*

For an item to be covered by The Health Plan, the supplier must receive a written, signed, and dated order before a claim is submitted to The Health Plan. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

Suppliers are to follow The Health Plan requirements for precertification as applicable.

High frequency chest wall oscillation devices require precertification and a physician's face-to-face.

National Coverage Determination Policy	None
Local Coverage Determination Policy	J- B/C
Effective Date	For services performed on or after 10/31/13
Revision/ Review Date	01/19, 12/18, 06/04/2018, 01/01/2016
The Health Plan	Plans will follow Coverage Determination posted on the CGS website unless otherwise indicated in sections of this policy, contractual agreements, or benefit plan documents.

DESCRIPTION

A high frequency chest wall oscillation device (HFCWO) is an airway clearance device consisting of an inflatable vest connected by tubes to a small air-pulse generator.

COVERAGE GUIDELINES

HFCWO (E0483) are covered for patients who meet:

A. Criteria 1, 2 or 3, and
B. Criterion 4
    1. There is a diagnosis of cystic fibrosis
    2. There is a diagnosis of bronchiectasis, which has been confirmed by a high resolution, spiral, or standard CT scan and which is characterized by:
        a. Daily productive cough for at least six continuous months; or
        b. Frequent (i.e., more than two times a year) exacerbations requiring antibiotic therapy.
        NOTE: Chronic bronchitis and COPD in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion.
    3. The patient has one of the following neuromuscular disease diagnoses:
        - Post-polio
        - Acid maltase deficiency
        - Anterior horn cell diseases
        - Multiple sclerosis
        - Quadriplegia
        - Hereditary muscular dystrophy
        - Myotonic disorders
        - Other myopathies
        - Paralysis of the diaphragm
    4. There must be well documented failure of standard treatments to adequately mobilize retained secretions.

If all of the criteria are not met, the claim will be denied as not reasonable and necessary.

Replacement supplies, A7025 and A7026, used with patient owned equipment, are covered if the patient meets the criteria listed above for the base device, E0483. If these criteria are not met claims will be denied.

NONCOVERAGE STATEMENT

It is not reasonable and necessary for a patient to use both an HFCWO device and a mechanical inexsufflation device (E0482).

REPAIR, REPLACEMENT, AND REASONABLE USEFUL LIFETIME

Device is in the capped rental category- during the rental period repairs and replacements are not separately reimbursable.

CODING INFORMATION

CPT/HCPCS codes: The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS

EY	NO PHYSICIAN OR OTHER LICENSED HEALTH CARE PROVIDER ORDER FOR THIS ITEM OR SERVICE
GA	WAIVER OF LIABILITY STATEMENT ON FILE, ISSUED AS REQUIRED BY PAYOR POLICY, INDIVIDUAL CASE
GZ	ITEM OR SERVICE EXPECTED TO BE DENIED AS NOT REASONABLE AND NECESSARY
KX	REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET

HCPCS CODES

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
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM, INCLUDES ALL ACCESSORIES AND SUPPLIES, EACH

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY

The presence of an ICD-10 code listed in this section is not sufficient by itself to assure coverage. Refer to coverage guidelines and documentation requirement sections for further information.

ICD-10 CODES

A15.0	**Tuberculosis of lung**
B91	Sequelae of poliomyelitis
D81.810	Biotinidase deficiency
D84.1	Defects in the complement system
E84.0	Cystic fibrosis with pulmonary manifestations
E84.9	Cystic fibrosis, unspecified
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.20	Motor neuron disease, unspecified

G12.21	Amyotrophic lateral sclerosis
G12.22	Progressive bulbar palsy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G35	Multiple sclerosis
G71.0	Muscular dystrophy
G71.11	Myotonic muscular dystrophy
G71.12	Myotonia congenita
G71.13	Myotonic chondrodystrophy
G71.14	Drug induced myotonia
G71.19	Other specified myotonic disorders
G71.2	Congenital myopathies
G71.3	Mitochondrial myopathy, not elsewhere classified
G71.8	Other primary disorders of muscles
G72.0	Drug-induced myopathy
G72.1	Alcoholic myopathy
G72.2	Myopathy due to other toxic agents
G72.89	Other specified myopathies
G73.7	Myopathy in diseases classified elsewhere
G82.50	Quadriplegia, unspecified
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
J47.0	Bronchiectasis with acute lower respiratory infection
J47.1	Bronchiectasis with (acute) exacerbation
J47.9	Bronchiectasis, uncomplicated
J98.6	Disorders of diaphragm

M33.02	Juvenile dermatopolymyositis with myopathy
M33.12	Other dermatopolymyositis with myopathy
M33.22	Polymyositis with myopathy
M33.92	Dermatopolymyositis, unspecified with myopathy
M34.82	Systemic sclerosis with myopathy
M35.03	Sicca syndrome with myopathy
Q33.4	Congenital bronchiectasis

Diagnoses and ICD-10 codes that either support or do not support medical necessity are indicated above.

DOCUMENTATION REQUIREMENTS

For the purposes of this policy, it is expected that the medical record will support the need for the care provided. It is generally understood that the medical record includes the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports.

This documentation must be available with precertification.

Medicare has made changes to its requirements for dispensing orders, detailed written orders, and proof of delivery. The Health Plan will require the following:

1. Physician detailed written order. Order must include the following:
    a. Member's name
    b. Date
    c. Description of item. The medical record must contain the information that supports the request for each item and must be submitted with the precertification, if the item requires precertification, or with the claim, if no precertification was required
    d. Order must include diagnosis code
    e. Physician signature with date. Date stamps are not appropriate
    f. Quantity of items required and duration. A new order is required if there is an increase in the quantity of the supply used per month and/or the type of supply used

    The supplier is to contact The Health Plan in this instance to update referral

2. There must be documentation in the supplier's records to support the medical necessity of that item. This information must be available upon request, usually with precertification per The Health Plan policy.

3. Proof of delivery to be kept on file by the provider of the item.

    Note: If templates or forms are submitted, (i.e., a Medicare Certificate of Medical Necessity, and/or a provider created form), The Health Plan reserves the right to request the medical

record, that may include, but not limited to, the physician office notes, hospital and nursing facility records, and home health records.

Note: Template provider forms, prescriptions, and attestation letters are not considered part of the medical record, even if signed by the ordering physician.

Precertification is required when supplies used are greater than the usual maximum quantity listed in above. There must be adequate, clear documentation in the medical record corroborating the medical necessity of this amount. This documentation is to be submitted with precertification.

ITEM PROVIDED WHILE MEMBER IN COVERED PART A FACILITY

Reimbursement for a **HFCWO** provided to a member while the member is covered in a Part A facility is based on specific contract information with the individual facility, and whether or not the device is intended for use while the member is in the facility.

Payment for the **HFCWO** is included in the payment to a hospital or inpatient rehab if:

1. The **HFCWO** is provided to a patient during an inpatient hospital stay prior to the day of discharge; and
2. The patient uses the **HFCWO** for medically necessary inpatient treatment or rehabilitation.

Reimbursement for the **HFCWO** provided while a member is in a skilled nursing facility (SNF) receiving Part A services, will be reimbursed according to the facilities contract.

EQUIPMENT RETAINED FROM A PRIOR PAYOR:

The Health Plan will not pay in excess of the contracted purchase price for any item in this policy. If the provider is seeking payment from The Health Plan, the item must be precerted and The Health Plan will pay the remaining rental months up to purchase price- if member meets guidelines above.

KX, GA, and GZ MODIFIERS

Suppliers may submit a claim with a KX modifier only if all the criteria for that item is met.

If coverage criteria are not met, the GA or GZ modifier must be used. When there is an expectation of a medical denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier, if they have not obtained a valid ABN.

ADVANCED BENEFICIARY NOTICE

The Health Plan expects providers to follow the Medicare policy on ABN across all Medicare, Medicaid, and Commercial plans.

NOTE: Providers may be held financially responsible if they furnish the above items without notifying the member, verbally and in writing, that the specific service being provided is not covered. This must be done prior to the dispensing of the device. The provider must submit the waiver or ABN to The Health Plan with the claim showing the member agreed to pay for the device. Generalized statements on waivers or ABN are not acceptable.

PRICING, DATA ANALYSIS, AND CODING (PDAC)

The Health Plan has implemented use of Medicare's PDAC contractor for review of authorizations. Suppliers should contact the PDAC contractor for guidance on the correct coding of these items. dmepdac.com/

AMA CPT/ADA CDT COPYRIGHT STATEMENT

INTERNET LINKS AND SOURCES

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